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A Case Of Masochism

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Reich's elucidation of masochism was one of his major contributions to psychoanalysis and biopsychiatry (1). He demonstrated clinically that masochism is not a primary biological drive (*thanatos*, or death wish) as Freud had postulated, but, rather, a secondary defense against pleasurable expansion. It is therefore, at least in theory, a treatable condition. The medical orgonomist understands, however, that because the masochist's biophysical intolerance of expansion is extreme, this character type is one of the most difficult to treat. This is especially true as deeper layers of armor are encountered.

For the masochist, experiencing expansive pleasurable emotions and sensations has the significance of dissolution (bursting) or castration (1). In contrast to other types of orgastic disturbance, the masochist inhibits sexual pleasure at the point of highest excitation and maintains this inhibition. This is the basis for the development of great inner tension. In all other forms of orgastic impotence, the inhibition sets in before the acme and so inner tension does not build as much. Thus all the traits essential to the diagnosis, taken collectively, are a direct result of the fear of expansion.

A further complication is that the diagnosis is often difficult to arrive at. This occurs because all the cardinal features of the masochistic character may not be evident during the initial consultation or in the earliest stages of therapy. In fact, it may be months or even years before all the distinguishing traits reveal themselves.

A related problem is a characterologically-determined disturbance of perceptual function: Experiences that would ordinarily be held as pleasurable are perceived as painful. This occurs because the masochist is contracted biophysically at the periphery including, especially, the genital. When expansive impulses pass outward through the contracted periphery, a sensation of pain, and not pleasure, is experienced. Because this intolerance of pleasurable expansion is profound and central to the masochist's armored structure (spastic pelvic floor), he apprehends the melting sensations of orgas-

tic surrender as a threat to his very existence. This is the basis for his frequent fantasies of being made to burst by someone else.

The masochist not only perceives pleasure as pain but will also accept emotional and/or physical pain as the price for having someone else secure for him relief from his inner tension. It is this aspect of the painful experience that is perceived as pleasurable. In addition, there is a strong tendency to covert exhibitionism and an inordinate need for love from others, including the therapist.

In sum, the therapist's diagnostic and therapeutic acumen can be thwarted by a clinical presentation that cannot be fully understood until the bioenergetic functions underlying the masochist's cardinal symptoms are placed in correct perspective. Furthermore, any character type can have masochistic symptoms and all patients develop some of these during the end stage of therapy. What defines the masochistic character is a specific constellation of symptoms (1).

Case Presentation

B, a fifty-three year old, separated, white, female bookkeeper, came to therapy because she was becoming bored with life, felt herself slowing down and having to force herself to accomplish things, and was afraid of "collapsing inside." She had been married twice. Each time she eventually walked out on her husband when she realized that she wasn't getting anything from the marriage.

B emigrated with her family from Europe to America when she was five years old. The youngest of seven children, she felt rejected by everyone throughout her life, including her family and her husbands. One childhood memory she recalled initially was that she was given a doll by her aunt. When her mother found out about this, she immediately took it away from B and gave it to an older sister. B recalled never having had a doll either before or after. Another memory was being told by one of her sisters about another sibling who died at birth. Commenting on this child, her sister remarked that she was lucky, she died! The implication was that the patient would have been better off dead.

B characterized herself as a social rebel, never able to adapt to "middle class" values. She typically associated with people who lived on the fringe of society, such as artists and bohemians. She felt like a pariah

both in relation to her family and to the mainstream of society. She gave the appearance of being socially naïve and often claimed that she did not understand accepted modes of behavior in social situations.

