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TREATMENT OF MASOCHISTIC DYNAMICS IN THE CHARACTER DISORDERS: THE VICTIM-AGGRESSOR INTROJECT

A Dissertation Presented

By

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ABSTRACT

Treatment of Masochistic Dynamics
in the Character Disorders:
The Victim-Aggressor Introject

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This work is a theoretical exploration of the functions and meanings of masochism across individuals with varying character pathology. Aspects of moral masochism are viewed from a psychoanalytic, object relations perspective. An historical overview of psychoanalytic writings on moral masochism is provided and advances in object relations theory are outlined, with emphasis on how the nature of one's early experiences can evolve into an internal sense of self in relation to others. From this perspective, the inner world of the moral masochist may be seen as featuring an ongoing tension between self/other as victim or aggressor. A theoretical contruct of the victim-aggressor introject is introduced as a means of conceptualizing masochistic dynamics as they unfold in the treatment setting.

An in-depth qualitative analysis of masochistic dynamics was obtained through a study of verbatim transcripts of the long-term psychoanalytically-oriented psychotherapies of three patients with moral masochistic features. The cases are presented and discussed in terms of the functions and meaning of their masochistic features, particularly in the context of their specific character pathology (i.e.: borderline, narcissistic). Special emphasis is placed on how the victim-aggressor introject was externalized and manifested in the patient-therapist

relationship.

A central conclusion of this investigation is that masochism is a complex and multi-determined phenomenon, serving a variety of functions within and across individuals, and conforming to the unique structural organization and developmental level of the individual. Although the cases differ in terms of character pathology, certain commonalities are noted: 1) early object relationships were characterized by closeness in association with suffering; 2) there was significant emotional deprivation in childhood, such that the need for closeness was intense enough to warrant an acceptance of suffering along with it; 3) rageful and self-destructive affects co-existed and were split into polar dyads, with one affect being projected while the other was experienced internally.

TABLE OF CONTENTS

CHAPTER I

CHANGING CONCEPTUALIZATIONS OF MASOCHISM IN PSYCHOANALYSIS: AN HISTORICAL OVERVIEW

Masochism is a term which has had many meanings throughout the decades, making a conceptualization of a masochistic character quite challenging for diagnosticians. It is possible that masochism will never be embodied in one definable disorder, since it appears to be a complex and multiply determined phenomenon which exists across a wide range of diagnostic categories and severities of psychopathology.

This work aims to shed some light on the question of how masochistic character traits can best be understood in the context of our current diagnostic system. More specifically, is it most useful to view masochistic character as a personality disorder, with a unique set of behavioral traits and a specific structural organization? Or, in contrast, does the masochistic character differ according to the unique structural organization, ego strengths and specific symptoms of the individual patient? In addition to these considerations of how masochistic dynamics intermingle with other pathologies, there are the specific questions, which have been debated for years now, as to what masochistic dynamics reflect in terms of intrapsychic conflict and developmental impairment. All these questions have important implications for the treatment of individuals with masochistic features. Developing a model of understanding and treating masochistic dynamics as they occur in the psychotherapy relationship will be a focus of this dissertation. As a first step in achieving these goals, the various conceptualizations of masochism throughout psychiatric history will be reviewed in this chapter.

Early Conceptualizations

Masochism as Sexual Perversion

It was Krafft-Ebing who, in 1896, introduced the term masochism in his writings on sexual perversions. He derived the name from a contemporary novelist named Masoch whose current book featured a character who allowed himself to be humiliated and tortured by a woman friend. Freud quickly became interested in the concept of masochism as he was developing his theory of libidinal drives and infantile sexuality. In his ground breaking "Three contributions to the theory of sex", Freud (1905/1962) carefully studies sexual abberations and makes connections between them and the psychoneuroses. He hypothesizes that a sexual perversion is the expression of an unconscious infantile sexual impulse whose object and/or aim has become distorted or misdirected due to psychic inhibitions fueled by guilt and shame. Although he acknowledges the complexity of masochism, viewing it as a "union of many motives" (p. 26), his understanding of masochistic pathology exists within the confines of his drive theory. He views the perversions, masochism being one of them, as fixations or regressions to infantile sexuality, or as "fragment[s] of inhibited development and infantilism" (p. 87). In addition, Freud asserts that masochism and sadism are intricately connected, as contrasting pairs, with sadism perhaps being the primary form:

> ...it can often be recognized that masochism is nothing but a continuation of sadism directed against one's own person in which the latter at first takes the place of the sexual object...a sadist is simultaneously a masochist, though either the active or the passive side of the perversion may be more strongly developed and thus represent his preponderate sexual activity. (pp. 22-23)

In order to more fully understand the neuroses and perversions, Freud turned to the study of the sexuality of children so as to "follow the play of influences which control the process of development of the infantile sexuality up to its termination in a perversion, a neurosis, or a normal sexual life" (p. 34).

Following his path of study of childhood sexuality in "On the Sexual Theories of Children", Freud (1908/1924) hypothesizes that the child perceives intercourse as a violent or sadistic act, the victim being the woman, who is assumed to be in the passive position. He furthers this link between active-passive and sadism-masochism in his paper "Instincts and their Vicissitudes" in which he continues the assertion that masochism is a distortion of a primary sadism, through a "reversal into its opposite" or a "turning round upon the subject" (Freud, 1915/1957, p. 77). Intolerable aggression directed at the object is redirected toward the self, and active (sadistic) aims are transformed into passive (masochistic) ones.

Masochism and Oedipal Strivings

Using these fundamental notions about the mechanics of repressive forces acting on instinctual aims, Freud (1919/1955) integrated them into an important paper on the etiology and dynamics of masochism. Its title, "A Child is Being Beaten", signifies the masturbatory fantasies of several of Freud's female analysands. A thorough reconstruction and analysis of his patients' masochistic fantasies revealed several key transformations in the fantasy material. Originating as a nonsexual fantasy of father beating a sibling, it transformed into the often repressed libidinal fantasy of father beating the subject, and then into a more consciously sexualized (and tolerable) masturbatory fantasy of children, often boys, being beaten by an authority figure.

Freud traces the origins of the fantasy to the girl's incestuous wishes for the father, which stir up the first sadistic version: fueled by longing and envy, it expresses the wish that the father favors the subject over the sibling. Guilt and repression cause the reversal of subject for object and the beating fantasy, in its second version, is now masochistic in nature. However, the fantasy is not only an atonement for incestuous wishes, but serves as a regressive substitute for the incestuous wish itself: libidinal aims have gained expression at a pregenital, anal-sadistic level of organization. This is an important concept, for it speaks to Freud's early appreciation of the complexity and overdetermined nature of masochistic dynamics. The final version of the fantasy is the least threatening one, and it emerges into consciousness as a masturbatory fantasy. This fantasy is sadistic in form, but it is actually a reworking of the masochistic beating fantasy preceding it: the children pictured by the patient are substitutes for the self and the sexualized quality of the fantasy is derived from the patient's identification with them.

Metapsychological and Diagnostic Elaborations

Adding both clarity and complexity to his ideas on masochism in "The Economic Problem of Masochism", Freud (1924) addresses broad issues such as the definition and nature of the phenomenon. Elaborating on the notion of a death instinct, which he proposed in "Beyond the Pleasure Principle" (1920/1955), Freud asserts that the origins of masochism can be both primary (death instinct) and secondary (sadism directed toward self). In addition, Freud delineates three categories of masochism: erotogenic (the original sexual perversions), feminine (now associated with women) and moral (self-induced emotional suffering). It is

important to note that he remains committed to drive theory in his elaborations of these three variations, asserting that the "lust for pain" characteristic of erotogenic masochism is "found at [the] bottom in the other forms" (p. 258). A further development in this paper is the attachment of structural importance to masochism and sadism through a viewing of them as components of id, ego or superego processes. For example, Freud explains the motivating force behind moral masochism in terms of the resexualization of the superego, whereby the bringing of suffering and misfortune onto oneself in life, as an expression of guilt and the subsequent need for atonement (a superego function), is also instinctually gratifying. This elaboration of masochism as a structural component was an important one, paving the way for future work on the multiple functions of masochistic behaviors apart from their signifying libidinal expression.

Feminine Masochism

With the introduction of the concept of feminine masochism in his 1924 paper, Freud was making a link between passive (masochistic) aims and the development of the feminine identity. (At the time, he was not using the term feminine masochism to connote masochism characteristic of women, but was instead making the connection between passivity and femininity.) As he asserts in the paper, men who have elaborated sexual fantasies of a self-punishing nature usually imagine themselves in a feminine position, such as through thoughts of castration, giving birth, or taking the submissive position in intercourse.

However, in his subsequent writings on feminine identity formation Freud (1925, 1931, 1933), suggests that the growth of a feminine identity is spurred on by passivity and a sense of inferiority.

Specifically, in early development, the girl must change both her primary love-object and her erotogenic zone. According to Freud, the realization that she is without a penis is what provides the impetus for the girl to experience the Oedipus complex and relinquish her masculine sexual emphasis for a feminine one. Femininity, in Freud's eyes, is the abdication of the male, superior role and its replacement with the sexual longing for a male instead. This abdication of masculinity is seen as the relinquishing of an active stance and the taking on of a passive one. Freud (1931/1974) quotes Deutsch as stating that, "the girl's turning toward her father takes place via her passive trends" (p. 69).

Masochism, along with narcissism and insufficient superego development, are features that Freud connects to femininity as a result of its having evolved through the acceptance of passivity and inferiority. Influenced by Freud, Bonaparte, in her 1934 paper, "Passivity, masochism and femininity", views masochism as the woman's natural response to her perceived castration and her childhood perception of intercourse as a sadistic attack on the woman. Bonaparte utilizes some of Melanie Klein's early studies on the primitive fantasies of children, and elaborates on the anal-sadistic fantasies of children who have witnessed the primal scene. Bonaparte also links masochistic trends to the pain inherent in menstruation, defloration, pregnancy and child birth (1934/1974, p. 280).

Reactions to Freud

In the fifty years after Freud's original ideas on masochism, there has been a wide range of theoretical speculation as to the definition,

functions, etiology and treatment of masochism. In general, there has been a movement away from the view of masochism as being deeply embedded in instinctual strivings, and toward a recognition of the environmental forces which may influence the development of self-destructive trends in an individual. Object relational and ego psychological outlooks have encouraged more dynamic formulations of masochism as existing within the context of early, important relationships and serving some sort of defensive and adaptive purpose. Likewise, there has been a thorough reworking of the concept of female identity formation and its relation to masochistic and passive trends in women. The scope of these reactions is far reaching, and a general overview will concentrate on those pieces of work most relevant to later discussion.

Masochism and Feminine Identity Development

Since Freud's later papers relating masochism to the woman's notion of herself, by virtue of her anatomy, as castrated and inferior, a host of papers have supported a more sociocultural interpretation of masochism in women. One of the first proponents of such a view was Horney (1934/1973) who sees masochistic dynamics in women as complex, multidetermined phenomena which "must be considered as importantly conditioned by the culture complex or social organization in which the particular masochistic woman has developed" (p. 38). Calling for anthropological studies of masochistic traits in women, Horney questions the origin and frequency of occurrence of the masochistic features Bonaparte described.

In a response to Bonaparte's (1934) paper on female masochism, Person (1974) is in agreement with Horney that masochism is not the inevitable result of perceived anatomical distinctions but is a response

to social conditions. Person challenges Bonaparte's view that masochism is a gender component specific to femininity and suggests that both men and women are masochistic to certain degrees, but express it in different areas of their life. She suggests that female masochism is not instinctual but is an adaptive response to the dependent and inferior role that women have taken in a patriarchal society. She states that, "as long as woman's status is dependent, masochistic tendencies will be promoted as interpersonal coping devices" (Person, p. 294).

Although not abandoning Freud's instinctually based notions of the development of feminine masochism, Blum (1976) deemphasizes the biological components in his detailed analysis of the origins and nature of masochism in women. Blum believes that penis envy, castration anxiety and the female Oedipus complex do exist, but that these responses can be both facilitative and detrimental to the development of a female identity. As he states:

> Masochism is a residue of unresolved infantile conflict and is neither essentially feminine nor a valuable component of mature female function and character... Femininity evolves under the influence of parents and culture, with unique developmental challenges and transformations, and a universal psychobiological core linked to functions and roles that should be neither idealized nor devalued. (pp. 188-189)

Striving to maintain a connection to the mother, according to Blum, fosters superego development and the internalization of the mother's values and desires in the construct of an ego ideal. Masochism can be understood in the context of conflicts arising from the daughter's attempts to preserve an ego ideal even if it means tolerating discomfort or deprivation: loss of the valued maternal caregiver is the child's worst fear and maladaptive (masochistic) behavior will appear in the service of maintaining that object tie.

Masochism and Early Childhood Relationships

Blum's object relational emphasis is one which, in various forms, had already been applied to the understanding of masochism. Berliner (1940, 1947) was one of the first theorists to challenge Freud's oedipal/drive notion of masochistic character formation and to place it in the context of preoedipal object relationships. He views the masochistic response in childhood as a means of adapting to a hostile, unloving parent. In such situations, Berliner reasons that the child often has to repress his or her hatred of the depriving parent, since hate would lead to the loss of this caretaker. Instead, he explains:

> Not being capable of hating successfully he will submit and feel guilty and accept the hatred as if it were love. Thus he suffers for the sake of the love of those persons who hate or reject him, so that the object need not be abandoned. (1940, p. 326)

Individuals carry this masochistic inability to distinguish between hostile and nurturant caregiving into their adult relationships, again in an effort to ensure that their needs are met. Identity formation is organized around being what Berliner calls a "hate object", instead of a love object, in order to meet the desires of the parent.

Menaker (1953) also views the masochist's pursuit of punishment, and the formation of an identity as unlovable, in terms of an adaptive defense reaction to inadequate early caretaking. Linking nurturant parenting with the child's positive affirmation of the developing ego functions, Menaker asserts that a lack of adequate caretaking can lead to self-loathing and a resultant overdependence on the mother, "since the self can no longer be regarded as a source of pleasure" (p. 209). Therefore, maintaining of ties to the caretaker feels essential to the growing child's survival, and the perpetuating of oneself as unlovable

becomes an integral part of the preservation of this object relationship. Menaker sees the development of a masochistic self concept to be a primitive ego defense in response to maternal deprivation occurring on an oral level, at a time when the ego functions are quite weak. In fact, Menaker explains that, at this primitive level of ego development, a masochistic self-conception may be one of the more adaptive means of establishing an identity apart from the mother, and, thus, defending against psychosis.

Whereas theorists such as Berliner, Menaker, Bromberg (1955) and Panken (1967, 1983) have discussed the defensive aspects of masochism in terms of preserving an object tie, others have speculated about different defensive functions of masochistic character pathology. Eidelberg (1934, 1958), for example, points out that by provoking punishment, the masochist seeks to gain control over the parent and sustains a sense of omnipotence instead of narcissistic vulnerability. Reik (1939, 1941) coined the phrase "victory through defeat" in his discussion of the unconsciously aggressive, provocative and exhibitionistic qualities of the masochistic character (Brenner, 1959, p. 202).

Masochism and other Character Traits

Masochistic features have been evident across a wide variety of pathologies, and papers have been written associating it with obsessional neuroses (Fenichel, 1945; Bloch, 1965); depression (Caston, 1984); paranoia (Bak, 1946) and narcissism. This discussion will be limited to the writings on narcissism and masochistic character pathology. In addition to Eidelberg's thoughts on the connection between narcissistic vulnerability and masochism, there have been several other

theorists who have linked narcissistic components of character structure with the formation of masochistic features (Bernstein, 1957). An American Psychoanalytic Association Panel discussion (Cooper, 1981) was the springboard for several of these theories, which, in general, placed the development of masochism at a preoedipal level and saw oedipal masochistic trends such as those described by Freud (1919/1955) as being a reworking of earlier impairments. In the panel, Cooper speaks of the role of painful bodily sensations in aiding body and self-image formation. He hypothesizes that borderline and narcissistically vulnerable individuals may seek pain in order to increase boundary differentiation and to gain mastery over the narcissistic injuries inherent in the separation-individuation process. Whereas this type of patient may present as narcissistically vain or masochistically depressed, Cooper points out that underneath the surface is:

> a deadened capacity to feel, muted pleasure, a hypersensitive self-esteem alternating between grandiosity and humiliation, an inability to sustain or derive satisfaction from their relationships or their work, a constant sense of envy, and unshakable conviction of being wronged and deprived by those who are supposed to care for them, and an infinite capacity for provocation. (p. 677)

Glenn concurs with the thrust of Cooper's thesis and suggests that early childhood trauma of a narcissistically wounding nature is often connected with the development of masochistic character traits (Cooper 1981; Glenn, 1984). It is interesting that many of the cases presented in this American Psychoanalytic Association Panel had symbiotic attachments to a parent who was needy and not well differentiated from the infant child. For these patients, masochistic fantasies in adult life serve the purpose of counteracting the deadness experienced at

times of vulnerability by increasing self-cohesion through bodily pain and through the fantasy of a merger with an omnipotent (dominating) object (Cooper, 1981). These discussions/papers are noteworthy in their attempts to understand the functions of masochistic dynamics and symptoms at a particular level of structural organization, and in the context of a specific set of developmental (i.e., narcissistic) deficits.

Masochism as a Complex and Multidetermined Phenomenon

The fact that masochistic traits have been manifested across a range of psychopathology and character types has led to much confusion as to whether masochism is a singular phenomenon, with the possibility of agreement as to causation or even definition. Undeniably, there is a selection of individuals who may be grouped under the heading of moral masochists, as suggested by Horney when she stated:

> One feels justified in using the same term for widely discrepant manifestations because all of them have some trends in common: tendencies to arrange in fantasies, dreams, or in the real world, situations that imply suffering; or to feel suffering in situations that would not have this concomitant for the average person. (Horney, 1934/1973, p. 31)

However, the widely discrepant means by which masochism manifests itself is also open to debate. For example, Freud (1924), although grouping masochistic phenomena together through their roots in the death instinct, acknowledges that masochism can be expressed in a variety of ways according to the particular point of libidinal fixation. At an oral level of libidinal organization, fantasies/fears will center around themes of being devoured; at an anal level, beating fantasies and affects of humiliation and shame will preside; phallic masochism will be

manifested through castration fears/wishes; and at a genital level, "feminine" fantasies (submission, painful birth) are characteristic.

Recognizing that masochism is evident in various diagnostic configurations, Hoch (1959) asserts that an evaluation of masochism must occur in the context of the particular diagnostic framework in which it exists. He lights on a key issue in his comment:

> Masochistic manifestations in a psychopath are not the same as masochistic manisfestations in a depression; even more disparate is masochistic symptomatology in neurotics versus that seen in pseudoneurotic schizophrenics. The fundamental question is: do we have a psychopathologic entity which can be explained dynamically in a similar way in all persons, or merely phenomenologically similar features in which the causation is not the same? (p. 42).

Hoch maintains that the causes of masochism are indeed different across types of psychopathology. He contrasts the need for punishment in the neuroses with the need to ground oneself in reality through the sensory experience of pain or distress, which is characteristic of the more severely disturbed patient such as the pseudoneurotic schizophrenic (this term was a forerunner of the borderline and schizotypal diagnoses).

In disagreement with Hoch, Eisenbud (1967) believes that masochistic phenomena express similar causality even across diagnostic categories. She suggests that there is a functional unity in all masochistic striving, but the people, of course, are different: there are "diverse stages of development, identifications and environment that are embedded in the personality when we meet it. A diversity of striving at different developmental levels can have unity of ego functions" (p. 7). The ego function she is referring to is the adaptation to traumatic

loss of efficacy; reacting to the traumatic thwarting of a basic need in early development, the child's ego becomes overly dependent on the depriving parent and seeks to repeat the original traumatic struggle with the adaptive aim of mastery over the situation.

This notion of masochism as an ego adaptive response to a depriving parent is one shared by Menaker and Berliner, as has been noted. Even if there is a universal causality, however, attention needs to be directed toward the vastly different means of expressing an ego function. Quality of the ego functions will vary across levels of psychopathology, as will the level of libidinal organization and the unique interplay between basic components of the character structure.

In her theoretical and clinical paper on moral masochism, Brenman (1952) addresses the complexity of the phenomenon and cautions against attaching a singular significance to it as an instinctual, ego or superego related component. She sees masochism as:

> highly complex sets of configurations which issue from special varieties of infantile need and rage being pitted against a variety of mediating mechanisms and in interplay with the available creative or adaptive ego functions, whether these be humor, aesthetic talent or whatever. (pp. 272-273)

Essentially, Brenman advocates a detailed analysis of the interplay between drives, defenses and adaptive ego functions in the masochistic patient, with attention given to both identifying conflicts and assessing the developmental strengths and weaknesses of the character structure. Brenman's consideration of overall character structure and developmental level is highly relevant to the thesis of this paper. Breaking down the structural components of her "motivational hierarchy" of masochistic character pathology, Brenman identifies the masochistic

drives as unmeetable demands for love (along with a disposition to anxiety) and the subsequent rage when needs are not met. Masochistic symptoms will often express both the demand for love and the hostility over unmet needs, as self-destructive and suicidal gestures often illustrate. In terms of defenses, Brenman sees denial, reaction formation, introjection and projective mechanisms as common in masochistic dynamics and stresses that the strength of these defenses will vary, as will the particular combinations and forms which the defenses take. She points out that when ego functions fail, usually precipitated by threat of object loss, the drive components of need and rage emerge into the forefront of the character pathology.

If the need for expiation due to superego-generated guilt is a universal phenomenon, then so is masochism, reasons Brenner (1959) in his paper on the masochistic character. In seeking to explain its universality further, Brenner looks to Freud's dual instinct theory: aggressive and erotic drives are both self-directed in the newborn. Given regression, this will happen to the adult as well. Asserting that masochism is ubiquitous, Brenner distinguishes between normal and pathological masochism by viewing the difference as a quantative, not qualitative, one. As Brenner puts forth, this:

> has the further effect of inclining one to think of infantile factors as increasing or diminishing the individual's tendency toward masochistic character formation rather than to try to discover or establish a "cause" in infancy for the development of masochistic phenomena in later life. (p. 209)

Most important to the thesis of this paper is Brenner's assertion that masochism is multiply determined and can exist across a wide range of diagnostic categories and character pathology. He is a supporter of

the economic view of intrapsychic dynamics, and makes reference to a metapsychological paper by Waelder in explaining that, "every psychic act may be viewed as a compromise between the various parts of the psychic apparatus" (p. 211). In agreement with Brenman about the complexity of masochism, Brenner goes on to state that masochistic phenomena will serve a variety of purposes in each individual, and will represent an interplay between id, ego and superego components of the intrapsychic structure. Challenging the simplicity of the object relations theorists who cite object loss as a motive for masochistic ego defenses (Menaker, 1953; Berliner, 1947), Brenner views masochism as stemming from infantile sexual conflicts which can be centered around a variety of feared losses: object loss, loss of love, castration fears, other superego fears, "but the importance of each of these dangers as a motive for defense will vary from one masochistic patient to another" (1959, p. 225).