She was in excellent physical health, except for being about twenty pounds overweight, and had never had a serious medical illness. Biophysical examination revealed a somewhat stocky, slightly obese woman with long, stringy gray hair that seemed inappropriate for her age. On the couch she appeared ready to burst into tears at any moment. Her face expressed both sadness and suffering. There was moderate psychomotor retardation. She appeared most armored in the oral segment. The entire musculature of the face, in particular the masseters, was hypertrophic. The skin over her masseters was taut and extremely tender to touch. Her mouth was held tightly shut and the submental muscles were tender, as were the posterior cervical muscles. Her neck seemed to be compressed into the thorax. There was generalized muscular hypertrophy and some obesity in the upper segments. Her eyes were sad and, for brief periods, had an accusing look. The significance of this latter expression did not become apparent until much later in the course of her treatment. Another characteristic expression was a devouring look to her mouth and in her eyes, resulting from tension in her eyes and her tightly clenched teeth. This biophysical attitude was associated with considerable sarcasm. She could readily cry with tears but was unable to express anger. She had difficulty moving her eyes and her forehead was moderately immobile. Her chest was held high in inspiration and was not compressible. She seemed to be carrying a great burden on her shoulders. Her legs were shapely and appeared to be those of a much younger woman.

B harbored a great deal of bitterness and resentment toward people close to her. She had a strong sense of duty and behaved in a self-effacing manner. She seemed to enjoy the attention she received when talking about herself and did so excessively with the intention of drawing the listener close to her. There was no history of sado-masochistic sexual practices.

My initial diagnostic impression was that of a manic-depressive character who was in a state of moderate depression.

Course of Therapy

My therapeutic plan was to counteract B's depression by mobilizing rage and raising her energy level. I tried to do this by working on the oral segment and having B express her anger. Her eyes became frightened and she spoke of the repeated rejections in her life. Continued mobilization of the oral segment elicited resentment toward her first husband. This was followed by crying and then the reappearance of the frightened look in her eyes. She had fantasies of bursting. With biophysical work in this manner, her facial expression gradually looked less tense. Oral mobilization was typically accompanied, not by anger, but by crying and bitter complaints of never having been loved or shown any affection. She briefly felt that I also was not interested in her because of a "look" I gave her, but she soon dropped this idea. Despite her constant complaints, oral mobilization regularly produced deep sobs and some relief. More complaints followed, this time of being worthless, and in her typical sardonic fashion she said, full of bitterness and self-hatred, that she was no better than a bottle of Coca-cola®. Gradually it became clear that B was unable to express anger in a strong, direct and sustained manner and that aside from her ability to get relief by crying, she could only portray herself as miserable. She reacted to my efforts to elicit rage with self-belittling images (i.e., of seeing her mother laughing at her, old women with dried-up breasts, etc.). Having B bite on a sheet and mobilizing the back of her neck elicited a brief expression of anger. However, she then began to suffer and talked of suicide. At this point I modified my treatment plan and attempted to have her express her fear before showing anger. As I continued to work on her rage in this manner, she developed pains in her abdomen and lower back. Then, a pruritic maculopapular rash broke out on her arms and legs, evidence that the expansive energetic push became caught at the skin surface. Despite these attempts at eliciting rage, B was only capable of expressing bitterness, hopelessness and misery. During this early period of treatment people remarked that she looked more youthful. She also lost her excess weight.

It became evident that, despite the fact that she harbored a great deal of resentment, she only became angry at people behind their back, never to their face. Outwardly she appeared meek, saccharine, and helpless.

Her transference to me began to crystallize. Much of her behavior seemed to have a dramatic, exhibitionistic quality. She expressed herself in order to please and cling. On the surface she felt positive and warm toward me. In return she expected me to reach out and reciprocate her affection. When her expectations were not met, she ended up feeling rejected and depressed. The situation appeared to be an excessive demand for love and a fantasied rejection at the oral level. Her tendency to provoke rejection by becoming inappropriately involved with unavailable men was not evident at this time.

I continued to mobilize B's oral rage and did not recognize the masochistic picture that was unfolding. Keeping her mouth open produced an expression of disgust and helped mobilize her respiration. With deeper breathing, she quickly experienced periods of temporary expansion. She developed strong trembling of her legs and pelvis. Surprisingly, she reacted to these pleasurable sensations as if she had been victimized. She said accusingly, "Don't do this to me," and had morbid thoughts. Clearly, pleasurable pelvic sensations were being perceived masochistically. She also started drinking alcohol heavily "to avoid feeling something very painful." Continued breathing produced an image of a man whose genital area was covered with blood. She had the idea that she had somehow "cut it off." This indicated a close association for her of pleasurable sexual sensation and fear of castration.