Summary and Directions for Future Inquiry

As has most certainly been illustrated in this brief review of the vast literature on masochism, which has spanned the twentieth century to date, there is a wide range of definitions, uses of the concept, as well as ideas as to the etiology and genesis of masochism. Freud saw masochism as an instinctual, oedipal phenomenon which had at its base the physiological notion that infants can respond to an increase in psychic tension with increased sexual stimulation, hence relating pain and pleasure. He also linked masochism with sadism (aggression turned toward the self), superego guilt and a regression to the anal-sadistic level of libidinal organization. Three types of masochism were outlined

in Freud's later works: erotogenic (perversions); feminine (linked with inferiority, passivity and castration); and moral (the substitution of moral suffering for the physical torture characteristic of the perversions). For the purposes of this paper, moral masochism will be concentrated on, with the assumption that erotogenic masochists are contained within this category. Although feminine masochism will not be the focus, the role of cultural factors in fostering masochism in women will certainly be addressed where relevant.

It should be apparent from the previous review that there are many uses and definitions of the term "masochism" throughout the literature. In his 1959 paper, Brenner offered what then became a popular definition, which read as follows:

> ...the seeking of unpleasure, by which is meant physical or mental pain, discomfort or wretchedness, for the sake of sexual pleasure, with the qualification that either the seeking or the pleasure or both may often be unconscious rather than conscious. (p. 197)

It is important to stress that most of the modern literature recognizes that the seeking of physical or emotional pain is a necessary precondition for pleasure, but is not, in itself, experienced as pleasurable. Whether in the form of physical pain, or emotional self-sabatoge, these masochistic strivings are not stimulating; more accurate is the notion that they are the pay toll at the gateway to something pleasurable. This assumption will be inherent in subsequent discussions in this paper.

If masochistic features are the price one has to pay for good returns, this leads one to ask such questions as why, and what intrapsychic mechanism or external situation has made pleasure so

costly. Whereas Freud pointed to guilt over forbidden sexual impulses, other theorists have looked elsewhere. In the literature review, masochism was viewed as a defensive reaction (Berliner, 1947; Menaker, 1953); a superego component (Freud, 1924; Reik, 1941); a cultural manifestation (Horney, 1935/1973; Person, 1974); and even a normal phenomenon (Brenner, 1959; DeMonchy, 1950). Masochistic features were often seen as functioning in the service of preventing loss, whether it be object loss (Menaker, 1953; Berliner, 1958); loss of self-esteem or body cohesion (Cooper, 1981; Stolorow, 1975) or feared loss of the genitals (Freud, 1924; Fenichel, 1945). Both Brenman and Brenner recognized the complexity of the phenomenon: masochism is evident across different severities of character pathology, it can serve a variety of purposes and it may be representative of an interplay between all three intrapsychic structures, as opposed to being an operative of either id, ego or superego components.

In the past several decades, great strides have been made in both the descriptive and psychoanalytic orientations to psychopathology (not that they are mutually exclusive). While object relations theory has advanced our understanding of the complexity of our inner worlds, and has clarified the intrapsychic/developmental deficits inherent in the severe psychopathologies, descriptive/empirical work has paved the way for revisions and additions to the personality disorders as defined in DSM III (American Psychological Association, 1980). Recently a move has been underway to define and include a masochistic personality in the revised DSM III, an effort which has met with great resistance from the feminist community (Irene Stiver, personal communication, December 31, 1985).

Given its complex and multidetermined nature, it would be unfortunate, on many levels, to harnass the phenomenon of masochism into the one-dimensional level of a descriptive personality disorder. Not only might it encourage the overlooking of the cultural influences on masochistic strivings in women, but it would discourage efforts to understand masochism in the context of the unique structural organization of the individual patient, who has specific developmental deficits, ego strengths and weaknesses and an internal perception of self in relation to others. A recognition of the complexity of masochism, utilizing an object relational, developmental outlook of psychopathology, will facilitate the treatment of the sadomasochistic aspects of character disordered patients.

In this current work, an understanding of the specific structural organization, developmental impairments, quality of object relations, and stability of the ego functions will be assessed in patients with masochistic features. The purposes, functions and genesis of the masochism in each patient will be made clearer through this evaluation, and will be viewed as distinctions that need to be made in order to design a treatment plan for the individual. The victim-aggressor introject, an internal model of sadomasochistic dynamics, will be introduced as an assessment tool for the therapist in determining the developmental and structural level of the patient and modifying the treatment approach so as to meet the needs, and address the limitations, of the specific individual.

CHAPTER II

ADVANCES IN OBJECT RELATIONS THEORY AND THEIR IMPACT ON THE TREATMENT OF CHARACTER PATHOLOGY

This chapter will begin with a brief review of the literature on the treatment of masochistic pathology since Freud's initial concept of negative therapeutic reaction, and will parallel the theoretical advances which were outlined in the first chapter. After the brief review, a more in-depth discussion of recent developments in object relations theory and their impact on the treatment of the character disorders will follow. This will lead to an explication of the object relational concept of the introject and an understanding of masochism in terms of the victim-aggressor introject.

Treatment of Masochism: An Historical Review

The first discussions of the treatment of masochism were pessimistic in tone. Freud (1924, 1937) writes about the tendency of some patients to worsen in symptomatology following correct therapeutic interventions by the analyst. He terms this a negative therapeutic reaction and links it to pervasive guilt feelings and the need for punishment to appease such guilt. When speaking about the treatment of masochism, Freud asserts that the negative therapeutic reaction is characterisitic of the masochistic character and that these patients have a poor prognosis in psychoanalysis due to their strong tendency to undermine the work. However, Freud adds that if the masochistic dynamics seem to stem from an identification with a masochistic parent, the prognosis is a more hopeful one.

Upholding the classical viewpoint, Brenner (1959) is nevertheless more optimistic than Freud regarding the treatment of masochistic character pathology. In fact, he argues that severity of masochism is not necessarily in direct correlation with poor prognosis. Brenner advocates preserving the analytic stance of seeking to understand the meaning of the masochistic dynamics rather than to enter into them. As he states:

> The approach to it should be to analyze it, in the same way in which one would analyze any other transference resistance in a patient with a character disorder; to direct the patient's attention to it as an object of analysis, to view it objectively oneself, to attempt to discover as much evidence as possible about its present role in the patient's unconscious mental life as a defense, as a means of gratification, as an expiation or punishment, etc., as well as evidence concerning its genesis, and finally to communicate to the patient one's conjectures as to its genesis and its present role in a suitable way and at an appropriate time. (p. 217)

In his seminal writings on psychoanalytic technique, Greenson (1967) acknowledges the tenacity of the resistances accompanying masochistic character pathology. Taking issue with Freud's concept of the death instinct, Greenson feels more comfortable with the notion of masochistic dynamics as repetitions of past relationships with the aim of achieving mastery over them. He goes on to state that " masochism, self-destructiveness, and the need for suffering can be best approached clinically as manifestations of aggression turned upon the self (p. 82). This aggression needs to be brought into the tranference, according to Greenson, who sees the insufficiently analyzed negative transference as the "most frequent cause of stalemated analyses" (p. 234). In addition, the analyst needs to appeal to the patient's reasonable ego in an effort

to have the patient face the anxiety underlying the masochistic resistances. In terms of the analyst's basic stance, Greenson advocates that the analyst "concern himself with the patient's need for self-esteem, self-respect and dignity" in order to counteract the patient's tendencies toward masochistic submission to the various aspects of the treatment (p. 214).

Theorists such as Menaker (1942), Eisenbud (1967), Berliner (1958), and Panken (1983), who see the genesis of masochism as emanating from a traumatic relationship with a depriving, often unloving, parent, are in basic agreement as to treatment approaches in psychotherapy. Like Greenson, these four object relations theorists emphasize the importance of the therapist's maintaining a nonthreatening, uncontrolling and warm stance. In their understanding of masochistic dynamics, the transference will evolve into one where the therapist takes on the attributes of the depriving parent of childhood. They feel this needs to be lessened rather than heightened in the transference.

As Berliner suggests, the goal of the therapist is not to become the sadistic parent but rather to help the patient to realize that his or her sense of defeat and hidden hostility are internalizations of the unacknowledged sadism of his early caregivers (Brenner, 1959). Berliner advocates a stance of "friendly understanding" and gentle interpretation of the patient's substitution of suffering for love, which is one part of the overall effort of mask the sadism of the parent.

Menaker concurs with Berliner and points out that the therapeutic setting, where the therapist makes the rules, is evocative of masochistic, dependent and passive trends in the patient. In order to balance this, the therapist needs to approach the patient in a human

manner, emphasizing warmth and friendliness. This will help to protect against the undermining negative transference reactions, and will provide the patient with, perhaps, the first relationship in which she or he has ever been an equal member.

Taking a slightly different slant, Eisenbud (1967) sees the goal of the therapy as restoring the patient's confidence and proving that a positive, loving relationship is possible and acceptable. In achieving these goals, Eisenbud feels that patients with masochistic trends often need to overpower the bad parent and she recommends that the therapist, through a nonconfrontative stance, allow this to occur in the transference.

Panken (1967, 1983), who was influenced by both Menaker and Berliner, feels that masochistic dynamics often exist alongside intense separation anxieties. If the patient were to become aware of the early oral deprivation he or she suffered, this would mean a loss of the caregiver, who is often defensively idealized. Therefore, the sadomasochistic transference relationship exists in order to avoid separation, and this needs to be interpreted. Goals of the treatment include the working through of both separation fears and the rage over the depriving caregiving in childhood. By presenting oneself as a caring and autonomous person, the therapeutic relationship will foster the development of permanent ego autonomy in the patient. In supporting the notion that a negative transference should not be exacerbated by either silence or antagonism through outright confrontation of the hostile aspects of the patient's presentation, Panken states:

> ...one need not view masochistic transference reactions with pessimism, gloom or with the notion that patients with such traits are unanalyzable ...it would seem particularly crucial here to keep

> one's cool, avoid defensiveness, and judgement, and simultaneously, remain aware of the multifaceted aspects of the masochistic syndrome. (1983, p. 159)

In contrast to the previous theorists, others advocate a more active interpretation of aspects of the masochistic presentation. For instance, many therapists have as a goal the patient's realization that their suffering is self-induced rather than their lot in life: unlike the past, they now have control over what happens to them. Thompson (1959) suggests that interpretations be made of the patient's suffering as hostile aggression and as attention-getting behavior. He also points out that empathy is shunned by the patient because it threatens the sadomasochistic relationship that is being preserved: again, he argues for this being brought into the open.

Reich (1933) and Bieber (1966) both write about masochistic acting out and suffering as attempts to bring on the lesser of evils and to defend against anticipation of harm, such as castration fears. They both recommend that this be actively interpreted in the treatment. In a similar vein, Eidelberg (1959) speaks of masochism as an attempt to gain magical control over the environment, and, again, the emphasis is on addressing the active role the patient takes in inviting suffering and misfortune.

Salzman (1959) views masochistic dynamics in the therapeutic relationship as a tug of war which the therapist needs to directly acknowledge. He argues against the classical approach, stating that it evokes masochistic defenses which are impenetrable. As he states:

> Since this kind of fencing is inherent in the masochistic process, it cannot and should not be avoided in the therapy. Instead, it should be put to constructive use by drawing the proper battle lines and not prolonging the tussle unnecessarily. For the therapist, the battle as a technique must be highlighted. (Salzman, 1959, p. 13)

In his extensive writings on borderline personality organization, Kernberg (1966, 1972, 1975) includes a masochistic character under the aegis of higher level borderline functioning. Although this will be elaborated on later, the present point is Kernberg's emphasis on confrontation of the negative transference, and the underlying oral aggression of the patient. He advocates an approach which emphasizes limit setting and inherent structure in the treatment in order to help contain the patient's rage in a manner so that it can be analyzed.

Advances in Object Relations Theory and our Understanding of Character Disorders

In understanding and treating masochistic character traits, there are several important constructs concerning the impact of external experience on internal mental structures which will be central to this work. One way of viewing masochistic character formation is through a perspective that focuses on the specific nature of the patient's internal representations of self and other. Specifically, due to early developmental failures and the particular nature of the attachments in childhood, an internal split occurs between the self and object representations of victim and aggressor. The masochistic individual places his or her perception of self in relation to others within this polar configuration: either the self is experienced as a victim in a harsh and threatening environment, or as a powerful, provocative victimizer of others who weaken under his or her influence. These self-other constructs are often unconscious, yet emerge in the transference. By becoming attuned to the nature of countertransference reactions, the therapist can often gain significant insight into the degree of polarity

in the victim-aggressor introject or the extreme nature of the perceptions. Used as an assessment tool, an analysis of the quality of the victim-aggressor introject, which is characteristic in the treatment of patients with sadistic and masochistic features, can shed light on the severity of the psychopathology of the patient.

Treatment approaches need to be modified to address the specific developmental limitations of the patient. However, general goals in the treatment of masochistic dynamics in character disordered patients can include an exploration of the nature of early attachments, and a challenging of the patient's perception of the world as filled with either victims or aggressors, in an effort to integrate this extreme self-other configuration.

This is the central thesis of this work: it comes out of recent advances made in the psychoanalytic studies of internal conceptions of self and other and from the body of work collectively known as object relations theory. While it would be impossible to review all the theoretical advances in this area in the past fifty or so years, a brief overview will be provided. Although Freud's weakness is often thought to be the lack of attention given to the impact of external relationships on internal relational constructions, Freud paved the way for advances in object relations theory through his writings on identification and ego splitting.

Building on Freud's foundation of internal mechanisms and psychic structures, Klein (1945/1975, 1946, 1975) focuses on the fantasy life of the child and on the internal structures through which events, affects and people are represented in the psyche. Concentrating on the psychological development of the infant, Klein refines the notion of ego

splitting to embrace the mechanism by which the infant, whose ego is weak, deals with positive and negative affects surrounding the all powerful maternal object. The maternal relationship is preserved by means of ego splitting and failure to integrate opposing affects; the mother who is hated for her failure to satiate the child's needs is kept separate from the mother who lovingly meets those needs.

As does Fairbairn (1943), Klein (1946) outlines certain normal developmental positions, namely the paranoid-schizoid and the depressive position. The paranoid-schizoid position is typified by the child's relation to individuals as part-objects (good mother versus bad mother); the splitting process is central to the maintaining of this process. In negotiating the depressive position, the child begins to relate to others as whole individuals; the process is accompanied by depressive anxiety, ambivalence and guilt (Segal, 1974).

The failure to achieve the depressive position and the predominance of oral-aggressive impulses are connected in important ways. At an oral level, one's needs are equated with a wish to devour the good object. When the young child is orally frustrated, the good object is split off and the bad, depriving object is in the child's awareness. Oral frustration has a destructive, rageful tone to it, and the child fears that he or she has annihilated the good object due to both the ragefulness, and the devouring quality of the neediness. This basic oral demandingness and its accompanying rage, in tandem with the developmental limitations of a pre-depressive position individual, can spark symptoms such as separation anxiety, annihilation anxiety and other regressive symptoms.

A central belief of many of these theorists is that inadequate caretaking or a trauma in the symbiotic and separation-individuation phases of normal child development can cause later character pathology, specifically having to do with difficulties around ambivalence and autonomy. Much of the work in the area of early developmental failures in separation and individuation is connected to studies of borderline pathology. Since an understanding of developmental impairments, and of the origin of splitting defenses as well as the nature of separation conflicts, will be relevant to our discussion of masochism across levels of character pathology, they will be discussed here in the context of borderline and other severe character formation.

Through their studies of the psychological processes of normal development in these early years, Mahler (1975) and Winnicott (1955/1958), along with Klein have had a major impact on our understanding of developmental impairments in severe character pathology. During the separation-individuation period, several changes occur. The child starts to develop a sense of self separate from that of the mother. If the parenting has been consistent and has been able to contain the child's aggression in a nonretaliative manner, the child begins to integrate good and bad images of the mother into a single, more ambivalent image (Winnicott, 1955/1958). This fosters a realization for the child that the mother is autonomous from him or her and is not changed by the child's impulses toward her.

Winnicott discusses this integration of good and bad images of the mother as the achievement of the depressive position, which brings with it the ability to distinguish inner from outer reality, the ability to hold an object constant over time and the beginnings of the capacity for

ambivalence, guilt and concern. The developmental deficits linked to borderline pathology in particular are similar to these deficits which are associated with the failure to reach the depressive position in emotional development.

In the latter subphases of separation-individuation, the child obtains a mastery of separation anxiety by becoming able to maintain an image of the mother in her absence. What was initially just an ability to recognize an object, like the mother, from other unfamiliar objects (recognition memory), is now an ability is recall the object without any visual cues (object constancy). Characteristic of this period is the child's vascillation between a desire for autonomy and a desire to regress to the dependence on the mother typical of the symbiotic period.

In describing this conflict between autonomy and dependence, Mahler writes about the child's pattern of darting away from the mother and then returning for "refueling" (Mahler, 1975). During this time, the child shows an increase in separation anxiety as well as a sense of helplessness, loneliness and a preoccupation with the mother's presence (Shapiro, 1978). The mother who fails to respond consistently and empathically to the child's moves toward autonomy, leads the child to feel that any move toward separation will result in an abandonment. Children who have trouble in this subphase often vascillate between clinging to their mothers and rejecting them in a hostile manner.

The use of a transitional object has been noted as common in normal development during the separation-individuation period (Winnicott, 1953/1971). A blanket or teddy bear becomes, to the child, an object partly representative of the mother and partly representative of the child. It is an object under the child's control, which can be both loved and

hated by him or her, and becomes an important intermediate between internal and external reality. The fact that the object does not change in accordance with the child's projections onto it provides a significant step toward the child's realization that the mother is not a reflection of the child's impulses, but is, in reality, separate. The transitional object also plays an important role in the achievement of object constancy; it is an external cue which evokes the comforting, soothing presence of the mother without her being available. However, the ability to evoke the memory of mother as a soother in her absence is dependent on the mother's continued and consistent availability to the child and cannot be achieved solely with the use of a transitional object.

Throughout the last two decades, Kernberg (1966, 1967, 1975), through his significant contributions to a psychoanalytic understanding of borderline and narcissistic personality, has furthered our understanding of early developmental impairments and their impact on internal self-other representations. Kernberg views borderline personality in object relational terms, as a level of organization which represents "a stable form of pathological ego structure" (1966, p. 280). As mentioned before, Kernberg sees the masochistic-dependent character as functioning on a borderline level of organization. By addressing what Kernberg sees as the pathological ego structure common to all borderlines, it is important to note that the patients he defines as functioning at a borderline level vary widely in terms of symptomotology and presenting complaints; his borderline category can include the hysterical, paranoid, hypomanic, schizoid, impulse-ridden along with the depressive-masochistic character types. He differentiates between them

in terms of severity of illness and respective prognosis, "according to the degree to which repressive mechanisms or splitting mechanisms predominate" (1975, p. 13).

Kernberg writes extensively about the splitting mechanisms of borderlines and finds them central to an understanding of structural organization. He looks to the separation individuation period as the beginning of pathological development for the borderline, narrowing it to occurring after a tentative self-object differentiation has been achieved but before the mastery of object constancy (Shapiro, 1978). At this time, the child has begun to internalize object relationships as introjects, which Kernberg defines as affectively tinged organized clusters of memory traces. Each trace consists of an image of an object, and of the self in relation to that object. For instance, the child at this age has a positive introject of a soothing comforting mother as caretaker to the satiated child, and a negative introject of a depriving mother as persecutor to the needy child. As explained earlier, the pre-depressive position child does not have the capacity to integrate these images and they remain split.

Influenced by Kleinian thought, Kernberg sees a predominance of negative introjects in the internal world of the borderline. According to him, this is because the early life of the borderline child is characterized by severe frustrations resulting in feelings of oral deprivation and accompanying rage on the part of the child. This rage is projected onto the object, hence resulting in fears of retaliation from the object and the formation of more negative introjects. Given the splitting at this point in development, the child cannot evoke a sense of the good mother when experiencing the bad mother. Since the child

needs to protect the introject of the good mother from destruction by the persecutory and rageful introjects, the splitting remains intact and becomes defensive in nature.

Several other structural components of severe character pathology result from the splitting defense. In times of regression, as the splitting defense intensifies, there is a corresponding sense of fragmentation of the self; there is no coherent self around which to organize the opposite introjects. In addition, there is intense separation anxiety and fears of abandonment. The oral deprivation and rage of the borderline patient, for example, results in a fear of either having destroyed the object or, if the rage is projected outward, of being abandoned by the object. Also, as a result of the splitting, the ego boundaries of the individual begin to weaken, and, as Kernberg states, "projection remains at a rather primitive, inefficient level, in which what is projected outside is still in part confusingly felt inside" (1966, p. 251). This defensive process, called projective identification, has become one of the hallmarks of borderline pathology. Kernberg maintains that the more the self and object images are blurred, and the more extreme the splits are between good and bad introjects, the more severely disturbed is the individual.

Meissner (1982, 1985) has written extensively from an object relations perspective about the diagnosis and treatment of borderline, paranoid and masochistic character types. He maintains that these patients' sense of self is organized around pathological and contradictory introjects which have been constructed from important object relations in early development. As is often stated about the borderline as well as the masochistic character, past object relations

have provided ambivalent ties yet the individual is desperately dependent on those ties to remain organized. As Meissner states: "the internalizations reflect the inherent ambivalence to the object and the need to retain, control, and preserve some form of relationship with a loved, yearned for, feared, and hated object" (1982, p. 92).

Like Kernberg, Meissner highlights the splitting defense as central in severe character pathology. Meissner identifies three major introjective configurations around which the borderline, narcissistic or paranoid individual might be organized: the narcissistic, aggressive and erotic dimensions. However, given the inability of the these individuals to integrate contradictory affects, each of these configurations are split into polar components. For instance, the narcissistic dimension is divided into feelings of superiority versus inferiority; and the erotic dimension involves idealized longing in contrast to disillusionment over what these relationships fail to offer.

Likewise, the aggressive dimension consists of a victim-introject, characterized by feelings of weakness, vulnerability and impotence and an aggressor-introject, featuring powerful, destructive, evil and murderous affects. It is of special interest for the purposes of our discussion. Meissner explains that since the victim and aggressor introjects are based on past dyads, they coexist and interact together. However, as mentioned before, the two introjects are never experienced simultaneously by the individual; therefore, what is not introjected is projected onto others. Meissner focuses on the implications this has in the therapeutic relationship; the borderline, in particular, experiences the introject in an intense manner and compels the therapist to accept the projective component with an equal intensity. In contrast to what

might occur on a more neurotic level, the severely character disordered patient typically has these introjective constellations readily accessible and can fluctuate between the opposite configurations very rapidly. Given the power of the projections, the therapist is often unconsciously compelled to act out what the borderline patient has split off or dissociated. There is a danger of entering into a mutually-reinforcing cycle wherein the therapist, for instance, accepts a projected aggressor-introject and, in return projects his or her victim-introject to the patient, reinforcing the already activated victim-introject in the patient.

Meissner describes other countertransferential stresses for the therapist and makes use of the work by Racker (1953, 1957) in this area. For instance, in the face of his or her guilt over aggressive feelings toward the patient, the therapist may doubt his or her competence in working with her or him. As Meissner states, there is a strong temptation to masochistically submit to the patient and berate oneself for not living up to her or his magical expectations (1982, p. 109). At this point, the therapist runs the risk of becoming like the patient's incompetent and unresponsive mother.

Looking over these developments in object relations theory, it becomes possible to see how they not only pave the way for advances in the treatment of the severe character disorders but also allow for more refined distinctions to be made among character types. The nature of the therapist's countertransference, such as how regressive or intense it is, can provide clues as to the severity of illness in the patient being seen. The basis for this notion is reached by way of an acknowledgement of the workings of projective and introjective mechanisms and self-other

conceptualizations. What is not contained by the patient is split off and projected onto the therapist, who, depending on the severity of the splitting, will experience the projection mildly or in an intense manner.

Splitting does not only occur on a borderline level of organization, which in itself covers a wide range in terms of severity of pathology. As Kernberg says, the intensity of character pathology can be determined by the extent to which splitting or repressive mechanisms predominate. This can be very useful in making distinctions among patients with masochistic character traits. If we assume that some polar configuration between victim and aggressor exists in the internal self-other dyad of the masochistic patient, then several questions as to degree can be put forth. How severe is this configuration? Do self and other perceptions of victim and aggressor fluctuate rapidly in the sessions with this patient? Or are they relatively stable, and although divided, readily accessible to the patient's conscious awareness.

Asking these questions to oneself in the treatment hour can lead to an understanding of the level of early developmental impairment in the patient. As theorists such as Panken, Menaker and Berliner have pointed out, patients with masochistic traits have often experienced inadequate and unloving parenting: their masochism is an attempt to maintain a tie with this parent by repeating the early object relationship between abused and abuser. However, questions remain as to the structural and developmental milestones that the patient has achieved. Did the patient, for instance, ever successfully make use of a transitional object? Is there an ability to tolerate ambivalence suggestive of a depressive position level of emotional development? Or, does the patient view self

and other in part-object terms, not just in the victim-aggressor sphere but in all others? Does the masochistic character seem colored by delays as early as symbiosis, or somewhere through separation-individuation? All of these questions will help to place the patient's masochism in a developmental and structural context and will lead to tailor made treatment approaches which take into account these differences. The three case analyses which will be presented in Chapter IV will be organized around the understanding and treatment of the patient's masochism according to degree and type of character pathology.

CHAPTER III

METHODS OF INQUIRY

Nature and Selection of Case Material

The three patients discussed in this paper were training cases of mine at an outpatient psychotherapy clinic which was functioning as part of a graduate training program in clinical psychology. These two women and one man came from vastly different socioeconomic, educational and cultural backgrounds and were in very different life situations. All were young adults in their twenties through early forties and ranged from single, married, divorced, with and without children. The mode of treatment was individual psychoanalytically-informed psychotherapy, once or twice weekly for fifty minutes. The length of treatment ranged from one and a half to three years; two of the therapies were terminated prematurely due to the therapist leaving the area and one terminated due to the patient's plans to relocate. The majority of treatment hours were tape recorded and transcribed from the tape; for the hours which were not recorded, detailed notes were taken from memory shortly after the sessions. The work with all three patients was closely supervised by the training staff of the clinic, averaging about one hour per week of supervision for each hour of therapy.

Of the approximately sixty patients I have treated in psychotherapy during my five years of graduate training, these three patients stood out because of the aggressive and self-defeating aspects of their character structure in combination with the long-term nature of the therapeutic contact, thereby affording a detailed analysis of this structure. In working with these individuals, I became aware of

countertranference feelings of both a persecutory and a victimized nature, and came to realize that these affects were largely a response to the particular patient. I would feel like verbally attacking the patient who spent the hour martyrishly lamenting her misfortunes, and I would feel like hiding behind my chair while another patient bitterly insulted those around him, including myself.

Although experiences like this are not uncommon in this type of work, these affects comprised a major portion of the tranference-countertransference dynamics with these three patients. Meissner's (1985) concept of the victim-aggressor introject was applicable to their inner dynamics. Affects of a victimized and aggressive nature alternated between patient and therapist, and it appeared as if both these components were part of an internal dyad within the patient's personality structure. When the patient embodied one portion of this dyad, the other portion would be projected onto the environment, evoking a sadomasochistic drama between the self and other.

Sadistic and masochistic were adjectives frequently used to describe these individuals, both in the context of the therapy and in their personal lives. Each patient had a strong self-sabotaging, moral masochistic element to her or his character. With the recent advances in object relations theory in mind, I wondered how the victim-aggressor introject could be applied to the understanding and treatment of masochistic dynamics in character disordered patients.

This paper is an attempt to more closely examine some of the initial observations and hypotheses that resulted from my clinical work, and specifically from my treatment of these three patients. Therefore, the selection of these particular cases for presentation in this paper was

not intended to be a random one, and the material has been purposefully chosen because of its connection to the questions being asked. However, these questions are open ended, and a priori speculations are subject to disconfirmation by the material itself. This paper is an attempt to explore and examine theoretical and technical questions relating to masochism in a systematic and thorough manner using relevant clinical material.

Analysis of the Case Material

Certain questions and speculations arose in the course of treating these patients. This work will systematically discuss these questions and hypotheses through a detailed qualitatative analysis of the treatments. The major questions are:

1. How can masochistic character traits be understood in the context of our current diagnostic system. Do masochistic trends exist across a wide range of diagnostic categories and severities of pathology or do masochistic trends exist in individuals who have similar overt symptomatology.

2. What do masochistic dynamics reflect in terms of intrapsychic conflict, internal character structure and developmental impairment.

3. What observations can be made about the transference-countertransference dynamics in the treatment of individuals with masochistic, self-defeating, traits. Can these observations facilitate the understanding and treatment of masochism.

The speculations that accompany these basic questions are as follows:

1. Masochism is a complex and multidetermined phenomenon. It serves a variety of instinctual, ego adaptive, defensive and superego functions. It can originate from pathological object relationships that have occurred at various points along the developmental continuum (pre-oedipal, oedipal). Given these multiple variations, masochistic trends can exist in patients with vastly different overt symptomatology and character structure.

2. Recognition of the complexity of masochism will facilitate the treatment of sadomasochistic trends in character disordered patients. Treatment approaches need to be modified to address the specific character structure of the individual patient.

3. Internal self-other representations of objects as either victims or aggressors are prevalent in individuals with masochistic dynamics. This introjective configuration emerges clearly in the psychotherapeutic relationship, and is manifested by projections of either the victim or the aggressor component onto the therapist. Recognition and evaluation of this introjective configuration will contribute greatly to the understanding and treatment of masochism.

Before providing a format for the methods of analysis, there are certain underlying assumptions about the clinical and conceptual material which need to be addressed. The material represents, and is being discussed from, a psychoanalytic viewpoint. Both object relational and drive/structure models of psychoanalytic thought are given recognition. The analysis is qualitative, subjective and unavoidably based on the clinical experiences, skills and theoretical background of the writer. In discussing the material, masochism is defined as any self-destructive, self-sabotaging trend which has significant bearing on the quality and nature of the individual's everyday life. This concept is closely related to the original definition of moral masochism which was portrayed in the first chapter.

With these assumptions acknowledged, the means of reviewing the material in order to answer the above questions was as follows. All notes, from taped and untaped sessions as well as from supervisory hours, were carefully read. None of the patients are currently in treatment with the writer, and at least six months had transpired since the notes had been examined. In looking through the mass of clinical

material, further notes were taken in response to the following guidelines:

1. How can this patient be described diagnostically, with consideration given to the following indicators:
   a. overt symptomatology/behavioral traits of a stable and enduring nature
   b. level of functioning in everyday life
   c. quality and types of relationships
   d. quality and nature of drives and drive conflicts
   e. specific ego weaknesses
   f. specific defensive structure
   g. quality and nature of superego components
   h. developmental/family history-the quality and type of object relationships in childhood; the particular points of developmental delay; fixation or origination of conflicts.
   i. the quality and nature of internal object relations.
   j. treatment considerations: the nature of the therapeutic relationship; the course and success of the therapy.

2. How is this patient's masochism (if it indeed is noticed) manifested clinically. What are the specific symptoms, affects, patterns of relating and functioning that suggest that masochistic trends are evident in this patient.

3. What specific functions does the masochism seem to serve in this individual. What possible secondary gains, or motivating factors seem to underlie this behavior.

4. What are the salient features of the therapy relationship. How does the patient make use of the therapy; what are the particular transference-countertransference dynamics; what is the quality and nature of the countertransference. How were the therapist's affects utilized in assessing and treating the patient.

It was expected that an analysis of the case material using the above guidelines would readily facilitate a discussion of the questions and speculations which were outlined. These guidelines were designed in order to highlight the following issues: whether masochistic trends are evident across types of character pathology; whether masochism

represents a multiplicity of functions; whether specific dynamics of the therapeutic relationship are characteristic of patients with masochistic trends; and whether those dynamics can aid in the understanding and treatment of such masochistic phenomena.

Presentation of the Case Material

In the presentation of the analyzed case material in this text, an effort was made to use raw data, such as pieces of dialogue and vignettes from therapy sessions. This was judged to be important given the already subjective nature of the investigation. However, this immediately raised the matter of confidentiality. All identifying information such as name, age, occupation and place of origin were altered so as to protect the anonymity of the patient. When these individuals initiated treatment at the training clinic, they signed a document granting permission for information pertaining to their therapy and personal history to be used for scholarly purposes as long as confidentiality was respected. In addition, permission to use this material was granted by the Screening Committee (which oversees the use of all case material) at the training clinic. It was felt that the degree to which this material was disguised was in keeping with both the Ethical Principles of the American Psychological Association and the code of ethics for use of clinical material at the training clinic.

In the discussion of the patients, every effort was made to ensure that their identities could not be ascertained by a third party. The question remained, though, as to whether the patients could identify themselves in the presentation. Given the personal and descriptive accounts of the therapies, it is quite possible that these patients

would became aware that it referred to them. However, the analysis would have been seriously compromised if the raw material was omitted from discussion. An opposite but equally important consideration was the unnecessary discomfort that may have resulted to one or more patient if asked to read this personal discussion in order to consent for it to be printed.

In presenting the cases, only the information relevant to the discussion was elaborated. Since there was a bulk of material, editing made for a more concise and cogent presentation. In addition, it aided in preserving the confidentiality of the patients. The aim was not to omit any important data, but rather to highlight the most relevant details. The reporting of analyzed clinical material in the next chapter will consist of the following sections:

1. A presentation of the patient, to include history and current life situation and a summary of the course of the treatment.

2. A discussion of the etiology, functions and meaning of masochism at this patient's level of character pathology.

3. An outline of the specific nature of the victim-aggressor introject for use in discussing treatment strategies and diagnostic formulations later in the paper.

Critique of the Methods

It is important to consider what factors have impeded or enhanced the credability of conclusions drawn from an analysis of case material. First, if the concept of masochism had been more narrowly defined for use in the selection of cases for analysis, then any observations made would have carried more weight. It was problematic that masochism and sadomasochism were used somewhat interchangeably throughout the

description of the cases. This evolved out of the conviction that masochistic and self-destructive strivings occurred in tandem and appeared to be connected in important ways. However, the absence of a well-delineated construct makes investigation difficult.

Generating theoretical speculations based on case analyses brings with it many methodological limitations. Not intended to be a random sampling of character disordered patients, the cases were chosen because of their connection to the questions being asked. The sample size was undeniably small, there were no control cases, and there was no formal means of checking the reliability of my clinical judgements. These factors contributed to an overall subjectivity of the method, and the possibility that the observations would not be replicated by other clinicians treating the same patients.

A major limitation to the detailed analysis of the cases was the varying lengths and depths of the treatments, and the unavoidably different ways in which people used the therapy. For instance, one patient spoke at length about childhood experiences, while another filled the hour with intense interactions between therapist and patient. In comparing the two patients in terms of childhood experiences, and tranference dynamics, there was an inevitable unevenness. If analyzing treatments which have continued many years until their natural completion, or if comparing therapies of the same length, it may then be easier to contrast. However, the treatments presented here discontinued before their natural completion. Many aspects of the patients were left uncovered and not understood by me, impeding a thorough analysis of the case material.

The extent to which my own theoretical background, clinical skills and acumen as well as technical and personal style as a therapist has influenced every facet of this investigation needs to be addressed. The course of the treatments themselves were shaped by my unique combination of strengths, pitfalls and blind spots as a therapist. Not only was I responding to the each patient in a manner specific to his or her character, but each patient was responding to me as an individual. Although psychoanalytic technique attempts to minimize intrusions of affects and needs of the therapist, it is unavoidable that the therapist will attend to certain portions of the clinical material and filter out other portions depending upon personal issues. Although many interpretations can be made at any given point in time in the therapy hour, a therapist will choose a particular comment partly as a result of the limits of what he or she can tolerate, contain and acknowledge. In tandem with this is the consistent interpreting of nonpertinent material due to a personal need to work through that particular content.

The qualitative analysis and interpreting of clinical material outside of the therapy hour utilizes the same skills and suffers from the same weaknesses as that of therapeutic interpretation. I brought the same questions and speculations to this written study that I carried into my office when seeing a patient: the two are intricately interwoven. The interpretations made in this analysis evolved from the same strengths and pitfalls which had bearing on my original clinical hypotheses and interpretations in the room. In both settings there were alternate interpretations of the material, of course, which were not as apparent to me given my personal and theoretical biases.

The methodology was a double-edged sword; the strengths of the study were intertwined with its limitations. The task of studying the process of psychotherapy is a complicated and problematic endeavor. It is through analysis of the specific flow, timing, and content of the patient's communications, and of the dialogue between patient and therapist, that we are able to gain an understanding of the particular psychopathogy manifested. The case material analyzed in this study comprised over 250 hours of transcribed accounts of treatments. Although subjective, the study afforded the opportunity for an in depth analysis of the functions, meanings and treatment of masochism in these patients. There were several aspects of the design which aided in minimizing the subjectivity of the method. For example, my initial questions and hypotheses were firmly grounded in already existing theory: specifically, an object relations perspective on psychotherapeutic dynamics. When I originally applied these hypotheses to my clinical work, I shared my thoughts with trained supervisors on a consistent basis. Their role is often to help the therapist to acknowledge his or her blindspots in the work, and to make the therapist more aware of how personal issues may influence what he or she chooses to interpret in the hour. Another result of psychoanalytically-based clinical training is the ability to recognize when a patient is disconfirming an interpretation, which is evident through an analysis of the latent content of the material which follows that interpretation. The intensive supervision of my work helped to minimize the subjectivity of the clinical analyses and to ensure that my perceptions were attuned to central aspects and needs of the patients being discussed. The fact that almost all the case material had been taped and recorded verbatim in

process notes both allowed for in depth analysis and ensured that the therapist did not recall material selectively or in a distorted manner.

Furthermore, the process notes were read and discussed with many other clinicians over the course of three years. In that time, a total of six supervisors met with me on an average of a half hour a week for each hour of therapy that had transpired with each patient. Indeed, many of the ideas and insights as to function, expressions and treatment of sadomasochism came from supervisor's comments which had been noted in the margins of the transcripts. In addition to individual supervisors, the training clinic in which the treatments were conducted was structured around weekly case presentations to a small, consistent group of clinicians. The sharing of work and ideas was a central part of the environment in which these cases were originally analyzed and understood. Some of the process notes of particular therapy sessions had been discussed with a supervisor, presented to and discussed with a team of eight clinicians, and further discussed with a consulting clinician made available to the clinic. The environment in which these treatments were conducted helped to validate the general observations as to the masochistic features and character structures of these patients.

As was true in my work as a therapist, it was important that my written interpretations had some theoretical grounding. The background for my speculations were illustrated in the beginning chapters of this work. In addition, I remained open to alternate hypotheses while reviewing the clinical data. Data which may be lent in support of an alternate hypothesis were not excluded from the presentation of the cases. By sticking close to the clinical material, and by entertaining alternate hypotheses, it is conceivable that the case material itself

will disconfirm my original speculations. It is this cyclical means of analysis which promotes innovative and verifiable hypotheses: original speculations need to be questioned in an organized and systematic manner, allowing for both further speculation as well as conclusions to be drawn.

CHAPTER IV

SADOMASOCHISTIC DYNAMICS ACROSS LEVELS OF STRUCTURAL ORGANIZATION AND TYPES OF CHARACTER PATHOLOGY

This chapter provides an in-depth analysis of three patients treated in long-term psychotherapy, all of whom had sadomasochistic features which were expressed differently given their variations in degree and type of character pathology. Questions which will be addressed are: 1) how is the sadomasochism expressed; 2) what functions does it serve 3) from which structural components is it derived, and 4)how is the victim-aggressor introject evident in the treatment of this patient.

The presentation of the cases themselves begins with identifying data, early and current life history and includes a detailed summary of the therapy. In the next portions of the case presentation, the material has been analyzed and discussed in terms of the expression, functions, and meanings of the sadomasochistic dynamics. Specific examples from the treatment are provided, with attention to meanings of counter-transference. Details from the patient's outside life will be used where relevant, although the emphasis is on the therapeutic dynamics. In the final portion of each case analysis, the specific nature of the internal and external victim-aggressor self-other dyads are summarized.

Alex

Identification of Patient

Alex is a twenty-eight year old, white, single male from a working class rural Pennslyvanian family. He initiated psychotherapy with me after being asked to leave his job at a local television station, where he was involved in the production of several animated shows. The leave had been requested due to Alex's "abusive and intimidating" style of interacting with others. His coworkers found him verbally threatening and had filed a formal grievance as a result of their discomfort around him. The station manager requested that Alex take some time to sort through what was underneath his tense, difficult attitude and to reapply for his position in eight months. In the first year of the two year treatment, Alex was unemployed; he returned to his job at the year's end.

A tall, sturdy, boyish looking young man appearing younger than his years, Alex came to the initial sessions sporting the downtrodden look of someone who had seen better days, seeming dissheveled in his dungaree jacket and worn jeans. He emanated a sense of despair that appeared to be central to his self-experience and frequently sat slumped in his chair, speaking in a soft, melancholic tone. Along with Alex's dejected farm boy presence was the bitter, disdainful look of a rebellious adolescent, bringing to mind characters and performances such as James Dean's in "East of Eden." On first glimpse, Alex was the prototypical "angry young man", embodying a biting aggressiveness finely interwoven with vulnerability and angst. Given his profession, Alex was quite knowledgeable about films and plays and made frequent literary

references in the sessions. He was highly articulate, with a cynical wit and a theatrical manner of expressing himself at times.

Early History

Alex was not forthcoming about the details of his early history until well into the therapy, and even then he spoke sparingly about his family. It was his feeling that "nothing" happened in his childhood and this sense of nothingness was a despairing and empty experience for him. Since talking about his family filled him with sensations of death and annihilation, it was a dreaded endeavor. Alex was the youngest of three brothers, one being five years older and the other being two years older than him. His brothers were the object of a variety of feelings for Alex: hate, idealization, envy and love. Both high achievers throughout childhood, much in contrast to Alex, his brothers seemed to glide ahead without conflict. From an early age, Alex had the sense that he was continually "up against his brothers" for comparison, and no matter how hard he tried to best them, he was always overpowered and overshadowed.

Whereas the father was respectful of his eldest sons, he humiliated and berated Alex, who described his father as a "working class martinet" and merciless teaser who occasionally beat Alex in the face and head with his belt. According to Alex, he was the scapegoat or "whipping boy" for his frustrated father, who was cemented into a deadend factory job that he detested. When planning an autonomous and achievement oriented move, Alex had the conviction that his father wanted him to "crash and burn" rather than to be successful.

Alex described his mother as depressive and aloof, clinging to her children out of her own need for fulfillment. Childhood images of his mother were of a depleted and damaged woman; she allowed him to watch

her undress when he was five or six and he recalls her breasts as distorted and stretched out from breast feeding all three children. Whereas she had protected the older siblings from her husband's temper and severity, Alex felt that she had no fight left in her for him. The few recollections of her caregiving involved her attempts to comfort him after a beating from his father. Although he expressed anger at times for her "lame" attempts to help him, Alex also had fear that he was somehow responsible for having "worn her down" and once relayed a dream about her in which he woke up repeatedly saying "I'm sorry." A vivid memory of a trauma, at age seven, was Alex's only recollection of overt nurturance from his mother: she lay in his bed and held him throughout the night as he screamed in pain. Although unknown to them at the time, his appendix had ruptured and his life had been in serious danger.

Throughout elementary school, Alex was the class clown who used humor to get the attention he so badly wanted. Always one of the brightest children in school, he found a way to sabotage his successes. He once compared himself to Billy Martin, remembering scoring homeruns in softball practice, but striking out in the game. As he put it, "Something was holding me back then and it feels like something is holding me back now." Alex recalled that in grade school he was always peering over his shoulder for somebody to tear him down. Bullied in school on account of his small size, Alex remarked that "they could tell I was used to taking it."

Alex's separation from home was a conflicted one, characterized by several rough fights between him and his father. On one occasion, Alex beat his father when the man belittled the importance of his son's graduation from high school and refused to attend the ceremony. Alex

recalled that the fight brought with it the recognition that he was physically capable of killing his father. In a confrontation a few days later, Alex went to strike his father but, instead, rammed his own head into a glass window, causing severe lacerations and blood loss but no brain damage. This incident was mentioned frequently in the therapy by Alex in making connections between his self-destructiveness and his aggressive impulses.

Recent History

In the years following high school, Alex's life had been erratic in many ways. He attended several colleges and demonstrated a pattern of not completing his schoolwork, getting into confrontations with professors and incurring their wrath. As was characteristic of Alex in almost every arena of his life, he approached something new with enthusiasm and intensity, having high expectations and making unrealistic plans which were soon sabotaged by him in some manner. As he stated, "Once I define a role for myself, I feel limited by it." Becoming disillusioned, Alex would go through periods of depression, during which he would distance from people, overeat, spend a lot of money and engage in hostile interchanges when he did have contact with others.