B then had the following dream: She is lying in bed just as she does in therapy. She asks me to lie beside her because she is cold, which I do. Then I start joking with her and get up and leave.

Again, there was a strong desire to please me by being a cooperative patient. I continued my effort to mobilize her anger. She again responded masochistically by indirectly accusing me of hurting her. "What's happening to me? Why must it be so painful?"

Further attempts at mobilizing rage resulted in a combination of genuine relief and a tendency to please me by manufacturing every kind of emotional expression. B would do anything to maintain a close relationship with me, even if it required being mired in hopelessness and despair.

I began showing her how she tolerated abuse from everyone. She looked somber and expressed mild resentment toward me for "giv-

ing" her feelings that could not be satisfied. As she expressed these sentiments, she held on to me with her eyes and her mouth (teeth grinding). When I loosened her jaw she became frightened, but then briefly expressed rage from her eyes. She was then able to give in to deep breathing which was followed by more leg tremors and pleasurable sensations in her pelvis.

Again B contracted against this expansion as depicted by the following dream: She kicks her father in the genital area until he bleeds. To this dream she associated the memory of her father kicking a dog in the abdomen. She had always recoiled at this memory.

Following this, B had an urge to kick and make growling sounds. She became frightened and stopped short, feeling that something terrible was going to happen to her. She became despondent and talked of suicide.

I went back to mobilizing her eyes and face and also focused on her character. I pointed out how her unrealistic expectations of others rendered her miserable and disappointed by their subsequent rejection of her. Ocular mobilization produced a sensation of strong pressure in her head. Her head felt tense, as if in a vise.

I asked B to discuss her feelings about me. She stated that she would never find anyone as wonderful as I was, but also felt the same hopelessness in her relationship with me as she did in the past with others when she could not have what she wanted. I reminded her that she associated with people who could not give her what she wanted and that indiscriminately giving of herself and her possessions contributed to her becoming disappointed and depressed. She recalled that as a young girl she always faced life with high expectations and a feeling that there was never anything there for her. She felt like an orphan.

With further mobilization of the ocular segment, B gradually began expanding again. Now, her anger toward me took the form of a reactive independence. B began coming late to her sessions. She stated bitterly and somewhat dramatically with anger that she wanted to get up and stand on her own two feet and everyone be damned! She then reverted to feeling depressed and disappointed and had endless complaints about not having anyone in her life. She had no

real life of her own and used therapy as a substitute existence. She clung to me and kept emoting for my benefit.

In order to break through the stalemate, I decided to work on the small of her back and her legs. When emotions began to surface, B felt pain and a sense of being victimized. She did not want the emotional pain of feeling again. She did not want to feel in a vacuum; that is, to have feelings and to be alone. The element of provocation in these statements was still not apparent. However, it was clear that B would attempt to buy my affection no matter the price. She chose to put up with the emotional and physical pain of therapy in order to have and maintain a relationship with me—in actuality, the only way she could tolerate having any emotional warmth in her life. This attitude alternated with feeling hopeless and despised.

Her biophysical status at this time included being more open in the oral segment; however, her throat was still very constricted. I worked on this segment manually and for the first time B was able to shout out strongly. This was followed by an episode of severe diaphragmatic spasm with pain in the subscapular region and acute anorgonia manifested by feeling alternately hot and cold, weak and light-headed. The diaphragmatic spasm was relieved by eructation (burping), and she was able to breathe easier.

When I held her mouth open, B appeared terrified and experienced pain over the epigastrium. Pressing this area produced more terror, and I encouraged her to scream. Her face became pale and she held her breath in inspiration. Following this a tremendous rage began to surface which focused on her missing out on what her life could have been. She became terrified and gave in to more self-deprecation. Her old symptoms of teeth grinding and holding her breath returned. She became stuck, contactless and reclusive.

I returned to mobilizing her ocular and oral segments. Pressing on the masseters, while having her keep her eyes wide open, caused her to scream in terror. This was accompanied by images of being suffocated by her mother.