His romantic involvements were true to this pattern; he was involved in many brief relationships leaving very little time between each one. When he met a woman, he developed strong fantasies and desires of what she could offer to him, and usually the woman became burdened by the intensity of these expectations. In response, Alex became spiteful, belligerent and dejected over his disillusionment. Accompanying these swings was a pervasive sense of emptiness and self doubt, most strongly

experienced during his times of disillisionment. Feeling that he went from one person or life experience to another burning his bridges behind him, Alex once remarked that depression was the only thing he was able to sustain.

Summary of the Treatment

At the start of the therapy, Alex was intimidating, devaluing and antagonistic toward me. He refused to collaborate, at times staring at me and glibly asking, "are you finished?" when I had made a remark. In the first few sessions, he had numerous challenging requests: to make his own tape recordings of the sessions, to rearrange the furniture in the room and to bring in audio-visual equipment. At one point in the second hour, he paced around the room and loomed over me as I sat in my chair. It seemed that he needed me to feel as frightened as he felt in order to be assured that I would understand his experience in the room. When I shared this thought with him, he returned to his chair.

After the initial devaluation of the therapy, there were many rapid fluctuations in Alex's presentation in the room. First, he developed a strong idealization of me and began to regress in the hour. He spoke freely about his sexual desires for me and he wanted me to comfort him, massage him and magically lift him from his distress. Alex wished to "absorb" this magic strength of mine, hoping that I would hypnotize him or fill him up with the "perfect revelation" that would cure him.

Alternating with the idealization were bitter feelings of disillusionment with this perfect therapist that he had created. He expressed concerns that I was "absorbing" everything he said and giving nothing in return. Immediately following a time of regressed talk about wishes for ideal caregiving, Alex would ask me, "what the fuck are we

doing here anyway?" and would demand that I give him some feedback. At these times, it became apparent that he was not only rageful, but he experienced what he himself called "annihilation anxiety" and an empty sense that things were unreal and distant.

Following my three week summer vacation, Alex returned to the second year of treatment with a strikingly chaotic and anxious presentation. This seemed to result from apprehensions about returning to his job as well as from his longing for me during the break and his rage at my unavailability. The longing was intense and frightening for Alex and, to rid himself of it, he projected it onto me. Spurred on by a change to a smaller office without windows and by my obtaining a reclining chair like my own for Alex (the other chair was awkward in the room), he perceived me as terrifyingly seductive and engulfing. He tried to negotiate the distance between us by pacing around the room, hiding behind his chair and entertaining me with his jokes. He was not only trying to protect himself from the engulfing mother/therapist but also from the rageful attacker/therapist, a projective container of his murderous rage toward me. After continued interpretation of his acting out, and assurance, through my consistency, that I was not trying to seduce or kill him, Alex became able to recognize his own terrifying fears of and desires for me.

Several months later, Alex opted to increase his sessions to twice a week in order to facilitate working through some of his intense feelings of rage and longing for closeness. In the discussions that followed, sexual and aggressive material was strikingly fused, as evidenced in fantasies of raping then comforting women, beating me then having intercourse with me and so forth. It was the task of the therapy to

contain these fantasies, work with them yet not invite their elaboration. This was crucial given Alex's propensity towards acting out both in and out of the therapy.

In the room, he often relied on "props" to elucidate fantasies, such as bringing in a video cable that he held coiled and likened to a whip as he began the session with the desire to "lay into my ass" that day. He referred to the video cable as his "14-pin connector of power" and, as he got to some particularly painful and exposing material later in the session, he picked up the cable and draped it around his neck as if he were a proud and imposing warrior. This was one of the many examples of the projection of his victim-introject onto me when it became intolerable for him to contain.

All the antics and reliance on props served to keep things active and alive in the room and kept Alex from experiencing the sense of deadness and empty aloneness that is at the center of his experience of himself in relation to others. The aloneness was expressed, however, in his occasional preoccupations with death and in his quiet retreat from me at times. His first major video project, done that fall, was a movie of him filming his own suicide. During times of withdrawal from me, it was as if I had died and had nothing to offer him. Those hours were filled with dead silences and words which would trail off, failing to complete a coherent sentence. Alex had several dreams of performing oral sex on himself, having become unable to obtain any solace from me. In contrast to the previous erotic fantasies about me, he wondered if he were homosexual. Men were viewed as nurturant: he had a dream of sucking his brother's penis and he became closer to a bisexual male friend.

Several months into the therapy, when the working alliance was fairly solid and as the defensive function of what we came to call Alex's "theatrical productions" was consistently interpreted, new material of a more "real life" nature was brought to the hour. We used the dynamics of the therapeutic relationship to explore similar patterns with the women he dated. Alex had been involved with many women in rapid succession since beginning the treatment. We came to view this as his way of diluting the intense neediness that was stirred up in the therapy. Alex worked hard to understand and change his cycle of idealization, longing, disillusionment, rage and withdrawal with these women. Although he continued to have romantic involvements, they lacked the intense idealization and abrupt withdrawal that characterized the previous romances. Concurrently, Alex became more emotionally accessible and productive in our sessions.

As Alex settled down considerably in contrast to his earlier presentation, he became able to sit with his intense longings for nurturance without all the props and antics he formerly relied upon. For the first time in the treatment, he began to talk about what he called "the dreaded F-word": his family. We discussed his sense of betrayal by his brother, five years his senior, whom Alex looked up to but felt ignored by. He also recalled childhood images of his depressed, deficient mother, whom he felt he depleted and damaged through his intense oral cravings. The image he painted of his childhood was of a home as bleak and stark as the town they lived in. It was easier for Alex to elucidate the unpleasant memories than to recall the more benign ones.

A major focus of the second year of treatment was the working through of Alex's rage and self-destructiveness and the relationship between the two. Past and current incidents in which he brought harm upon himself in order to keep his rage in check came to the forefront. It became clear that Alex experienced himself as lethal and worried that he might lose control and hurt somebody. His anger had an oral quality to it and we often discussed how he wanted to possess all of me and, in the absence of this, he wanted to tear down and destroy everything in the therapy. A typical example of the flow of the sessions is contained in this example from the beginning of an hour, "I want to beat up on you today...I don't know if I want to beat you up. I just want to curl up and go to sleep. Take care of me...." Alex's anger usually coexisted with a sense of powerlessness and vulnerability and an intense, passive craving for nurturance from me.

In the midst of our working through his rage and self destructiveness, the therapy was catapulted into a premature termination phase on account of my leaving the area. The anticipated separation brought with it feelings of annihilation and death for Alex; he sat in dead silences through some of the hours and spoke of death, suicide and his fantasy of being "a killer". It was apparent that his annihilation fears had to do with his doubts as to what he would be able to take with him after our work had ended. For instance, he wondered whether he had enough of an internal sense of me to remember me when I was gone and asked where I was going and other personal questions about my identity.

However, in times of stress over the sense of annihilation that he associated with our separation, he retreated to a defensive hyper-sexuality. For instance, he began sleeping with different women more

than before and made an effort to tell me about this; he frequently came to the sessions late and detailed the love making that had just transpired. On several occasions, he proposed that we end our professional relationship and sleep together. These suggestions always had a desperate and pleading tone to them; it was as if this was a matter of life or death, which it must have seemed like for him at the time.

Functions and Meanings of Sadomasochism

In taking a closer look at this treatment, it is possible to obtain some picture of the nature of the aggressive and self-destructive affects and behaviors in this individual. Of concern in this discussion is the specific manner in which these aspects of the patient were expressed by him; what their function and meanings were; and what relationship existed between these opposing components of sadism and masochism in this young man.

It is hopefully evident, through the treatment summary, that Alex's self-destructive and rageful affects were often expressed through actions; both inside and outside of the therapy. His flare for the dramatic, along with his tendency to become impulsive under stress, paved the way for his enactment of internal struggles. Sadistic and masochistic components were intertwined in many complex ways for Alex, which will become more evident as his treatment is further discussed.

Alex's self-sabotaging side was only sometimes evident; people were known to perceive him as arrogant and antagonistic. However, it is interesting to note that his aggressive style often served to reinforce his identity as a victim. His provocative and aggressive stance was an open invitation for others to reject or abuse him and his timing as to

when to be provocative seemed set on maximizing the harm that could occur to him. Alex demonstrated this complex relationship between aggressiveness and victimization in the initial session, which was at a point in his life in which he was quite defeated. He entered the session in a very antagonistic manner, challenging me, insulting me and not allowing me to speak with him in a collaborative way. With ten minutes left in the hour, he still had not told me why he was seeking therapy, although he had showed me. I found myself quite frustrated with him, and wondered if others reacted to him this way as well. In speaking about his view of therapy, he commented that therapy was a replication of the person's stance in the real world and we then had the following interchange:

> Tx: Well, in here today so far, you have put me down and worked hard to get control of everything-shall I assume that you have showed me what goes on with people outside of here?
>
> Pt: Yes, exactly-that's my problem.
>
> Tx: Does it trouble you?
>
> Pt: It troubles me a lot. I push people away this way, and then they get sick of me, hate me, get mad at me and then they retaliate. [looks wistful]

In his relationships with others, and in his professional life, Alex did not allow for positive developments. It was usually through his sadistic tendencies that the good things would be torn down and his progress and happiness sabotaged. Although there are numerous examples of this throughout his life, the most pertinent to our work was his presenting complaint: having lost his job due to his intimidating and abusive interactions with others. This dynamic was enacted repeatedly in the therapy; a session which had engendered warmth would be followed by

one characterized by his bullying and devaluing me. The result would sometimes be my becoming sharp with or distanced from him, thus turning the tables: I became the rejecting and sadistic one in the room, hence, victimizing him. Alex would often find a way to evoke abuse from his strivings for nurturance and affection, hence replicating his past. The following is an example of a session in which he wanted to express affection for me but set things up so that my receiving this message was quite difficult. He began the hour in a highly provocative way.

> Pt: I'd like us to spar with each other-take turns and try to hit each other...you'd punch me in the kidneys, and then I'd say 'Ah, one for you' and punch you in the throat. Finally, I'd win, cause I try harder [looks serious, angry and frightening to me]
>
> Tx: What would this accomplish-what purpose would it serve?
>
> Pt: It's just habitual, self-defeating, and that's the way our family interacted, each at the expense of the other... Physical contact-it would be such a nice way to touch you, to just go bam!
>
> Tx: Nice?
>
> Pt: It's insane, isn't it? Like kids when they are frustrated. Instead of saying they like a girl, they cut off her ponytail or punch her in the teeth. Rather than to say I'm attracted to you and hold your hand, I could just go pow!

Towards the end of this interchange, the link between sexual and aggressive feelings became more evident and Alex then began to reflect on whether I liked him and whether he could ever "submit to me totally-give himself over to therapy." I asked what that would involve, and he elaborated on his wishes to be close to me, which to him meant that we would be sexually intimate. I found myself commenting rather coldly and anxiously about the impossibility of such contact, and these remarks were not very empathic toward Alex's extreme vulnerability in

the face of his affectionate feelings toward me. Although unattuned to it then, my own feelings had, for the time being, become rather hostile. During the hour, I can recall thinking that he was playing games with me with his aggressive talk at the start of the session, although it later became evident that he usually his boxing gloves on before venturing into unconquered territory.

This sadomasochistic dynamic of compelling others to be abusive through his own antagonistic style was a repetition of past object relationships in many ways. His father was both an aggressive tyrant to his son as well as a frustrated and defeated man in terms of his job and marriage. Alex had internalized his father's view of him, thereby expecting himself to crash and burn instead of meeting with success. In addition, he had identified with his father's angry, bullying style and, in a sense, he used this style against himself.

A situation, typical of many, shows how Alex sought to recreate his past in the present. He had been doing some filming at a hockey game and ran across a guy from college whom he, somewhat irrationally, was certain had stolen some expensive items from him several years ago. During a break, he followed this person into a locker room to confront him with this conviction. What had formerly been a desire for revenge, however, turned into a covert wish to be beaten by the object of his rage. Although surrounded by several of the athlete's friends, and having been asked to leave repeatedly, he baited the guy and then picked up his watch, saying he would take it and make things even between them. As he turned to leave, the player and his teammates jumped on him and, not only beat him, but humiliated him in many ways. Alex made no effort to fight back, although he had the capability and opportunity. As he so

perceptively stated as we discussed the incident: "It was a stupid thing to do, but it was me. I guess it was a kamakazee mission. I did it to get beat up, to reaffirm my low self esteem, to let Dad beat up on me...to be the helpless kid again".

In tandem with the father-son dynamics were Alex's conflicted interactions with his mother. Partly because of his harsh father and partly because of his depressed mother, Alex developed the sense that he had to be suffering or defeated in some way in order to be close to his mother. Much of the comfort he received from his mother was in response to his having suffered in some way. This sadomasochistic pattern was established early in the mother-infant relationship; it later became intensified by his punitive father and interwoven with oedipal anxiety. The memory of the mother holding Alex in his bed when he lay screaming in pain from a ruptured appendix provides a salient example of this early object relationship. However ambivalent the tie was, this sadomasochistic dynamic in his childhood provided him with what must have seemed like the only chance for nurturance he had in a family that seemed to have little caregiving to offer.

Not only did this sadomasochistic mother-son dynamic offer nurturance at a price, but it had another secondary gain as well. By viewing himself as both destructive and defective, he was able to preserve an image of his mother as good, taking the blame for her inadequacies. Alex often described his mother as having been worn down by childrearing. It was his sense that he had proven too much for her, and that his childhood needs were unlike those of other children: they were overwhelming and hurtful. Following a session where he discussed his sense of early needs as damaging, Alex began the next hour by

wondering if I could or would terminate treatment if he became "too much for me."

Now that Alex's sadomasochistic dynamics have been discussed in terms of repetitions of past object relationships, these sadistic and masochistic tendencies can be explored in terms of their defensive functions as well. Perhaps the most pervasive defensive function of his aggressive and self-destructive style was to ward off the central feeling of emptiness which seemed to be at the core of his self-experience. His bullying style often intensified at times when he was fighting off a sense of deadness, which was especially salient during the termination. During sessions where he was clearly depressed, speaking slowly and entertaining long silences, he made feeble attempts to stir things up through aggressive hypersexuality or bitter devaluing of me.

In our second to last session, he had the following dream about me which provides a good example of how, in the face of a loss which felt like death to him, he relied on his aggressive and hypersexualized defensive style. In the dream as Alex told it:

> I [Alex] was walking through a graveyard which looked like a supermarket because of bright lights and tombstones which resembled aisles. As I cruised the aisles, I saw an open, freshly cut grave, filled with icewater. A woman lay in the grave who looked like you. At first she appeared to be dead, then I noticed she was half alive, bobbing up and down, in the cold water. So, I climbed in and fucked her, but I realized it was too late-she was already dead.

Alex viewed relationships in terms of extremes: sex combated death; brute powerfulness countered childlike vulnerability. Therefore, his aggressive, sadistic style was used for a variety of defensive

functions, including the warding off of his masochistic sense of suffering and defeat. This example, also from the termination phase, shows the defensive function of his sadistic style and also illustrates his division of himself and others into either victims or aggressors.

> Pt: I feel like giving you a lot of shit today- showing you how combative I can be. In the movie "The Money Game", Rod Stieger showed how strong and effective he could be with this one look he had...he could cut people to shreds with his eyes...I'd like to try that look on you...[glaring at me in nasty way, but his sadness seemed just below the surface]
>
> Tx: [later in hour] There's been this sense of desperation lately...you sound as if you fear you've lost everything you've gained and you're trying to convince me that you've changed...that you can be effective.
>
> Pt: I feel like a greasy, gawky gas station attendant... who is lowly, unattractive and maybe a bit threatening. There's this real inferiority I feel now...I'm putting oil in your car while I don't even own one myself.
>
> Tx: Sounds humiliating.
>
> Pt: Yeah, it is.

Both Alex's sadism and his masochism were used in the treatment to negotiate the distance between us: to ensure that the closeness never became engulfing to him. Closeness seemed to signify submission to him, and his natural response was to counter it with a domineering and aggressive stance. In one session where he had been stirring things up with sadistic and sexualized talk, I remarked that these antics seemed to keep us at a distance. Alex agreed and added that "I keep sabotaging myself and I'm holding back, week after week, from really getting into therapy and giving in to you."

Much of Alex's sadomasochistic dynamics had an oral quality to them and seemed to be in response to the wish for fusion and total devotion

on the part of caregivers. The limitations of what I had to offer him were infuriating and the subsequent ragefulness was intense and frightening for him. His rageful fantasies were often of a primary process nature; he imagined ripping the head off of one of his housemates, for example, and then burying the body in the sand. This intense ragefulness was disorganizing for Alex and led to a weakening of his abilities to distinguish reality from fantasy. In many of the stories Alex related, it was clear that he worried about actually killing someone, and was not able to separate affect from action.

This suggests another defensive function of Alex's self-destructive and self-defeating actions: to bring harm onto himself in order to protect others from his potentially lethal rage. Alex wondered if this was partly why he would not fight the guys in the hockey locker room: he wondered aloud in the session whether he was rageful and out of control enough to have killed someone. He also drew the parallel between this incident and the time in his adolescence when he smashed his head into glass instead of hitting his father, which had followed a realization that he had the power to kill his father. The self-destructiveness prevented his committing a murder, at least in his own mind. Thinking of times when he had been furious with me, Alex recalled having entertained fantasies of throwing himself through the glass window in the office.

In the course of working through his sadomasochistic features, it became clear that many aspects of Alex's character served as defensive responses to his intense oral rage. A particularly salient example of this was Alex's confusion about his sexual identity and his envy of women. It became apparent that Alex equated his masculinity with his murderously rageful and aggressive aspects. In order to prevent himself

from being harmful, Alex would have to strip himself of his manhood: he would have to be a woman. This was apparent in the following dream that Alex had about his station's art director, Diane, with whom he was extremely angry:

> I was a girl, maybe my sister and I was looking in the second story window of Diane's suburban home from the bushes down below. I threw some rocks at the window to get her attention then called, " Diane, Diane- someone's out here to hurt you." She came outside and I turned into myself and said, "Run away, run away-it's me-I'm schizo-I'm a killer." I got really concerned, I thought I might hurt her, so I ran away, down a hill, so that I wouldn't harm her.

In the dream, Alex "threw his rocks away" or castrated himself in an effort to not be lethal with his aggressiveness. He also ran down the hill, or distanced, to keep his anger in check. This was a common pattern for Alex and illustrates the defensive nature of both his masochism and his confusion over gender identity.

Alex's masochism itself was employed in the service of his expressing rage over not getting enough from others, as was his sadism. For example, during a vacation of mine, Alex had a bicycle accident due to riding down a hill too fast. When I commented on his obvious injuries, he bitterly remarked, "I would have been glad to have you tend to my wounds, clean the tar out of my cuts, if you weren't in the Hamptons (his fantasy of my vacation)." On another occasion, while unemployed, he wrote and produced a short video about a man his age committing suicide and mailed it to one of his brothers. He told me, "it's my angry message to them-I want that message thrown right in their faces-I'm still fucked up and they're to blame."

The Victim-Aggressor Introject in the Treatment

From the preceding discussion, we can see that Alex had internal introjects of both victims and aggressors. There was a script, based on his childhood dynamics, which he played out over and over, featuring an aggressive, brutal tyrant and a defeated, bullied loser. For Alex, these two components were quite polar; there was little in between these two extreme ways of perceiving people. People, including himself, were either controlling and dominating, or were controlled and submissive. In addition, these polar internal configurations were projected onto those around him with great ease, and he was facile at engaging others in containing one or the other of these affects for him. Whether the other played the victim or the aggressor was open to frequent and rapid change. It could be said that these were part-object introjects: neither victim nor aggressor introject was consistently affixed to either himself or another person. Since Alex's projections onto others fluctuated wildly, it was difficult for him to develop stable perceptions of the people in his life, hence, exacerbating his fears that others were out to retaliate and harm him without clear warning.

The clearest examples of Alex's rapidly fluctuating victim-aggressor introjections and projections occurred when he was defending against overwhelming feelings of vulnerability and powerlessness through a combination of denial and projection identification of these affects onto others. At these times, he became the bully, evoking powerlessness in others and unconsciously identifying with this victimized projection. Alex was strikingly responsive to interpretations of his unconscious affects most of the time, and a remark by me such as, "It is usually when you feel the most vulnerable that you bully others", would often ease the denied affects into his conscious awareness.

It is interesting and important to note how easily the therapist can unknowingly embody such a warded off affect and project it back onto the patient. This happened numerous times in the treatment with Alex, usually in very subtle ways. In working with a young man who could be so intimidating and abusive, there was a continual pull on my part to not be victimized and to not accept such victimization. He often told me that I was the limiting factor in the treatment; I had somehow sold him short intellectually. When it became intolerable for me to contain these victimizing statements, yet when I still felt compelled to tolerate them, I was prone to project them back onto him in unconscious and unhelpful ways. My tone of voice might have become more hostile, or I might have mistimed a piercing interpretation so that it was painful for him. From time to time, Alex would say, "You're slaying me with your words today"; I learned to heed his warning, think about how I was responding, and then wonder with him how and why this interaction was seeming so mutually torturous.

There are helpful as well as unhelpful ways to avoid being victimized as a therapist, all of which will be discussed further in the next chapter. In short, kind interpretation of his projective identifications proved a more useful way to lessen my sense of victimization than the above mentioned responses. Since specific aspects of technique will be detailed in the next chapter, these accounts of the therapeutic dynamics were offered to help illustrate the rapidly fluctuating and intense nature of the victim-aggressor introjections and projections in this patient.

Jana

Identification of Patient

Jana is a forty-one year old, divorced, white female university professor and mother of a six year old boy. She began the two and a half year treatment with me during the break-up of her twelve year marriage which had caused her to move from New Jersey and accept a new academic position elsewhere. Her husband had, quite abruptly, demanded a divorce and Jana hoped that her attempt to get help would bring him back. In spite of this wish, she complained bitterly about her husband in the first sessions: his rude, erratic, tempestuous personality and infidelity. Also of concern to her was her increasingly severe depression which had developed over the past ten years; she was socially isolated, not sleeping well at night, and was increasingly unable to prepare her coursework.

A petite, neatly and stylishly dressed woman who appeared younger than her age, Jana carried herself in a tentative, almost apologetic manner suggestive of depression and low self-esteem. In the sessions Jana always made an effort to be polite and cordial, demonstrating an acute awareness of social protocol. She was clearly intelligent, articulate and had an obsessive style, as was quickly evident in the way she chose her words and elaborated on details with great care. She took herself quite seriously, and it was a year into the therapy before she would acknowledge the lighter side of some of the material. At times, Jana spoke with an angry, bitter, blaming tone to her sadness and at other times she was apologetic and self-loathing when communicating her distress. Although depressed, she characteristically appeared to be

holding back feelings of sadness and anger. She told me that she feared that her emotions would be repulsive or offensive to me, and it was well into the treatment before she was able to express very personal feelings without extreme discomfort.

Early History

Jana came from a conservative, upper-middle class, Jewish family from the Midwest, consisting of both parents, an older sister and younger brother. Her father, described by Jana as strong-willed, authoritative and hot-tempered, was the superintendant of schools in their city. When young, Jana was afraid of her father, who became enraged and physically abusive if the children disobeyed or even offered an opinion which differed from his own. He both encouraged intellectual growth in his children and warned them that others would be put off by displays of their knowledge and competence. Uncomfortable with intimacy, this father's most affectionate gesture to his children was a tap on the elbow, in lieu of a hug or kiss. Almost maniacally driven, Jana's father refused to take any vacation time from work; each year, the mother vacationed with the children without her husband.

Jana was very identified with her mother, who retired from a successful career as a school teacher to raise her children. Describing her mother as a slave to the father, she routinely did paperwork and typing for her husband upon demand and was not allowed to have the active social life she desired. However, Jana also painted a picture of her mother as resilient and resourceful and admired and emulated many of her talents such as gardening, cooking, sewing and playing the piano. When she would visit the home, they would engage in these activities together, with Jana trying to fulfill some of what was missing in her

mother's marriage by taking her out to numerous social events while passing up opportunities to socialize with her peers.

Jana's older sister was a librarian living close to their parent's home. In childhood, Cindy was the compliant, spiritless sibling who described herself as "my Daddy's girl". Jana spoke bitterly about Cindy, who was rarely disciplined by the father but who tried to get the sisters in trouble. Whereas Cindy was the obedient girl, David, the youngest child and only boy, was wild and rebellious. Jana recalls that although their father was tough with David, he also favored him and found ways to reward him for his strong will.

When recalling her childhood, Jana reported having felt alienated, lonely and unliked. Attributing it to there being few children in the area, Jana spent hours visiting the elderly neighbors instead of playing age appropriate games. Jana reasoned that her intellectual abilities caused her to be disliked by others, which is a belief she carried into her adult life. In grade school, Jana was quietly spiteful and envious of her peers, feeling that a more direct expression of emotions would provoke retaliation. She had a vivid memory of accusing a girl of lying about her social life and being punched in the mouth by her.

In her homelife, Jana also feared retaliation if she were to speak her mind; as noted earlier, her father did not tolerate any disagreement from his children. Jana recalled feeling caught between her siblings, and held the conviction that she got "nothing or a hard time" for being herself. Cindy was rewarded for her compliance and David was respected for his strong will. As the middle child, Jana thought she was found less exciting than "the first born and the baby boy" and noted that there were fewer photographs in the family album of her than of the

other two children. Also noting that she was punished more than her brother or sister, Jana recalled routinely gritting her teeth in an effort not to cry in the face of her angry and abusive father.

Recent History

Many of her childhood experiences of being an outcast and never receiving the recognition she desired continued through her adolescence and young adult years. While attending college near her family home, Jana overloaded herself with difficult courses in an effort to please her father. Under the stress of facing her father with failing grades, she cried uncontrollably for months, vomited involuntarily when she ate and weighed as little as 85 pounds. One of Jana's most painful memories was of going to her father to communicate her distress and receive emotional support. After listening awhile, her father stated that he would arrange for her to obtain some tranquilizers from the family doctor and added, "never ask me for this again."

It was not until she was in a chemistry doctoral program that Jana moved out of the house and began dating many men. There were many similarities in these men she dated: they were bright, aggressive and invested in their self-aggrandizement at the expense of her achievements. In her graduate program, Jana was engaged in a familiarly sadomasochistic dynamic with an advisor, whom she claimed hated her and abused her in many ways. After refusing to allow her to progress in the program, he reportedly "got rid of her" by obtaining a teaching position for her in New Jersey.

It was in New Jersey that Jana met her husband, a brash and hot-tempered man who fit the profile of the type of men she dated. The marriage was poor from the start, with Jana putting all her energies

into writing and editing her husband's papers and grant proposals, a task for which she received no credit. Although very successful in many aspects of her profession, Jana had long periods of inability to do her work. In describing her functioning over the past several years, Jana stated, "I can really see the wheels grind."

At the start of the treatment, Jana reported having an overall sense of loneliness and isolation. At times, she would wake up in the night with her teeth clenched in anger. She had distressing dreams of being attacked, such as one in which snakes were crawling over her and biting her. Over the past ten years, Jana had found it difficult to make friends, although she maintained two close female friends over the course of her graduate career. Ostensibly due to her husband's social isolation, Jana kept her colleagues at a distance. She found it hard to socialize since she perceived others as critical of or repulsed by her. With colleagues at work, she frequently got into altercations. A familiar pattern in these incidents would begin with her feeling of having been slighted by someone and her then following through by confronting that person and provoking an altercation, hence resulting in her feeling victimized, rejected and unliked.

Summary of the Treatment

At the start of the therapy, Jana was depressed and grieving the loss of her husband. Throughout the first year of treatment, she was outwardly polite and cooperative with me. The sessions were characterized, however, by a sense of cautiousness and distance between us. Typically, Jana would come to the sessions with several planned stories to tell me; the content always consisted of her being taken advantage of in some way. At times, she would nastily confront the other

person and engage in a battle, while at other times she would become more masochistic. Jana would offer these stories to me as proof of how horribly others treated her. While not making use of any transference comments I made about her reactions to me, she nonetheless repeatedly stated that I was extremely helpful to her. In contrast, however, the room was filled with feelings of bitterness and spite which were not being discussed, but were being withheld by Jana.

Toward the start of the second year of treatment, Jana and I began talking about her "stinginess" with people, and her tendency to withhold parts of herself from others. We came to realize that the distance between us, which was partially my inability to empathize with her, stemmed from her reluctance to let me see her as in pain and in need of help. As we worked through some of her humiliating memories of past requests to express herself or request help, Jana began to show me more of the self she usually kept hidden. She brought in pictures of herself and her family in an effort to do this. More importantly, she gradually became more spontaneously sad, angry and needy and recognized me as someone from which she could ask for help.

The second year of treatment was a time of significant movement in the therapy. Issues around the termination led Jana to have an increased sense of desperation about her life and a corresponding increase in the availability of her affect. We continued to work through themes which had been familiar to us for some time, however, Jana used the sessions in a different way than previously: her associations became freefloating and rich in metaphors; her affect was intense; and she recognized and used aspects of the transference much more easily than in the past. This provided me with a clearer sense of Jana's internal representations of

herself and others. Whereas in the past, she spoke of feeling isolated from others, she now described herself as existing in a glass bubble, where she could never really reach others. (This speaks to the former sense of distance between us in the room: it was a sense of her being unreachable). Since she was so cut off from those around her, it was difficult for her to be nurtured and helped by them. As a result, parts of her felt distant and dead, while other aspects of her felt like they existed just to serve the needs of those around her. More specifically, Jana was severed from her spontaneous and genuine affects, whereas she experienced the professional and achieving parts of her as belonging to others, who robbed her of her goods and left nothing in return.

Jana's metaphors helped to elucidate this sense of herself in relation to others. She frequently associated to flowers when describing her sense of desperation and aloneness; she would speak of beautiful flowers that were neglected, not watered and left to wither up and die. Another frequent self-metaphor was that of cats: she collected stuffed animal cats and associated positive aspects of herself with these cute and furry animals. When she described her cats, however, they were depicted as packed away in boxes; one story involved a broken glass cat which was "glued together, cute, but worthless". A metaphor which Jana used frequently when reflecting on her sense of self was that of a skeleton. The skeleton metaphor was one of deadness; she saw herself as a bunch of bones which have been picked of all flesh and sensuality. Her erotic side was kept hidden and when it did surface, such as a time she wore a seductive piece of lingerie to a costume party, it had a split off and dissociated quality to it.

A salient theme running throughout Jana's life was her inability to relinquish and integrate the various aspects of herself. However, over the last few months of the therapy, Jana relinquished a bit of her withholding stance and was able to show me parts of herself that she usually kept hidden. She was able to show me some of her sadness, sense of desperation and aloneness as well as her anger. Perhaps most important, Jana was able to recognize her needs for me to help her, which was essential for any significant progress to be made.

The week following my announcement that I would be leaving, Jana told me that the rest of the day, on which I had told her this upsetting news, had been so horrible that she had almost returned to my office. She partly wanted me to see what I had done to her, and partly wanted me to hold and comfort her in her distress. In future discussions of the termination, Jana was spontaneously tearful and full of sadness. She regretted that it took so long to feel comfortable with me, and was angry at me for leaving just as she was using the therapy in a productive manner.

Just as she perceived others in her life, Jana saw me as having pried precious things from her and then left her, robbed and empty. She became envious, resentful and bitter toward me. Termination material was centered around trying to make me feel inferior and deficient in comparison to her; this material was largely unconscious, however. Her conscious experience of the termination was one of sadness, regret and of warmth and affection for me. In our final sessions, we worked on her integration of these opposing views: to recognize that the therapist that she bitterly resented was the therapist of whom she was also quite fond.

Functions and Meanings of Sadomasochism

Jana's sadomasochistic dynamics were expressed and enacted in a passive and withholding manner, with her general defensive style being an obsessive-compulsive one characteristic of regression to an anal level of libidinal organization. Jana saw her affective outpourings as messy and ugly, and described herself as clamming up and holding on to what was inside of her. Her achievement conflicts, such as her inability to progress in her profession, seemed to be expressed as this pervasive unwillingness to "let go" or relinquish what talent and drive she did have inside of her. In the sessions, she frequently told lengthy, elaborate stories of how others were abusing her, or trying to rob her of her important possessions. By embodying the stance of the victim, she was able to project the angry, greedy aspects of herself onto others.

The therapeutic relationship, particularly in the first year of treatment, was characterized by Jana's stingy, withholding style which invited a sadomasochistic dynamic between therapist and patient. Her lengthy, eloborate stories of victimization were, in some indirect way, an angry attack on me and a degradation of what the purpose of our work together was all about. For instance, in the service of telling me all the details of a particular story, she would ignore input from me and would deny having any reactions at all to the therapy. The excessively detailed and unspontaneous manner in which Jana spoke, along with my feeling of not being useful to her made the sessions become boring to me. Her tales of victimization became tedious and, rather than empathizing with her, I found myself identified with the aggressors in her stories. At one point, in the tenth session, as she elaborated on, in painstakingly detail, about her ex-husband having grabbed popcorn out

of her hand in a movie theatre and drop-kicked it across the aisle, I began to chuckle. It became obvious at this point that something was amiss in the room, and I directly addressed my having laughed inappropriately. This prompted a discussion of the distance between us, and her conviction that it was not all right to ask for help. Jana told the story of having asked her father for help in college, when she was bulimic and depressed, and his having fundamentally misunderstood her needs, offering her medication instead of advice.

Just as we were beginning to talk about the relationship between her masochism and her inability to ask directly for help, Jana demonstrated this dynamic for me in an even more obvious way. She was driving to her parents vacation home in Florida for the winter holidays when her tire blew out and her car went out of control into a ditch. After waiting hours for help and spending the night in a truckstop so that the car could be repaired in the morning, Jana discovered that she was now almost out of money, due to the cash output to tow and repair the car, and the fact that a gas station attendant told her her credit card was over the limit. Although she knew this could not be the case, she did not question it, and instead, drove to Florida on no food, using her only cash for gasoline. She spent nights on the side of the road, hungry and cold and missed a holiday party her parents were giving. When she returned, she said something brief about an accident and then began talking about other things. Later in the session, I asked if I had heard her mention an accident, and she burst out crying and told me the details, saying it was a horrible experience. I questioned whether she might have called her parents and she emphatically stated that she had to handle it herself, adding that she would not have told me if I had not asked about it.

This was interesting, because one would expect Jana to have relished the telling of such a story of true suffering. However, it seemed that this event was one in which she truly needed help and, therefore, stirred up fears of not being understood if she were to communicate it. The other stories, obsessively told, were defenses against these more genuine needs for help and understanding. In fact, the meaning of Jana's masochism, on a broad level, was that of not being able to empathize with others, connect with others, in some basic way. The suffering that she expressed was the suffering of someone who was so cut off from others that she was dying inside. Here is a typical story that Jana told in the second year of treatment, before a three week vacation. It was about how new tenants in her duplex accused her of having stolen and hogged their garden plot, while in reality that plot had always been shared by both sets of tenants. She had been using her half of the garden plot, but had not used their half.

> Pt: They called me outside and said they had cleared away their garden plot for planting. There had been some rocks and rock garden plants there when I moved in, and I had fixed them up over the years, cultivating and weeding the area. They were nice plants. The people pointed over to the side of the house and said, "Oh, there they are." I looked and there were my plants, dug up, lying in a tub with no water or soil-just pulled up from the ground and thrown away. How could they have made me feel like I had stolen something, when they destroyed my garden like that. I couldn't say a word. Now it's eating away at me. It's like I practically foam at the mouth and get furious when I think of it...Sounds very petty.
>
> Tx: Sounds very important! It seems like you can never have something special for yourself without it being taken away, destroyed.

There were numerous stories like this; her father gave away the weeping willow she had planted when young; her best friend didn't water

her plants and they died. It often seemed as if her very soul was being attacked and murdered along with the destruction of the plants. My associations to plants were also of a feminine nature: that they seemed to have something to do with the mother-daughter relationship. At one point, Jana told of planting something for her mother that her mother had never been able to grow; she was very pleased at being able to give her mother this tree.

The evening after the rock garden story, I had one of my only dreams about Jana. In the dream, I went to her family home, which I noticed was surrounded my lush plants, a weeping willow, and lots of newly planted garden space. Walking around the house, I knocked on an open porch door in the back and Jana came to answer. I affectionately put my arms around her, feeling very close to her as well as nurturant, and said, "I've come to see your garden-show me all those flowers and trees I've heard about." The dream was about many things, one of them being empathy and a desire to get close to someone who had made it very difficult for me to get close to her. Although her stories, and the way she told them, seemed designed to shut others out, this was also how she felt: boxed up, behind a glass bubble, uprooted and disconnected. It was how I had felt at the start of the treatment with her, and the dream was leading me out of the disconnectness and to a place where I could be of more help to her.

A function of Jana's masochism was to obsessively mask important feelings that she felt were too ugly or messy to divulge. She had been told, as a child, that crying was a sign of weakness to be avoided; that talking about feelings was indulgent; that being assertive was "ugly" in a woman. In describing her upbringing, Jana recalled her mother taking

the children to a mall and leaving them in an area of a dress shop while she tried on clothes. She stated that they sat completely still, and her mother had many compliments on what "angels" she had for children. As Jana remarked, "It wasn't as if we had to keep from playing, or running around, it was as if there was no spirit left in us by that time-the fear of what would happen if we disobeyed killed any spirit we may have had then".

A sequence in a session in the first year of treatment portrayed how her stance as victim functioned to recapitulate this childhood dynamic of sitting lifelessly in the dress shop. She told this story, with precise detail, on the day that her divorce had been finalized in court. In the story, her (crazy) landlord claimed that her car was leaking oil on the driveway and he demanded that she do something to prevent the spillage. Although she proved to him that her car was just fine, he would not listen to her and he insisted. She brought her car to the shop and had all the pipes tightened "so that nothing would possibly leak out." When I interpreted this story in terms of her wanting to make sure no feelings about the divorce leaked out, Jana burst into tears and openly grieved the loss of her marriage: tears like that were not allowed in her household as a child.

As the treatment continued, we were able to address her defensive processes more directly, and I was able to empathize with her more easily. This was a constant challenge, because Jana's transference to me was of someone who was robbing her or hurting her in some way. Here is a typical example from our second year of treatment, when I wondered about her role in a confrontation with a professor:

> Tx: Not that you enjoy these struggles, they cause you alot of pain, but, as we've talked about, you seem to pull for them at the same time.

> Pt: Karla [friend] was into astrology and she said my sign was of a person 'split', with various reasons for doing one thing-multifaceted. She was into phrenology, astrology, all those 'ologies'. I don't really believe in 'ologies'. She even had a voodoo doll and she'd poke pins in it. I wondered if she used her doll against me.
>
> Tx: Does it feel like I just poked pins in you, used my psychology to hurt you?
>
> Pt: Yes. A bit. But I know it is all to help me in the end. I just don't understand. I try so hard to be nice to people, so it's hard to think that I deliberately do something to get into a struggle...

Whether or not my interpretation was delivered prematurely is open to debate, for certainly if it was it would have enhanced her feeling of having been needled by me. However, this perception did apply to almost everyone in her life. It is also interesting to note, in this example, that there was also hostility expressed on Jana's part: she insulted all the "ologies" and, while speaking of someone harming her, she was also speaking of her own contempt. This brings our discussion back to the functions of Jana's masochism, and the fact that her self-sabotaging tendencies seemed to be a necessary precondition for self assertion. Also, as noted before, her stance of victim left others as the aggressors, and in this way a split off part of herself was expressed through others. Not only did these projected "bad" qualities provide vicarious satisfaction for Jana (because they were really parts of herself), but she was also able to use them against herself and atone for her strivings. Masochism, for Jana, took on many complex and interwoven functions. Asking others for help, getting close to others, pursuing autonomy, expressing anger, feeling positively about her accomplishments, all were linked in some way to a punishing action or thought.

Her masochistic style served as a necessary precondition for her competitive achievement-oriented strivings as well as her sexual impulses and positive feelings about her own attractiveness. As she frequently exclaimed, "I'm not stupid, but people think I am!". Or, she would tell of her indignation at a man having complimented her looks; "What does he think I am, a prostitute?". At one point, she told me, quite confidently, about a research contract she was fighting to obtain; that night she had a nightmare of a chemical explosion in the lab where the work on this contract would take place.

Jana's continual sense of having been robbed by greedy others, appeared, in part, to be a projection of her own greediness and desire to gain possession of precious items. She told of having gone to a friend's apartment, who was selling some furniture, and rather spontaneously complimented some items in the room. The friend looked at her and condescendingly stated, "Oh, those are not for sale..." Like so much of the material presented in the sessions, the emphasis here was on the behavior of the other person, yet the pictures these others painted of Jana seemed to be her own worst fears about herself.

Anger was the other major by product, or side reaction, of her tales of victimization. Any direct expression of anger had been forbidden in Jana's upbringing and she felt it to be rude, improper and out of control. However, if others were rude and she was simply reacting to them with indignation and outrage, this made the anger more acceptable. In relaying to me how others had slighted her, Jana's tone was often rageful, with her ending the tale with a statement like, "I could have jumped all over her for that", or "I will yell at him, let him have it, when he gets back to town". This is true in the rock garden story, in

which Jana felt like "foaming out the mouth" with anger at having been violated by these neighbors. Most probably, this feeling of having been robbed, violated and misunderstood was a central one from her childhood, but she could only express anger over the past through atrocities in the present.

There were many reasons for the suffering being the necessary precondition for assertion of needs and affects, which had to do with Jana's identifications and ties to both her mother and father. Early memories of retribution for assertive acts were abundant. Her masochistic strivings had a dual purpose in her adult life. First, they were expressions of instinctual desires for her father. She told many stories of her desires to be close to her father, only to be rebuffed by him in some way. Her achievements thus far had been in an effort to please her father. However, this meant that these same achievements were a betrayal of her mother, whom Jana stated wanted her to sew and sell baby clothes. Her achievement conflicts were, secondly, expressions of her Oedipal guilt over betraying her mother.

In addition, her masochism was, in itself, reflective of her strong identification with her mother and of her desire, although conflicted, to possess her father as her mother had. Identification with her mother was bound to bring conflict with it: here was a competent and talented woman who had given up her achievements for her marriage. As Jana stated once, "My mother understands what I say, yet in her marriage, she always says 'yes' to Daddy.

The frequency with which Jana got into struggles with others suggests her compulsion, on some level, to maintain and seek out such relationships. It seems that, as the middle child in the family, she

never felt as valued or special to her father as her siblings. She told many stories of Cindy being allowed into "Daddy's inner chambers [his study] to discuss important matters while me and Momma stayed and washed the dishes." Her tie to her father was, by her description, special by way of its sadomasochistic nature. At times, she almost sounded proud at being able to take his criticism of her. Whereas her sister was valued for her quiet compliance, her brother was respected for his spiritedness. Jana remarked several times that she was the child who was punished the most by her father, and she prided herself on having "taken it" without crying. Her repeated choice of men like her father speaks to her strong wish to maintain this tie, even if the price to pay was her accepting abuse.

In fact, Jana was only sometimes aware that her father and many of the men she dated were indeed abusive. Masochistic self-derogation served to protect a positive image of them at the expense of herself. When I would comment on the seeming cruelty of her father's disciplining, Jana would counter it with, "I really deserved it." Even after bitterly complaining about her husband's outrageous behavior throughout their marriage, Jana would, in the next breath, wonder if there was anything she might have done to get him back.

One memory of an early childhood trauma portrays many of Jana's current dynamics in the context of past dynamics. As a toddler, Jana stood with her mother as they watched a family friend drive away. Impulsively, Jana grabbed the bumper and held on to it, refusing to let go as her mother screamed that she do so. The driver finally stopped and Jana's legs were scraped to the bone and bleeding profusely. Her father was contacted and he took the screaming child to his office, cleaned her

wounds and then beat her for having used such poor judgement. On a relational level, this was the tie to her father that Jana so tenaciously repeated as an adult; being hurt and abused in order to have a precious possession. As an adult, Jana remained impaired in both her ability to obtain help which was not fused with aggressiveness and to relinquish her grip on things when they become destructive to her.

The Victim-Aggressor Introject in the Treatment

From the preceding discussion, we can see that Jana had an internal relational dynamic between a victim and an aggressor, which she both tenaciously held onto and compelled others to enact with her. The almost continual confrontations in which she would become involved were usually provoked by her in some way. However, she unconsciously chose a certain type of individual with which to become involved in such a struggle: someone who was prone to play a bully to someone else's victim. Jana's victim-aggressor dyad was a fairly stable introjective and projective configuration. Once she felt abused by a person, she tended to remain identified as the victim in the face of a bully; these were whole-object constellations, not rapidly fluctuating but rather corresponding to specific people at all times.

Although her perceptions of herself in relation to others were stable, what was not conscious for Jana was her own sadistic impulses, whether projected or contained by her. For instance, when looking depressed and complaining about an incident, Jana would speak in an angry tone about how horrible someone else had been. While the emphasis was on the other person's anger, it was her own rage which was masked. In addition, Jana would have a perception of a woman her age as very competitive in an aggressive and underhanded way, trying to cut her out

of grants and projects. However, Jana's tone and her savvy about professional matters would shine through this talk, making it clear to me that this was achievement-focused strivings were very much a part of her internal world as well.

In addition, as mentioned earlier, Jana's means of expressing her stance of victim was, in itself, a hostile gesture at times. By obsessively elaborating on stories and not allowing others room for comment, she was being as rude (indirectly) as the people about whom she spoke. It was the task of the therapist to empathize not only with the victim Jana said she was, but to empathize with the aggressive-other in her stories, for this was also a central part of Jana's identity.

Kathryn

Identification of Patient

Kathryn is a twenty-one year old, white, Catholic woman from a working class California family consisting of a divorced and remarried mother, stepfather and two sisters and six brothers. At the start of her three year therapy she had been married four years and had one daughter, age three. She was awaiting finalization of a divorce, which was precipitated by problems arising from her husband's cocaine abuse; he had exhibited increasingly paranoid behavior and had been having affairs with other women. Unemployed and without a high school degree, Kathryn was on general relief and was studying for her G.E.D. The main issues that Kathryn articulated at the start of the therapy were her mistrust of others, particularly men, and, corresponding to that, her unmet dependency needs. She related a chaotic and traumatic childhood history, which included forced sexual contact with her stepfather. Kathryn had mixed feelings about her role as a mother, and had a history of physical abuse of her daughter during times of stress.

A soft-spoken, pleasant woman who dressed in athletic or casual outfits, Kathryn appeared older than her age, as if worn by the hardships of life. Often mildly anxious and depressed in the sessions, she typically fidgeted with tissues or swiveled in her chair and gazed down at the floor. To understate her need for help, Kathryn often described the hardships of her everyday life in a playful, joking manner. Although she laughed easily about life, she also displayed appropriate sadness at times. However, she was less direct about her anger; although routinely denying any angry affect, Kathryn frequently

spoke in a bitter, clipped tone. At the start of the treatment, she typically countered and disagreed with anything I said, even the most obvious and benign comments.

Early History

Kathryn was the last of ten childen born to a chronically depressed mother and an alcoholic father. She was raised in a poverty stricken and chaotic home characterized by unpredictable violence; she recalled her brothers and their friends running wild around the house, throwing beer bottles through the windows and turning over the furniture. When Kathryn was four, her father was barred from the house by a restraining order, after he had smashed a beer bottle over his wife's head in a drunken brawl. Although she had fond memories of her father in early childhood, she rarely saw him after he left the house. Her mother remarried when Kathryn was six to a man whom Kathryn decided "looked like a criminal" when she first met him. In contrast to her siblings, she was a quiet, sensitive and cooperative child who tried to stay out of the way of the chaos. From ages seven through twelve, she was molested by her stepfather, who has since been convicted on several rape charges and had sexually abused her older sisters as well. When Kathryn told her mother about the incest, her mother suggested she "stay close" to her thereafter but did not intervene in any further way.

In describing her mother, Kathryn recalled her as a victim of unfortunate circumstances, particularly of the abusiveness of men. Consistently stressed by poverty and the demands of nine children, her mother had limited amounts of nurturance to give to each child. As Kathryn remembered it, her mother only kissed her and hugged her once. Since Kathryn's sisters were older than her, they were married or away

from the home when she was five and older. As Kathryn recalled, all her sisters were married to or involved with abusive, alcoholic men. Generally, when Kathryn had needs, she would go off alone and appreciate the quiet around her.

Although her sexual relationship with her stepfather was traumatic in many ways, it also was the most intimate relationship she had with anyone throughout her childhood. It was unheard of, in her crowded household, to have time alone with a family member. Certainly, her brothers were to be avoided at all costs, and her sisters and mother were unavailable for companionship. Her stepfather took her to a friend's trailer on some nearby land where they would often spend the entire afternoon. Although there was the forced sexual contact that she had with him, her stepfather was never physically abusive and Kathryn described him as gentle in many ways. During their time at the trailer, they spent pleasant hours fishing in a nearby lake and did some farmwork together. It was not until she was entering puberty that Kathryn fully realized that the sexual contact was unusual and wrong. It was at this point that she told her mother, and there were only a few contacts with her stepfather after this time. Several months later, her stepfather was indicted on rape charges involving a neighborhood girl, and she told her sisters about his abuse of her. Although she was mortified to be telling about something she felt was both so horrible and so private, her sisters shrugged it off, giggling that "he did that to us too." Kathryn later recalled having felt shocked and hurt that their "special time had not really been all that special."

Kathryn had chronic ear infections as a child which led to her missing school often; she quit school altogether in the seventh grade.

At that time, she moved out of the home and in with her aunt Cindy, who was a maternal figure for her during her youth. Kathryn's tendency to stay out of the way grew into agoraphobia in her adolescence; she was fearful of the men she met in everyday life, became quickly anxious while shopping, for example, and tried to stay in the home as much as possible. In late adolescence, she worked at a retail store, where she met her husband. She was married at age seventeen to her husband, whom at the time promised to take her away from her impoverished background. Although he was abusing drugs then, Kathryn was not aware of it.

Kathryn remained in close contact with the women in her family when she moved to the East Coast from California; both of her sisters were in the area. Her family viewed her as the "pillar of strength" because of her relative stability and she was frequently called upon to take care of needy family members. Throughout recent years, Kathryn had struggled with issues of individuation from her family and a corresponding sense of guilt; her family seemed to bond together through suffering, and success was seen as disloyal. Kathryn was frequently called upon to care for her aunt Cindy, who was physically abusive to her three children and had a history of suicide attempts, substance abuse and an extremely unpredictable temperment.

Recent History

Shortly after their marriage, her husband got a job offer on the East Coast and the couple moved. This was an extremely difficult time for Kathryn, who was socially isolated, had a small infant and whose husband was away at work for much of the time. Feeling overwhelmed and uncared for, Kathryn struggled with her impulses to beat her daughter, Amy, whose spunk and natural ability to engage others had always

bothered her mother. For a brief period of time, Kathryn was punching Amy with her fist; she described times when she would grab Amy by the edge of her diaper and throw her into the bedroom, lock the door and go jogging in order to prevent herself from being abusive. During this time, she had a fear of the knives in the house due to her poor impulse control.

When she began treatment, Kathryn had stopped the abuse, yet continued to struggle with her sense of deprivation and her conviction that receiving nurturance was intricately connected with being hurt and helpless. For instance, throughout the time she was in therapy, Amy was rarely allowed in the kitchen, because of the presence of knives with which she feared she might hurt her. She rarely tucked her in at night and did not like going up to her room because of the possible rage that might get stirred up by seeing toys not put away or whatever. Although her rage and impulses to hurt Amy remained out of her conscious awareness throughout the bulk of the past few years, in times of stress she worried that she would stab her to death, "like you read in the paper sometimes."

Shortly after her worries over hurting her own child, Kathryn became preoccupied with taking legal action to stop her aunt's abuse of her three children. Whereas in the past, she took Cindy's children for weekends while Cindy was having trouble, this time she contacted the appropriate social service agencies and reported her aunt. The subsequent investigation, in which Kathryn testified against her aunt, was a major step toward individuating from her family. This court battle became her statement against child abuse, against her family's pattern of not protecting the victim and against her identity as the sweet relative who could be used as needed.

The outcome was less than satisfactory and led to a reversal of many of Kathryn's stated battles. In the face of what appeared to be rather incriminating evidence, Cindy was granted custody of her children. Kathryn became furious with and mistrustful of the mental health system, including myself, and experienced herself as the uncared for child in the face of neglectful institutional caretakers. Whereas in the last several years, she had become increasingly social and independent, she became withdrawn and depressed. The trial had exacerbated the sense of not being in control of her life which characterized her childhood, and she regressed; she began binge eating, drinking and being short-tempered with the children.

Summary of the Treatment

The transference emerged quickly and it was difficult to effectively interpret it so as to prevent Kathryn from acting out. Specifically, Kathryn viewed therapy as a "torture chamber", comparing it to bad tasting medicine that she had to force down. At times she reacted to benign questions as if they were attacks, and she would answer me in a clipped and hostile manner. The painful breakup of her marriage had exacerbated her mistrust and fear of dependency, and she was both rageful and not about to feel "too comfortable" with me. She missed many sessions in the early months of the therapy, and was freqently late to others. Any interpretation of hostility toward me or of her resistance to treatment was rejected when I offered it, however, she would then introduce my comment on her own later in the session. At the start, Kathryn experienced herself as a passive victim in a threatening and unpredictable environment; she desperately fought to be in control of every aspect of the therapy.

As the therapy became more collaborative, Kathryn began to work through the sexual experiences with her stepfather as a child. We explored her view of the therapy as parallel to the incestuous relationship with her stepfather; she described both as relationships in which special attention and nurturance were linked to humiliating exposure and victimization. Kathryn began to question her stance as the passive victim of my torture; witnessing an interaction between patients in the waiting room prompted her realization that others had different perceptions of therapy and that she chose to view the treatment in this particular way. She also became aware of a wishful fantasy that she was my only patient, and maybe the only patient in the clinic. This led to a reconsideration of the experience with her stepfather as not only painful and humiliating but as one of the only relationships in her childhood that offered her some special attention and nurturance. It was through this realization that she became aware of her investment in being the victim and she began to work on ways she could be taken care of without being abused. It was at this time that Kathryn became involved in a variety of social activities.

Kathryn continued to examine and take responsibility for her role in unfortunate events, rather than to view them as her "lot in life" because of her family background. A focal point in our second year of the treatment was Kathryn's relationship with her daughter. She painstakingly recalled her physical abuse of Amy during infancy and, for the first time, she viewed herself as having been the perpetrator and not only the victim. A corresponding development was a reworking of her views of both her mother and her stepfather Raymond, she came to see them both as an integration of victims and abusers as opposed to either extreme.

Well into our second year of the work, there was an intense time of significant movement in treatment. Kathryn verbalized fears that if unleashed, her rage would "destroy us both" and her tears would "never stop". Based on her volatile and abusive family of origin, Kathryn had no evidence that anger and sadness could be directly expressed in a modulated and productive manner. At one point when she was overwhelmed with painful feelings of abandonment before my vacation, Kathryn related a fear that the "men in white coats" were coming to take her away and would place her in a room like my office, where she would sit forever. She imagined that the dependency she began to feel toward me would lead to a merging between us; the outcome would be an abandonment by me and a loss of her own identity, as had happened when her husband left her.

As Kathryn worked through her extreme wishes to be cared for and the rage accompanying her sense of deprivation, there were several significant occurances in her outside life. Whereas she never allowed herself a "day off" from her role of mother, she did so occasionally. As a present to herself, Kathryn flew to California for a vacation. She spent her birthday driving alone to her childhood town, where she looked for her father at a local bar. She saw him and followed him for awhile, filled with pleasant memories of closeness to him in early childhood (severely demented from alcoholism, he does not remember his children's names or faces).

What followed this intense and productive time in the therapy was a very stormy time, from which we never entirely recovered. Kathryn began devoting her attentions to a crisis with her aunt Cindy's children, and placed me in a difficult position where my reactions to child abuse and how to intervene were tested through her urgent questioning of how to

proceed legally. She was both identified with her aunt: the abuser, and her niece: the victim, and she was testing both how I would intervene to prosecute her in potential future child abuse and how I would intervene to protect her when she experienced herself as a helpless victim. Although I tried to provide her with options as to how she might proceed, while mainly interpreting what this crisis meant for her, Kathryn decided I was responsible for her decision to testify against her aunt. When she lost the case, I became the mother who failed to protect her from abuse; she became disillusioned with me, increasingly depressed and isolated from her family and friends.

Kathryn dropped out of treatment for several months and then reappeared for several weeks at a time, only to leave again. This went on for about six months. When she made her final decision and concrete plans to move, she returned to the therapy for a final two months to terminate with me. It was a productive and moving time, as she reviewed her changing perceptions of herself and me, and did so with a minimal amount of defensiveness. She acknowleged her feelings of closeness to me and the amount of energy she invested in fighting such closeness.

Functions and Meaning of Masochism

Before examining what Kathryn's sadomasochistic dynamics meant in terms of past relationships and defensive functions, we will first take a look at how they were expressed. Kathryn's masochism was not overtly manifested in every area of her daily life, for she was a hard working and effective woman in many ways. However, her self-concept was that of a victim: she was a slave to the needs of others while denying that she had needs and desires of her own. She was always burdened, rushed and never had time to herself. Therapy was considered by her to be a luxury

that she could not afford. As she frequently complained, "everything I do in life is for somebody else".

There were many ways that Kathryn had of communicating her stance of victim in the therapy. If she did not show up for a session, it was because her children needed her or she could not justify taking the time away from important household matters. And if a session brought up painful material or affect, Kathryn would go home and retreat to bed with a headache or stiff neck for the next several days. Instead of acknowledging her need for rest, she felt that her body had caused her suffering.

Kathryn was even more indirect in expressing her sadistic, rageful affects, since most of these feelings were inaccessible to her. Maintaining that she would go out of control with her anger if she did experience it, Kathryn was phobic and avoidant toward such affect. This was most clearly seen in her fear of touching sharp objects around the house because of the possibility that she would lose control in an angry rage and kill her children. Her anger was also acted out through her physical abuse of Amy; if she had been more attuned to her rage, it most likely would not have been expressed in this manner.

In the therapy, Kathryn was equally ill at ease with her anger and tended to express it through avoidance, such as through lateness, failures to attend the sessions or her lengthy, stubborn silences. At these times, she would perceive me as angrily trying to pry things out of her, which she was unable to give to me. Or, if she was angry at me, she would turn the tables and perceive me as the angry one, who was challenging her to a duel: in her view of the interaction, she could either stand up to me, or be considered weak. A session early on in the

treatment helps to illustrate how Kathryn was able to express anger by imagining that I demanded it of her.

> Pt: (start of session, after silence) I thought for sure you'd have something to talk about when I came in today. Last time, I mentioned that the therapy might not be going as well as it could because of my inhibitions about how young you look and how this is a training clinic...I was warned against coming here, but I really don't have a choice- there is nowhere to go that I can afford that isn't staffed by UMASS students.
>
> Tx: your concerns last time were important ones-who I am, whether I will understand you, whether this setting is a trustworthy one...
>
> Pt: the setting is a valid concern, but I feel narrowminded worrying about your age. But I remember my shock when I first saw you-you looked so young!
>
> Tx: And what have been your impressions since then?
>
> Pt: In the beginning I tried to be on my toes all the time with you-you are a challenging person. I'm always on guard for people to disapprove of me, and I felt I had to back up everything I said to you...I thought for sure you'd jump on me the minute I walked in today. I thought to myself, now I've got to come back and face the fire. I knew you wanted me to tell you what I thought of you, and now I did...listen, you wanted this-not me!

The previously quoted session was noteworthy because of Kathryn's explicit comments about my age and about the clinic. It was more usual for her to deny any such negative feelings, but to express them in her tone of voice and through her actions. Her hostile feelings were often expressed in the context of her experience of being victimized, as if that justified the anger. For instance, early in the therapy, Kathryn dropped in on a local exercise class and, upon seeing me there, watched me, quite obviously, for several minutes. Feeling rather intruded upon, I experienced the incident as a hostile one. Kathryn introduced our chance meeting in the next session, and, again, the anger was expressed in the context of victimization:

Pt: I saw you at Aerobics-did you see me there? (Yes). I thought I saw an uncomfortable look come over your face. It was the first time I saw you outside of this room, and it felt good to see you as the one who was sweating and working for once. I was happy to see you look slightly uncomfortable-it evened up the score. I am resentful that I have to take therapy-that I have to come here and be put through this...

Tx: You make it sound like torture-and like I'm the one who puts you through it...

Pt: Yes. You put me through it, and you get to see me at my worst-so you get the worst of me...

Kathryn's stance of being the victim of other people's torture had its roots in the important relationships of her childhood. As mentioned in the previous section, her stepfather's sexual abuse of her was in the context of what Kathryn perceived as a special and intimate relationship in some ways. Her brothers were distant and physically threatening; she could only recall her mother having kissed her once; and her sisters were older and unavailable. The physical closeness with her stepfather was the only physical closeness this child had, and it was clearly interwoven with suffering and guilt. However, it was also special. As Kathryn once remarked at a time in the treatment when she was working through the sex abuse, "It did happen. I got so little attention growing up that I was happy to have someone to myself. Plus, no one ever tried to interfere and stop it, so it was hard to really think of it as abuse."

Kathryn's identity as a victim was also closely connected to her relationship with her mother, who saw herself as someone who was suffering due to having been given a gotten deal in life. In thinking of the many ways that her mother had let her down, by not adequately protecting and nurturing her, Kathryn would fall back on this notion of

her mother as a helpless victim. In this way, her mother was absolved of all responsibility for her inadequate caretaking, and Kathryn did not have to be angry with her. Kathryn was closely identified with her mother, and was also loyal to her in many ways. Holding onto her own identity as a victim preserved her image of her mother as someone who had no control over the ways she disappointed and hurt her daughter. As Kathryn once remarked, "I was always so proud of my mother and how well she managed in her life. Now I realize that she made those choices and she had other options." This was a major realization, and the working through and relinquishing of her role as victim meant a relinquishing of her view of her mother and a corresponding separation from her.

Finally, Kathryn's early experiences with family members in her childhood had a major impact on her split view of the world into those who were victims and those who were perpetrators. In fact, it seemed as if the women were the sufferers, and the men were the abusers. For Kathryn, the role of victim kept her from angry affects. When she began to relinquish the victim stance and experience the anger, she feared that she would go from being like her mother to being like her father or brothers. As she once remarked, "Nothing good ever came from anger in my family. I don't want to unleash my anger. I saw my father beat my mother, my brothers abuse their wives. I don't want to feel guilty about hurting anybody." In Kathryn's adult life, her view of herself vascillated between the two opposite configurations she witnessed in her childhood: if she was not the quiet child who stayed close to her mother, she was the abusive, explosive tyrant who would lose control and wreak havoc on those around her.

Now that Kathryn's sadomasochistic dynamics have been examined in the context of her early object relationships, it is possible to take a closer look at the functions and meanings of her fluctuating identity between victim and perpetrator. First, in considering the defensive functions of her stance as victim, we will once again look at Kathryn's incest history and its impact on her maintaining and replicating this identification as sufferer. As Kathryn painstakingly discussed in the treatment, the incest brought with it some pleasurable feelings of being cared for and wanted that were, unavoidably, associated with guilt and shame. As a result of this early experience, Kathryn tended to link many nurturant experiences with suffering, as they were indeed connected in childhood. This was the essence of her masochism: experiences which did not have to be torturous were perceived as such by Kathryn.

This served a dual purpose for Kathryn, on two different levels. First, her masochistic view of relationships was a means of replicating the most nurturant and intimate relationship of her childhood. Furthermore, in addition to satisfying a libidinal aim through this unconscious repetition, it also served, on a more conscious level, to appease her guilt over the special satisfaction she had derived from the incest. Kathryn was compelled to make things painful for herself: that way no one could ever accuse her of enjoying something from which she should not be deriving pleasure. This was most clearly evident in the therapy relationship, which Kathryn experienced as a parallel of the nurturant, yet illicit, relationship with her stepfather. The only way she could tolerate participation in the therapy was to perceive herself as forced to do so.

Another defensive function of Kathryn's masochistic view of relationships was that it protected her from painful feelings of dependency on others. In childhood, Kathryn was not given the opportunity to depend on a caretaker who was stable and trustworthy. Her mother was not in control of her actions; her father left her at an early age; her stepfather combined suffering and betrayal with closeness. In the therapy, Kathryn invested a lot of her energy in convincing herself and me that our relationship was painful and torturous, not pleasurable or comforting. In this way, she would never let me become important and, thus, could not be hurt by me. An illustration of this defense against dependency is provided in the sixth session, which she began by describing therapy as another stress in her life.

> Tx: Do you ever imagine you could come here for comfort, or just to get away from it all?
>
> Pt: My life is too messed up to sit here for comfort. If this got to be a comfortable place, that would mean I should stop coming.
>
> Tx: How's that?
>
> Pt: This is a very isolated place. I don't think I'd want to get too comfortable here. I only want to be comfortable with myself. This atmosphere invites dependency and I have to ward that off. I have to appear strong here. This relationship is so one-sided that I fight it doubly hard. If it were a give and take, it would be better.

From the way Kathryn was talking in this early session, she sounded counterdependent, as if she had little needs for others. As the work continued, her strong unfulfilled dependency needs emerged, and she struggled to fight them off with perceptions of the therapy as a painful, unpleasant struggle. This example from our second year of

treatment captures a sense of both the strong needs for nurturance and the defenses against them.

> Pt: (start of hour) It's nice in here, warm...Don't sit there staring at me like that!
>
> Tx: It makes you uncomfortable?
>
> Pt: I feel like I should have something to say. I never knew how much I dominated in here. The focus is on me. I feel so selfish. [talks further about getting good things she doesn't feel she deserves]
>
> Tx: This sense of having someone's time or attention to yourself and feeling bad about wanting it seems to have some parallels in your childhood-do you think so?
>
> Pt: You mean Raymond? [stepfather] Yes. But it was the wrong kind of attention, just like here. Here, I'm attended to because of the weak, sick sides of me.
>
> Pt: (end of hour, after long silence-she's rocking in her chair looking comfortable) I hate when I rock in my chair. It reminds me of those retarded children who can't care for themselves. Just sit all day and rock...And you look like you're going to fall asleep. Please don't fall asleep-my faith in you will be completely lost.
>
> Tx: Why would I fall asleep?
>
> Pt: It's almost time to go. You're tired. Is it time?
>
> Tx: Yes, actually it is time. I'll see you next week.
>
> Pt: There is one next week? (Sure-Yes). [Opens the door with difficulty] One of these days, I'm going to open the door and it'll be locked and I'll panic. I'll be stuck here forever.

Another function of Kathryn's sense of herself as passive victim was that it served to ward off her murderous rage over her unmet dependency needs. Rather than to directly confront me with her anger over a break in the therapy, Kathryn expressed it by skipping sessions due to somatic complaints. Upon discussing this further, Kathryn exclaimed, "I would

rather be the one who was hurt than the one doing the hurting." As she recognized her more active role in presenting herself as a victim, as well as explored her history as an abusive mother, she became more in touch with both her neediness and her rage.

In fact, being the passive victim not only buffered Kathryn from anger, but from a range of feelings and desires. Furthermore, there was a great deal of strength to be gained from this victim stance. As the victim, the incest was beyond her control. She was the weak martyr who withstood horrible deeds, not only in childhood but continuing on into adulthood. However, to see oneself as having had control over something takes away that strength that comes with being a martyr. As Kathryn began to relinquish her identity as a victim, she felt "weak, as if I could have changed my life but I didn't."

Kathryn's ragefulness, which was so closely defended against early in the therapy, was nonetheless present throughout the treatment. Her aggressive affects, in the treatment and in her history as an abusive mother, served many purposes and expressed many things. As was mentioned before, her rage was primary in nature, in response to early maternal deprivations and a childhood of unmet dependency needs. When Kathryn analyzed her abusiveness of her daughter, she came to understand it in terms of her own needs for nurturance and her envy and rage over her daughter's seemingly unlimited needs for care. Her rage took on a sadistic tone not only because it was primitive in nature, but because the only anger displayed by those in her life had been expressed in intense and destructive ways.

One of the functions of Kathryn's rage was as a defense against the closeness and dependency that she longed for yet feared. As her hostile,

mistrustful presentation relaxed a bit, and her cravings for closeness emerged, it became apparent that these wishes for closeness were on the level of symbosis and engulfment. Kathryn wanted to be cared for completely, which made her fear that she would lose herself to the other person. This was illustrated in the previously quoted segment of a session where she feared that she would trapped in the office forever. Hence, Kathryn's projected sadism, such as her perception of me as forcing things from her, was a way of keeping distance between us; it served as a means of not depending on me in this woman who was so prone to depending on others.

As mentioned before, Kathryn's anger and her ability to turn the therapy hour into a challenge or battle was a defense against the therapy feeling too enjoyable. Not only would that replicate the illicit libidinal pleasures of her childhood but it would also foster dependency, which brought with it the threat of abandonment or engulfment. In this way, her hostile affects were not only primary in nature but they served several defensive purposes as well.

Kathryn's hostile gestures, such as devaluing the importance of the therapy in many ways, was closely linked to her experience of herself as a victim. In a sense, it was used as an expression of her identity as victim. In the last session, Kathryn, for the first time, shed light on this aspect of her anger when she explained:

> When you are sexually abused as a child, you tend not to trust relationships and I always expected that you would leave. I figured if you could stay with me through my lateness and my skipping sessions, then maybe I could trust you.

The Victim-Aggressor Introject in the Treatment

As has been discussed, Kathryn's object world was divided into victim and aggressor dyads, and her self-concept would fluctuate as her perception of those around her changed. Her identity as victim was most often intact, with a sense of others as persecuting her. However, an experiencing of dependency needs, and accompanying rage over them being unfilfilled, brought with it a shift in her perception of herself in relation to the world. When anger or cravings for closeness and sustenance came into her conscious awareness, she felt herself to be cruel, selfish and dangerously unnurturant. At these times, she became the aggressor, and others were suffering because of her sadistic oral cravings and ragefulness.

This victim-aggressor self-other split was evident in the childrearing. Most of the time, she thought of herself as the altruistic mother who existed only to serve the needs of her child. Her complaints about having no time for even the slightest pleasure of her own conjured up the image of a woman victimized by her role of wife and mother. However, when she did become aware of needs for nurturance, and a corresponding resentment of her needy infant, the self-other perception reversed itself. Kathryn imagined that she would become so hostile toward her daughter that she might even kill her; her neediness was destructive and her daughter was the victim of her murderous rage. The split itself was enacted in the history of the mother-daughter relationship: Kathryn had gone from spoiling her infant to physically abusing her. Even when the abuse subsided, the pattern remained of either being the "perfect mother" who gave everything of herself; or the overburdened mother who snapped at her child and resented feeding her at mealtimes.

This victim-aggressor split was, as has been discussed previously, a projection of an internal object relationship between these two polar dyads. Based on her childhood relationships people were either one extreme or the other. In recreating this relational dynamic, Kathryn projected one or the other of the dyad onto a person in her life, and maintained the other affect herself. What was introjected and what was projected was fairly stable and not prone to rapid fluctuations. However, Kathryn would identify with the projection as well as what was intojected. For instance, by perceiving others as sadistic, Kathryn was able to create and identify with an affect that was frightening for her to contain.

This was apparent at the start of the therapeutic relationship, when Kathryn experienced herself as a passive victim in a threatening and unpredictable environment. Although she experienced me as victimizing her, she sought to victimize me through her unpredictable attendance and her rejecting stance in the sessions. Similarly, by being silent and uncollaborative at first, Kathryn prompted me to ask her questions. When I did, she then saw me as having forced things out of her that she did not want to tell me, leading me to feel inept as her therapist. I began to understand that Kathryn was inviting a struggle that did not need to exist, and that she was just as identified with the sadistic, angry role and with the part of the suffering victim.

CHAPTER V

UNDERSTANDING AND TREATMENT OF SADOMASOCHISM IN THE THREE CASES

The cases which were presented and analyzed in the previous chapter highlight the complexity and richness of meaning contained within a given character trait. A drive theorist might understand the masochistic traits of these individuals as the redirection of aggression upon the self. In contrast, theorists adhering to an object relational perspective would emphasize the degree to which past experiences and relational ties have been sadomasochistic in quality. In accepting either of these hypotheses, however, one still needs to attend to the specific nature of the individual's anger, as well as the unique features of those early relationships, in order to obtain a full understanding of what masochism means in a person. This chapter will further this notion through a comparison of both the meanings and the treatments of the sadomasochistic features across the three cases. Before contrasting the cases, it is important to begin with an overview of the functions of masochism which were reported in the previous chapter in order to highlight the similarities across these three very different patients.

One of the central similarities among these three individuals is the extent to which important relationships in their pasts involved suffering and aggression. In each case, suffering was linked to closeness in childhood: Kathryn's incestuous interactions with her stepfather; Jana's relationship with her harsh father; and Alex's dealings with his abusive father and depressed mother. Given that the nature of their strong attachments involved emotional and physical pain,

it is not surprising that they had maintained attachments in their adult lives that were unpleasant, self-defeating, and at times torturous. Their adult relationships were replications of the object ties in childhood which had become internalized and were then continually enacted with willing partners.

In the cases, a repetition of past object ties involving sadomasochistic dynamics occurred in both same and opposite sex relationships. In the opposite sex interactions, instinctual desires and longings for closeness became intertwined with suffering in clear ways. Jana longed to be the special child in her father's eyes, and since his main interaction with his children centered around discipline, being punished by him was a means, albeit a masochistic one, of obtaining special attention. This dynamic of seeking punishment from her father seemed to have evolved as a last resort in her search for closeness; her father did not seem to respond to, or appreciate, her in the same ways that he appreciated her siblings. Likewise, for Kathryn, an incestuous relationship seemed to be the only opportunity for special closeness and attention; if others attended to her in caring ways, it is likely that the incest would not have been experienced in as positive a light. For Alex, as well, his mother was not forthcoming with affection, unless he had been defeated or hurt in some way. Pain became the price these individuals had to pay in childhood to obtain closeness and affection from an opposite sex caregiver.

Not only did normal instinctual drives for intimacy foster masochistic strivings, but the developmental process of identification with the same sex parent also reinforced the masochism. For all three individuals, the same sex parent had an identity as either a loser,

victim or sufferer. Alex, Jana and Kathryn identified strongly with these parents both in childhood and on into their adult lives. Relinquishing their masochism had inherent in it a separation from the same sex parent, which was very problematic, particularly for the women. The reason for these separation conflicts may have to do with the deprivation, although of various degrees and types, that each patient experienced in childhood. Each of them received little or no positive physical affection from their parents and there was a general lack of warmth in the households. Since deprivations make it even harder to relinquish ties to childhood caregivers, one craves and searches for the nurturance missed and is willing to pay an increasingly steep price for some affection. Hence, it is possible to see how both separation difficulties, and hence, masochism, could result from the backgrounds of each of these individuals.

There were noteworthy connections between ragefulness and self-sabotaging strivings for all three patients, making an exploration of this connection important. In various manners, these individuals expressed anger through their own victimization. Suffering, whether by threatening suicide, or by being unable to provide oneself pleasure or achievement, was employed in the service of delivering an angry message to another person. It seems that a possible reason that anger could not be directly expressed had to do with the nature of the anger witnessed and experienced in childhood. In all three families, anger was expressed in destructive and painful ways. Particularly for Kathryn and Alex, there was a sense that an expression of anger would prove destructive to others. For Jana, any communication of anger was severely punished in her home, hence making it difficult for her to communicate it in a direct, verbal manner.

Not only did masochistic behavior bring with it secondary gains, such as a safe expression of anger or instinctual strivings, but it served a multitude of defensive functions in these patients. Playing the part of the sufferer or victim kept others at a distance for both Jana and Kathryn, who, for different reasons, were hesitant to get close to others. And for Alex, it was both his self-sabotaging style and his angry, intimidating stance that kept people at bay. The fears of intimacy were most probably connected to both early deprivation and the fact that closeness was associated with pain for them. However, as mentioned before, even though painful closeness was feared it was also longed for: it was the only closeness available.

The masochistic strivings in these patients both expressed a wish for a certain type of relationship and defended against these wishes at the same time. Jana, for instance, through her replication of sadomasochistic interactions in adult life, had both recreated her longed for relationship with her father and punished herself (through her suffering) for such oedipal strivings. Likewise, Alex both recreated the closeness he had with his mother, yet evoked abuse from his father, atoning for his oedipal guilt.

There are many other functions of aggression and self-destructive behavior, but they are best addressed in more detail while contrasting the cases. Before doing so, it is important to mention one more major similarity, albeit an obvious one. Both sadism and masochism existed simultaneously in the patients. When one of these affects was felt, the other was often projected onto the therapist. These individuals employed splitting defenses in varying degrees, as well as used projection in different ways. But the internal object worlds of all three individuals

featured an ongoing tension between victim and aggressor, which were based on childhood dynamics and were played out in the relationships of their adult lives.

Contrasting the Cases According to Developmental Differences and Diagnostic Features

If, as was discussed, sadomasochistic dynamics are repetitions of object ties from one's past, then it is the unique features of these early relationships which determine the nature of the masochism, how it is expressed, and the specific defensive functions that it serves. Furthermore, the nature of the early attachments play a central role in the formation of the child's structural organization, and, in turn, this organization colors the expression of the masochism along with its functions and meanings. This will hopefully become clearer as the cases are contrasted in terms of their underlying structure, developmental impairments, and quality of object relationships.

As was discussed in the second chapter, the earlier the point of maternal deprivation, the weaker the ego functions in the developing child. In taking a closer look at the character structure of Alex, we can see an individual functioning at a borderline level of organization in many ways. A central function of Alex's masochism was to defend against as well as express his intense oral rage. This rage was activated when Alex was faced with some form of deprivation, stirring up regressive affects centering around the early maternal deprivation he most probably suffered in childhood. At these times of stress, Alex's ego functions would weaken and the boundaries between fantasy and reality as well as between self and other would become blurred. Primitive defenses such as splitting, denial and projective

identification would intensify. His object relations would be reduced to one-dimensional dyads: victim versus bully; ideal caregiver versus barren, depleted mother.

Given these structural features, Alex's sense of himself and others as either victims or aggressors was intensely experienced by him, with the self-other splits being extreme in nature. This is characteristic of a pre-depressive position level of development, wherein ambivalence has not yet been achieved. In contrast, when Alex's oral rage was projected onto the other person, they were then experienced as sadistic: all good features of the other person would be wiped out. This led to an absence of good introjects for Alex, and following from this, he often experienced an inner sense of aloneness, emptiness and annihilation. Faced with such frightening feelings, Alex employed an aggressive, sadistic level of activity in the service of stirring things up, and making himself feel more alive.

A diagnostic indicator of Alex's ego strengths was his proclivity toward expressing his feelings through actions, suggesting that he had weaknesses in the areas of impulse control. If feeling rageful, Alex would fear that he would cause or had caused me harm, and he frequently asked me whether I was frightened of him or angry with him. Alex's reality testing was easily shaken by his rage, causing him to feel as if he had actually done harm through his thoughts alone. Alex had poorly modulated instinctual impulses, and often had primary process level sexual and aggressive fantasies involving, for instance, rape and murder. Since his ego functions were not consistently strong enough to help him contain these fantasies, he experienced anxiety over the possibility of decompensating around his thoughts and impulses.

Furthermore, Alex's superego was also weakly developed, making it difficult for him to make use of helpfully restrictive feelings of guilt and concern. Instead, he maintained more of a primitive, sadistic superego based on his early history with his abusive father. When acting on his impulses, Alex, could not experience guilt; instead he worried that he would "get the shit kicked out of him" for his unacceptable behavior.

Much of this analysis of Alex's structural organization, and the nature of his sadomasochism, was reached through an awareness of the transference-countertranference dynamics in the treatment, particularly in terms of how the victim-aggressor introject was enacted in the therapy relationship. For instance, on many occasions I was fearful of Alex as he spoke of his intense hatred of me or others. At other times, I was convinced that I had failed him in some way, and felt an intense pull to gratify his regressive wishes for closeness. Feelings that were not, in themselves, unusual for me to experience took on an intense and exaggerated quality in the room. My guilt over terminating the therapy developed into a sense that I was abandoning him, or worse, killing him. Since I sensed the all-or-nothing, life-or-death quality to his pleadings for physical contact, the pull to gratify was often quite powerful. These countertransference affects helped me to appreciate the extreme nature of Alex's splitting defenses, and how his use of projective identification had caused me to experience what he had split off from his conscious awareness.

The observations, reported in the previous chapter, that Alex's perception of himself and me as either victim or aggressor were rapidly fluctuating, extreme, and unintegrated in nature helps illustrate his

pre-depressive position, borderline level of structural organization. For instance, when experiencing me as sadistic, Alex would lose a sense of my good, helpful qualities. When holding a sense of himself as an ineffective loser, it was difficult for Alex to realize that others saw him as an attractive, talented and appealing young man. In sum, his sadomasochism expressed primitive feelings of oral rage, deprivation and emptiness and were conveyed in an intense and unintegrated fashion.

Like Alex, Kathryn had a history of early maternal deprivation; both of them had mothers who were depressed and unnurturant during their infancy. Kathryn's anger was on the level of a primary, oral rage over unmet needs for nurturance, as was the case with Alex. Just as Alex would become bitter over the limitations of what I could offer to him, Kathryn would become enraged when others were given the care that she wished she had been given in childhood. Like Alex, the intensity of her rage sometimes led to a weakening of ego functions, such as the impulsivity evidenced by her physical abuse of her daughter. Kathryn, as did Alex, equated anger with destruction, also suggesting that her ego boundaries between reality and fantasy were sometimes blurred. This was illustrated through her commenting, for instance, that she did not want to express anger toward me because she didn't "want anybody to get hurt."

Although she had expressed anger overtly through physical abuse, Kathryn usually employed strong ego defenses against the expression of her primitive oral rage. She was avoidant and phobic about placing herself in situations where her anger might be evoked. Also, she expressed hostility in a passive manner, through lateness and failures to attend sessions. Whereas Alex had a sound capacity to observe and

acknowledge his negative affect, Kathryn was often unaware of her anger, instead projecting it onto others.

In terms of developmental level, Kathryn often functioned on a high borderline level of organization, featuring strong rage along with unconscious cravings for a symbiotic dependency on others. A fiesty counterdependent stance covered over these oral cravings for closeness, again demonstating how her ego strength was employed to defend against her primitive impulses. Her stance as victim served as an expression of her instinctual aims, in so far as it maintained object ties which were replications of her incestuous relationship with her stepfather. This was illustrated through her perception of therapy as "the wrong kind of special attention". Her masochistic approach to not only represented id impulses, but expressed superego forces: by making sure she remained the sufferer, she punished herself for her instinctual impulses.

It is important to note that early object ties color later ones; for instance, Kathryn's enjoyment of the closeness with her stepfather was of a sexual, oedipal nature. However, since she had not received closeness as an infant, she craved maternal nurturance on a preoedipal level: this was superimposed on the incestuous relationship with her stepfather. Kathryn longed for the special, intense, symbiotic connection that is a normal part of the early mother-infant bond. She projected this preoedipal longing onto the incest, thereby appreciating it for its "specialness."

Kathryn's splitting of self and others into victims and aggressors was whole-object splitting, and demonstrated ego strengths on a high borderline or neurotic level. For instance, others were either victims or aggressors, but did not fluctuate rapidly between the two extremes.

In addition, it is important to note that her ego strength increased substantially during three years of psychotherapy. Kathryn worked steadily on integrating her extreme perceptions of others, and was able to employ insight in the service of change. Also diagnostic of her developmental strength was the fact that the severity of self-other splitting was most pronounced around this victim-aggressor dyad; her perceptions of self and other in other realms was more integrated. This stands in contrast to Alex, who demonstated a lack of integration in many areas of his object world.

An awareness of transference-countertransference dynamics aided me in understanding the nature of Kathryn's sadomasochism. This was especially true since she was so guarded about her hostile and dependent affects. Although she presented herself as victimized by others, I often felt like the one who was abused in the room. In somewhat subtle ways, Kathryn would express her hostility, such as by moving the clock in the room so that I could not see it, saying that it was only fair that we both had some control over the time. As mentioned before, Kathryn often told me I was incorrect when I made the most simple of observations, and then proceeded to confirm my observation without acknowledging it. The control struggles in the room had a stubborn, oppositional tone to them and I experienced her as taking advantage of me. It was through an openness to my own reactions that we were able to discuss some of the hostility behind her sense of being victimized.

Likewise, Kathryn's oral aggression and cravings for nurturance were also accessible through an analysis of the therapeutic relationship. For a period of time, Kathryn perceived me as younger than her and as someone whom she had to care for. Rather than to experience this in an

angry way, Kathryn saw it as evidence of her being a nurturant, giving person and a "perfect mother." However, this was a replication of her relationship with her daughter, whom she bitterly resented because she was young and needed care. While being the put upon, all giving mother, Kathryn experienced me as the daughter who was continually challenging her. Although I was seen as the aggressive-other, I was the one being victimized in the room, through her continual challenging of me and devaluing of me. When I was able to acknowledge my own feelings of being abused by her, she then was able to contain and become aware of the aggressive, abusive parts of her that existed alongside the victimized ones.

Whereas Alex and Kathryn demonstrated aggression that had an oral quality to it, Jana was filled with a narcissistic rage conveyed in an obsessive-compulsive manner. Although not subject to early maternal deprivation, Jana's sense of anger over unmet needs was associated with her feelings of having been misunderstood and overlooked in her family. Taking the form of envy, spite and greed, Jana's rageful affects were experienced by her as a desire to outshine others and hoard sought after possessions and spoil others enjoyment of them. Jana's sadomasochistic dynamics existed on a neurotic level, featuring the repression of instinctual impulses against a strong, punitive superego. Since asserting herself, whether it be through an expression of anger, professional achievements or sexual desire, was forbidden due to a sense of guilt and shame, Jana expressed her strivings in indirect ways. As discussed in the previous chapter, her masochism was used to atone for her assertions; suffering always accompanied them. In addition, through her use of projection, Jana saw others as embodying the greed and spite which she could not allow herself to experience.

The obsessive-compulsive components of Jana's sadomasochism were manifested not only through her strong superego and her use of projection, but through her pervasive inability to relinquish that which she had acquired. Jana often described herself as "feeling stingy" on a particular day, not wanting to hand over the information she held inside her. This applied to her identity as a sufferer, which she clung onto despite an intellectual awareness of it. In the sessions, she provided intellectualized accounts of why she may have engaged in a particular struggle with someone, but her affect was kept under the surface through this distanced means of communicating. Furthermore, her detailed, dry stories of everyday occurrences were obsessive defenses against the immediate affects surrounding the therapy relationship.

The quality of Jana's sadomasochistic dynamics with others can be viewed as existing on an oedipal level: as replications of her conflicted relationship with her father, in which abusiveness was fused with desires for closeness and recognition. However, questions arise as to why the approval from this man meant so much, and why her sense of her own capabilities was so dependent on him. Just as Kathryn's experience of the incest was colored by earlier maternal deprivation, the nature of Jana's oedipal conflicts were intricately connected to her relationship with her mother.

Jana's mother was ambivalent about her daughter's achievements, conveying the notion that strivings for professional competence made women appear aggressive and distasteful. She had given up her own career at her husband's request, and had suggested to Jana that a marriage should take precedence over professional progress. This laid the foundation for Jana's strong sense of guilt and anxiety over her

desires, which she later experienced on an oedipal level, as evidenced by her conviction that others were accusing her of "stealing things that did not belong to her." The connection between masochism and achievement conflicts in women has been discussed in the literature as revolving around the identification with a mother who is ambivalent about her daughter's success (Kanefield, 1985). These ideas seem particularly relevant to Jana, whose relentless sabotaging of her achievements seemed to exist alongside a strong identification with her mother and an inability to separate from her.

As was true with Alex and Kathryn, remaining alert to transference-countertransference dynamics was essential in understanding the meaning and functions of Jana's masochism. A simple example of this was my boredom with her detailed stories of victimization, which I realized served to keep an emotional distance between us. Also, an awareness of my inability to empathize with her helped us to see how her masochistic stance prevented others from understanding her, and had evolved out of her childhood feelings of disconnectedness and aloneness.

Since Jana evoked responses from others which served as vicarious expressions of her own unacceptable feelings, my feelings in the room provided important clues as to what she unconsciously felt. In working with Jana, I noticed that while getting her from the waiting area I was filled with warm and positive thoughts about her. Upon entering the room, these strong postive feelings dissipated into indifference or dislike. Jana spoke of her perceptions that I disliked her, finding her stupid and unattractive. My awareness of the change in my feelings before and during the session led me to view my sense of her in the room as reflective of affects being projected onto me. As the work proceeded,

what emerged was Jana's sense of me as being distasteful and inferior to her in many ways. In a woman so fearful of expressing her negative affects directly, it was easier for her to vicariously experience these affects by evoking them in others, placing herself in a masochistic rather than hostile aggressive role.

A recognition of my own affects in the room was also useful diagnostically. In contrast to widely fluctuating countertransference such as was the case with Alex, there was a consistency to what I was containing of Jana's warded off affects. Her projective and introjective configurations were of a whole-object nature, characteristic of a depressive positive level of emotional development. Although she split the world into victims and aggressors, her use of splitting remained confined to this one internal dyad.

Technical Considerations in the Treatment of Sadomasochism

Some technical issues in the therapies will now be discussed with special reference to the use of the victim-aggressor introject in the treatment of sadomasochistic dynamics. A central idea throughout this paper has been the existence of splitting as a major underlying component in sadomasochism. We have discussed how masochistic character formation is due, in part, to the splitting off of destructively aggressive impulses; and a sadistic stance is, in part, employed to ward off painful feelings of powerlessness and defeat. Furthermore, the masochistic patients' childhood has often featured a relationship in which extreme positions between victim and aggressor were taken, hence forming the basis for the unintegrated nature of these two components in adulthood.

The use of the victim-aggressor concept brings into focus a major task in the treatment of sadomasochism: helping the patient to integrate these contradictory and polar ego states. Technique differs according to diagnostic issues. At a borderline level, splitting is intense and use of projective identification is common to ward off uncomfortable affects. In the treatment with Alex, consistent interpretation of his extreme view of the world was important, such as through my observing that it was often when he felt the most vulnerable and in need of others that he showed them how intimidating he could be. An awareness of countertransference was useful in understanding when, through projective identification, Alex was compelling me to experience the side of him that he was warding off. An example of this was provided earlier: of an incident in which Alex loomed over my chair and stared down at me menacingly. He had made me uneasy at a time when he was frightened by me; when this was pointed out, he was able to recognize this aspect of his self-experience.

Confrontation was an important technique in fostering integration between extreme perceptions of self and other. Again, the techniques have to be tailored to fit the patient's particular defenses. Kathryn was highly sensitive to my trying to control her, or impose thoughts on her, that she did not agree with. Actions that appeared hostile to me, such as her lateness to sessions, would be denied by her as having any meaning if she were to be confronted directly. However, since Kathryn could often be unaware of her rage until it was acted out in an extreme way, such as through the child abuse, it would have done her a disservice to accept the missed sessions without working to understand their meaning.

Dissociation was a main defense for Kathryn against unacceptable rage, and gently addressing her warded off anger was necessary in order to bring it slowly but steadily into her conscious awareness. Since she employed a rejecting and oppositional stance in order to cope with her mistrust and vulnerability, it was essential to approach her in a collaborative manner. I found myself empowering her, such as by asking her reflective questions and engaging her assistance in helping me to understand a particular problem. If I made a challenging, interpretive statement, she would counter it; but if I made a gentle observation she would be more likely to respond to me. An typical example of my commenting on her lateness would be, "How do you make sense of the lateness today- do you think it was due to things being so busy for you?"

Just as was the case with Alex and Kathryn, Jana split off aspects of her sadomasochism, making it important for integrative work to be done. Again, the specific technique was based on the type of pathology and nature of the defenses. Jana's obsessive-compulsive defenses often left her affect inaccesible and masked through defenses of intellectualization and reaction formation. Jana's obsessively defensive presentation in the room needed frequent and persistant confrontation and interpretation. Without my intervening, Jana tended to structure the sessions around incredibly detailed stories which either obscured all affect or masked her bitter feelings by depicting herself as the helpless victim. It was useful and necessary to interrupt her stories and comment on their detailed nature and wonder what affect was being hidden from us.

As was noted before, all three patients had experienced the extreme and destructive expression of anger in their childhoods. This reinforced their views of their own rage as lethal and unacceptable to communicate, leading to it being warded off or expressed in extreme ways. In treating the sadomasochism of these patients, a more modulated, normalized sense of aggression needed to be put forth. For instance, comments like, "sounds like that would make most people angry", or "how might you let that person know you're angry in a way that won't alienate him", were useful in conveying that anger is not always equated with destructive sadism. Also, since these patients were accustomed to retaliation for their aggressive impulses, a nonretaliative therapeutic stance was important. However, this stance can often be challenging, in light of the pull for the therapist to enact one part of the victim-aggressor introject.

Earlier in the paper, the importance of the mother in providing a holding environment for the child was mentioned in regard to the child's development of ambivalence and a sense of separateness. It was stressed that the mother be comfortable with her own impulses and respond in a nonretaliative way to the child's aggressive impulses. These holding functions are also important in the psychotherapy of the individual who has failed to receive adequate parenting.

In considering what it means to "survive" the sadistic, rageful onslaughts of a patient, it would be a mistake to liken this to a blind acceptance of whatever he or she brought to the hour. This stance would be a particularly dangerous one in the treatment of the patient functioning on a borderline level: for both therapist and patient. In surviving the patient's rage, an approach that emphasizes limit setting,

consistency and fosters reality testing is essential in working through the sadomasochistic features of the borderline. Since self-destructive behavior can result from the regressive effects of oral rage, it is essential that this rage be contained by the therapist. It is both frightening and disorganizing for the patient to experience his or her rage as out of control. This was relevant in the work with Alex, in which I responded to his attempts to be abusive by setting limits and exploring with him the function of the abusiveness. Often, such exploration led to his being able to tolerate feelings of powerlessness and vulnerability that were being warded off by his bullying me.

In working with a borderline level patient, the therapist often provides the ego functions that the patient loses in times of regression. The distinction between reality and fantasy, and between thought and action, are essential when it comes to working through oral rage. When Alex acted out in the hour, such as by threatening me with a video cable, I quickly asked that he put it down. I noted that his angry message was clear to read, but that he would have to find a way to express it in words rather than in actions. In this way, the regressive effects of the rage are minimized, yet the therapist has tolerated, contained and survived destruction (in fantasy) by the patient.

Both Kathryn and Alex experienced their rage intensely, and feared that, if expressed, their anger might prove lethal to others. A strong ego is needed to neutralize this powerful, primitive rage and to provide good judgement as to what is safe communication of one's sadism. Whereas Alex needed containment to prevent acting out, Kathryn was often overcontrolled, fearing that any experiencing of rage would make her lose control. It was important to reinforce her strengthening ego, as

the treatment progressed, by supporting her appropriately angry remarks. Integrating functions needed to be supported, such as by stressing that there are many ways to express hostility in between dissociated silence and physical abusiveness.

It is important that the therapist, as is the case with the mother, be aware of and comfortable with his or her impulses and feelings in the treatment. A failure to do so runs the risk of these feelings being projected onto the patient. Often, the therapist's countertransference responses can be used in productive ways in the treatment, which is something Meissner has commented on at length (1982). For instance, at a time when Alex worried about the lethal effects of his rage, he asked if I were afraid of him. Exploration of this uncovered his fantasy that my fear would mean that I did not want to work with him. It was not only useful to point out that these two feelings need not go together, but to be clear as to the limits of what I could tolerate and still be comfortable working with him.

In striving to strengthen the patient's integrative functions, a recognition of the specific nature of the aggression or masochism is helpful. For instance, the borderline's anger is in the form of oral rage, which has a demanding, biting, incorporative feel to it. At times when the borderline desperately wants to consume and digest the therapist whole, nothing less than this is of any comfort. The rageful patient is unable to use anything of what is offered and is then catapulted into a sense of aloneness and despair. The therapist needs to take an active stance in pointing out the ways that the patient chooses to abandon him or herself. An example in the work with Alex occurred when he sat in a rageful silence; any effort to engage him in dialogue

had failed. Finally, in response to my asking if anything was on his mind that he could put into words, he glibly asked me if I "had three days to spare." I pointed out that his anger over the limitations of what I had to offer were preventing him from using what he did have available to him. He responded well to this, realizing that he had some control over whether he made use of things in little bits as opposed to in an all-or-nothing manner.

Another aspect of the borderline's aggression is its fusion with sexuality. Kernberg has described this in terms of a "premature flight into genital strivings" in order to escape frightening oral rage (1972, p. 263). Therefore, the early object relations which are reactivated in the transference are characterized by, as Kernberg puts it, "the particular pathological condensation of pregenital and genital aims under the overriding influence of pregenital aggression" (1972, p. 262).

This was apparent throughout the treatment with Alex, who had both erotic and aggressive fantasies about me. In addressing the erotic fantasies as well as his hyper-sexuality in his outside life, it was important to emphasize his sense of oral deprivation. His hunger for women was not lust as much as a wish to be passively nurtured and cared for by a maternal figure. For example, Alex related a wish to take my skirt off and put his "head between my legs." Although he said this in a seductive manner, exploration of the fantasy led to a wish to be enveloped by me and kept safe from danger (such as termination). The oral, fused quality of this sexual fantasy needed to be interpreted on a pregenital level.

As has been discussed earlier, one result of the regressive effects of rage is the inability to preserve good internal objects. In the face

of a rageful onslaught, the therapist needs to both limit set and to provide transitional objects which facilitate the maintenance of the holding self-object introjects. This was true in the termination work with Alex, who in his rage over my departure, risked obliterating his internal sense of me in my absence. It seemed that his frequent curiosity about where I was going, etc., was not merely a provocation, but was an attempt to form and hold an image of me after our meeting stopped. It is the task of the therapist to decide which questions would be useful to answer and which information would undermine other aspects of the transference that are best left intact.

For all three patients, the sadomasochistic struggles in which they became embroiled appeared to be repetitions of past dynamics, which they had internalized in the form of the victim-aggressor introject. A central use of the victim-aggressor concept is in helping the patient to see that his or her perceptions of the world are subjective and based on an internal script of oneself in relation to others. The realization that their suffering is brought about through their own provocations is the first step in their accepting control over their fate, which is essential in order for change to occur. This understanding comes about through the gradual working through process, and is facilitated by interpretations of the patient's past and its replication in the therapeutic relationship and in his or her outside life. In enabling patients to comprehend that they invite abuse from others, it is also essential that they can accept their own sadistic aspects.

This was particularly difficult for Jana, who found angry affects unacceptable in herself. It was important to interpret Jana's sadistic as well as masochistic side, and the fact that she invited

confrontations from sadistic others in order to enact her internal drama between victim and persecutor. When I first made this interpretation to Jana, she perceived me as having abused her with my comment and she became enraged. This was the beginning of her ability to make use of the transference and to bring her sadomasochistic dynamics into our relationship, where it could be most usefully understood. This was essential in working with her, since she often tried to get me to take sides in the altercations she had with others. It was important to both acknowledge her reality of these people and to try to move beyond it. For example, I might tell her that, based on her story, the person in question did sound rude, however I thought she sought out or provoked people's rudeness in order to engage in what was an internal struggle. I would also suggest that the best way for me to comment on what happened between her and others was to base it on what went on between us.

In sum, in treating sadomasochism in character disordered patients, it is essential to keep in mind that victim and aggressor introjects exist as contradictory ego states; when one is experienced, the other is dissociated and projected onto the therapist. A central task of the therapist is to interpret and work toward an integration of these contradictory states. The technique of confrontation is important in facilitating such integration. However, specific technical points vary according to the particular defenses of the patient. Likewise, the meaning and interpretation of the masochism and sadism of the patient needs to be reflective of the specific developmental struggles of that individual.

The victim-aggressor introject is important insofar as it emphasizes the internal, intrapsychic nature of the patient's sadomasochism. Once

the patient realizes that he or she is repeating past dynamics through provoking abuse or alienating others, then specific ways in which the patient can move to change his or her life can be pursued. Since the internal struggle between victim and aggressor represents past relational dynamics, it is best worked through in the context of present relationships. The therapist needs to facilitate the replication of these dynamics in the transference, through the use of transference interpretations and a nonretaliative and open stance. In this way, the sadomasochistic dynamics can be replicated, yet worked through in a different way, in the therapeutic relationship. The therapist will hopefully provide a safe place in which intimacy can exist without being linked to suffering and where anger can be expressed and tolerated without being connected to retaliation and rejection.

CHAPTER VI

DISCUSSION

The central aim of this work was to investigate the expression, functions and meanings of masochism across individuals with varying character styles and types of pathology. The inquiries put forth here evolved out of a conviction that masochistic dynamics are overdetermined in the patient who utilizes them frequently; they represent an interplay between id, ego and superego aims as well a recapitulation of important relationships from the past. It was felt that a recognition of the complexity of masochism would facilitate the treatment of these trends in character disordered patients. And, specifically, by attending to the nature of and interplay between victim and aggressor introjective configurations as they were manifested in the therapy relationship, it was felt that the clinician could modify treatment approaches to address the specific character structure of the patient.

In the previous chapter, the results were discussed as they pertained to the three patients in the study and without any attempt to generalize beyond this sample. This chapter will provide a more general discussion of some of these results in order to generate some preliminary considerations about masochistic pathology which could prove useful both for future research and for use by clinicians.

The hypothesis most supported by this study is that masochism serves a variety of functions within and across individuals, and that these functions conform to and are associated with the structural organization and developmental level of the particular person. Concurring with the work of Brenman (1952) and others, the self-sabotaging trends of these

patients expressed instinctual aims; adaptive and defensive strivings; and superego functions involving appeasement of guilt. Not only did masochism appear to exist as a component of id, ego and superego structures, but it was expressed on varying levels of libidinal organization, such as oral, anal, phallic or genital. Furthermore, there were varabilities in ego strength, overt symptomatology and the quality of object relationships displayed across the patients who manifested masochistic pathology.

Before discussing these relational differences further, some commonalities will be highlighted. Sadomasochistic dynamics seemed to result, in part, from past object relationships in which closeness had been associated in some way with suffering. In addition, the childhoods of these masochistic individuals featured some form of deprivation, such that the need of closeness was intense enough to warrant the acceptance of suffering along with it.

Rageful feelings seemed to not only be internalized as affects witnessed from a caregiver in childhood, but were often the primary response of the child who had been deprived. Rageful and self-destructive affects existed alongside one another in the masochistic patients, and an internal relational dyad formed featuring a constant tension between victim and aggressor. It appears that patients with masochistic features often find their anger unacceptable to express, possibly because anger was expressed in destructive ways in their childhoods, as was the case with the patients in this study. The masochism itself may be both the redirection of one's sadism onto the self (Freud, 1915/1957), while at the same time serving as an indirect means of conveying hostility. Projection, projective identification and

splitting appear to be used in varying degrees by masochistic patients in order to ward off an unacceptable affect or to enact, with others, the internal drama between victim and aggressor.

The sadomasochistic dynamics of the patients in this study replicated past relationships with important childhood figures, in which identification, fear of separation, as well as longing for closeness played a role in maintaining the pathological connection. Since the relationships occurred at various points along the developmental continuum, from early maternal ties to later oedipal ones, this suggested that masochistic dynamics can exist in individuals with vastly different diagnostic makeups. One of the more interesting results of this investigation was the meaning of sadomasochism on a borderline level of organization; this emerged because two of the three patients had some features of a borderline structure. It is worthy of taking a closer look at what sadomasochism might mean at the borderline level.

The sadomasochistic dynamics of the borderline seem to be colored by the splitting defense and the failure of the borderline to integrate conflicting introjects. The internal world of these patients appears two dimensional, often consisting of opposing dyads of love and hate, superior and inferior and so forth. The polar configuration of the victim-introject and the aggressor-introject that Meissner writes about is one such example; without the capacity to integrate, the extremes of the borderline's childhood inner (and probably outer) world remain a reality. In the borderline adult, these polar constellations remain intact and fluctuate rapidly as to what is introjected and what is projected. Therefore, in the inner world of the borderline, a drama is being staged between masochist and sadist; aggressor and victim. The

self can take on either of these identities, projecting the dissociated introject at any given time.

In both descriptive and psychoanalytic descriptions of borderline personality, self-destructive and rageful behaviors are thought to be major diagnostic features (APA, 1980; Kernberg, 1975). It is important to recognize the complexity of these sadomasochistic affects and actions in the borderline. The fact that they are so strong a component of borderline dynamics supports the notion that they are multiply determined. The preliminary investigations presented in this work support the notion that oral rage is a hallmark of sadomasochism at the borderline level of organization and is pivotal in the formation of masochism and sadomasochistic object relations in childhood and later life.

It is interesting to speculate as to how masochism may evolve out of the specific features and impairments inherent in the early development of the borderline. As has been discussed, intense rage can result in the weakening of ego boundaries for the borderline. Therefore, the aggression of the other, whether it be reality or projection of the self's oral rage, is felt to be part of the self. The borderline's ragefulness and sadism intensifies as he or she is caught in a vicious cycle. Masochistic dynamics can result from the regressive effects of oral rage in many ways. First, the borderline child may confuse aspects of the mother's masochistic identity with his or her own in times of regression; mothers of borderline children are often described as self-loathing and insecure (Masterson, 1976). Secondly, the loss of evocative memory capacity which can occur during borderline regression can result first in a sense of aloneness and then in masochistic loathing, feelings

of worthlessness and depression (Adler, 1985). In addition, since rage for the borderline is often equated with having destroyed the hated object, this also gives way to aloneness and masochistic self-loathing.

Masochistic behavior can have several defensive functions at the borderline level of organization. Masochism has been viewed by some theorists as the maintaining of a relationship with a persecutory object and as an ego defense against the loss of that object (Berliner, 1947; Menaker 1953; Panken, 1983). This seems particularly relevant to the borderline, since there is much supporting the hypothesis that borderline pathology has as its roots the child's relationship with an ambivalent, inconsistent or depriving caretaker. The child is motivated to maintain this connection upon which his or her survival depends. The child's masochism may express a desire to preserve the mother as loving by viewing the self as the mother would view the child: as unlovable. It is sometimes the most adaptive means the child has of insuring that the mother will not reject him or her.

Masochism can also arise as one's own oral rage turned against the self in order to protect the object from feared destruction. Again when the ego functions buckle under the power of ragefulness, reality testing becomes impaired: thought and action become blurred. The borderline fears that his or her murderously rageful fantasies actually have been lethal or that the object may detect these fantasies and plan to retaliate. A victimized and masochistic stance can be a way of gaining mastery over such anticipated retaliatory sadism by bringing it on oneself.

The complexity of the sadomasochistic dynamics of the borderline, in combination with the intensity with which they are expressed, makes

their treatment a challenging task. The model of a victim-aggressor introject, based on past object relationships and resulting from the splitting defense, is particularly useful in working with masochism on a borderline level. By continually pointing out fluctuations between victim and aggressor to the patient, integrative ego functions are strengthened. In addition, enabling the patient to see that he or she superimposes this internal construct onto external relationships is the first step in one's realization that he or she has control over his life. Eventually, these individuals can see how they provoke or evoke struggles and abuse from others, and can then prevent it. Since victim and aggressor components are intensely projected in the therapeutic relationship, it is through an awareness and use of countertransference that the therapist can most effectively understand this sadomasochistic struggle and help the patient to change it.

Further research needs to be done to study masochistic dynamics at the borderline level, particularly since self-destructive actions are typical of this type of pathology. Another area in which further research needs to be done is in the relationship between masochism and incest. A childhood history of incest seems to be connected to the development of severe psychopathogy in many ways, and this connection has been investigated in recent literature on incest (Shrum, 1985). In her review of the literature on incest and severe psychopathology, Shrum cited several studies which correlated an incest history with the existence of low self-esteem, self-destructive behaviors, and an identity as a victim in these abused women. In this dissertation, the case analysis which involves a patient with an incest history suggests, in a preliminary way, that there are connections between incest and the

development of masochistic behaviors. This leads to some speculations as to possible causal relationships between the two. From an object relational perspective, the masochism in adult life may signify a repetition of an abusive relationship in childhood, in which suffering was the price one had to pay for closeness and affection. In addition, the masochism may reflect a condensation of id and superego strivings. Specifically, it serves as both an expression of the sexual impulses which seek gratification through an incestuous relationship, and at the same time atone for superego guilt through suffering. It is also likely that the guilt over an incestuous relationship grows into a masochistic self-hatred for what one has done.

In its most simplistic connection, a person with an incest history is prone to think of oneself as a victim and there is a tendency for one's identity to be organized around this concept. In reworking the incest experience in order to obtain mastery over the actual suffering it involved, it is likely that the person will think of oneself as a victim in a world of aggressive-others.

Another area which was touched upon in this investigation was the significance of masochism in feminine identity development. Both of the women in the study had strong identifications with their mothers, and both mothers had strong masochistic trends. It is noteworthy that the strong identifications with, and ties to, their mothers existed in spite of the fact that both of their mothers failed to protect them from abuse of which they were aware. This, in itself, established a sadomasochistic dynamic, in which closeness to mother existed alongside the mother's devaluement of her daughter.

Growing up with a masochistic and, in turn, devaluing mother may influence the development of masochism in women in many ways. The most obvious way is simply through identification with the masochism of the mother. As mentioned before, the identifications for these girls might have been especially strong because they were deprived of protection and nurturance in many ways. This serves to strengthen a connection to the parent, and increases the willingness to accept abuse in the service of obtaining affection. In addition to primary identification, the daughter might also internalize the mother's ambivalence toward, or even hatred of, her, leading to the emerging of a negative self-concept in later development. It also makes sense that sadism would be interwoven with the masochistic self-concept, not only because it represents the affect of the object, but also because it reflects the self's rage over unmet needs and abuse. Just as the masochism is formed in early development, it also becomes reinforced through later relationships, which are often replications of the original sadomasochistic object tie.

The relationship between masochism and achievement conflicts in women could not be explored in any depth in this investigation, although it was a major theme in one of the cases. As mentioned before, identification with a mother who does not value her own strivings can evolve into such conflicts in the daughter, since achieving is then equated with separation from the mother. Also, a mother who has denied her own strivings often feels ambivalently toward the achievements of her daughter, again establishing masochism in the service of maintaining an object tie and defending against guilt. In the case of Jana, her libidinal wishes for closeness with her father were equated with achieving in order to be like him and win his affections. However, the

achievement conflicts arose when she realized that to do this meant to separate from her mother, who had established a slave-like relationship with her husband in which all her needs were denied. A close analysis of this case suggests the importance of considering women's achievement conflicts and masochistic strivings in the context of both oedipal guilt and primary attachment to, and inability to separate from, the mother (Kanefield, 1985).

In sum, the view of masochism presented here concurs most strongly with the ideas put forth by Brenman (1952), who not only acknowledged the complexity and multidimensionality of masochism, but also saw it as having resulted, in part, from rage over unmet needs for nurturance. In addition, she emphasized the prevalence of projective mechanisms in the masochistic patient, in keeping with the concept of a victim-aggressor introject which is projected onto others in varying degrees. The case analyses also strongly supports the object relational work of Menaker (1953) and Berliner (1940) in that the patients studied showed evidence of replicating and repeating past sadomasochistic object relationships. Theorists such as Montgomery (1985) and Panken (1983), who have pointed to the role of masochism in defending against separation, are also supported by the data in this study.

This work, while maintaining an object relational perspective, brings some important revisions to the former theories. Specifically, the writings of Menaker and Berliner tend to overlook the existence of the primary oral rage which may evolve from the unmet needs and deprivations in the childhood histories of these individuals. They, instead, view aggression in the masochist as secondary, having resulted from an incorporation of the parent's sadism. The notions of Klein

(1945/1975) and Kernberg (1975), involving primary aggression, have been integrated with an object relational perspective in this paper, enabling sadomasochism on a borderline level of organization to be more clearly understood.

In addition, the victim-aggressor introject, conceptualized by Meissner (1985), has been put forth as a internal model of sadomasochism, which may assist clinicians in making diagnostic judgements based on the specific qualities of this introjective configuration. By attending to the intensity of the splitting defenses, the strength of the integrative functions, the nature of the rage, and the intensity of the therapist's countertransference, distinctions can be made as to structural organization and developmental impairments of the patient which will prove useful in the treatment of the character disordered individual.

Delineating specific personality disorders based on overt symptomatology and behavioral traits is helpful in providing a uniform model of diagnosis for use by clinicians. However, masochistic traits can exist in varying degrees across many types of psychopathology. A DSM III category of masochistic character may compromise the in-depth exploration of the expression, functions and meanings of masochism in a given patient. Masochism is a complex and multi-dimensional phenomenon; clinicians need to understand and treat masochism in the context of intrapsychic development and structure, and weave it into a picture of the specific individual.

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