She also remembered how much during her childhood she was used by everyone. Sent to work at an early age, the only interest shown her was how much money she brought home. She had always felt bitter at the abuse but had never been able to express her resent-

ment. Quite simply, she never knew what or how much she could expect from her mother. She was given nothing by anyone but was expected to give everything.

At this time, as a result of initial mobilization of the diaphragm and the expression of stronger rage, B developed a distressing symptom: the very discomforting sensation as if her stomach was overinflated with air and a strong tendency to belch. Again, she reacted by having an anorgonotic reaction: there was a pallor of her face and head and she felt faint. Since the upper segments were fairly open, it was permissible to continue mobilization of the diaphragm. This produced increased respiration, hiccuping and burping, followed by strong spasms of the musculature of the head and throat. This proved to be too much for B and she became confused and contactless.

Her masochistic symptoms intensified. She appeared stupid, dumb and clueless; she became self-deprecating and looked at me with an expression of intense suffering. I therefore returned to the ocular segment once again and worked layer by layer down through the oral, cervical, and thoracic segments. Spontaneous mobilization of the diaphragm was again followed by belching and hiccuping alternating with periods of anorgonia.

Any genuine relief was almost immediately experienced as painful. I again asked B to tell me what she felt about me. She was evasive and obtuse. Finally, she shouted angrily, "I don't know anything!" That put an end to my inquiry. However, she had the following dreams: 1) She is having sex with a man who is wearing a long coat and a turban wrapped around his head. She feels agonized. She asks a girl how it was and the girl says, "It was more horrible that you can imagine." And 2) A man is standing over her laughing and exposing his genital.

The sadomasochistic content of these dreams is unmistakable. On the couch B was able to express some angry shouts at an imagined man laughing and making obscene gestures at her. During the following week she again began choking and burping and had terrifying images of being strangled by her mother. Very strong angry shouting then followed.

As she began expanding again, B's dependency on me and the masochism reappeared. On the couch, breathing produced images of a man bending over her. She began to ache all over and said she

could not go beyond this point. Her despondency and self-pity intensified. In a bitter, mocking tone she complained of how she had to pay emotionally for enjoying sex. She whined in her typically melodramatic and helpless voice, "There is nothing but pain for me! It's too late!" It was clear that all her resistances had returned in full force. Looking at me accusingly, she asked why she had to travel such a long distance to see me. She seemed to be groping with the idea of giving me up as a fantasized lover. She was becoming more independent. She obtained a driver's license and was beginning to express rage without my assistance. Her hatred toward men began to surface more consistently.

Again B ended by settling for "contact at any price" with me. It became clear that as she began to choke, her misery took over as a defense against her rage. Her throat block was holding back rage and expansion.

I returned to mobilizing the first three segments and was successful in eliciting some rage at her mother. She felt her mother's despising contempt and lack of concern for her. In the following session, she appeared expanded and seemed to have no inner tension.

Then an incident happened in B's daily life that finally confirmed her biopsychiatric diagnosis. She revealed that she could be overtly provocative, something that she had succeeded in hiding from me until then. In a social situation she did something that placed herself in a bad light and allowed someone to behave in an insulting manner toward her. When I confronted her about her behavior, she became full of righteousness and bitterness, and sank into a strong masochistic reaction. She appeared pathetic and had a look of suffering. This occurred several years after the onset of therapy.

I again returned to mobilizing B's eyes and face. Now I was able to focus intensively on her masochistic character. I pointed out her pathetic, whining voice and how she put herself in a bad light by acting stupid and awkward. I imitated her suffering expression, her pathetic voice and her self-effacing attitude.

B felt strong rage but expressed only bitterness and self-mockery. She looked at me accusingly and in a whining voice full of bitterness said that she had fought all her life and had nothing to show for it, that she was vilified, etc., etc. I told her she acted like a suffering old

woman and accepted "pain" from me as the price she had to pay for seeing me. She took all this stoically and, in her typical obtuse manner, told me how "stunned" she was by what she had learned in therapy and how she had been lamenting everything she had missed during her life. She added in martyr-like fashion, "But I'm not permitted to be sad over any of this." Her statement was a veiled accusation that I was not allowing her to have her own feelings. I told her that she simply loved to suffer.

From glimpses I had of her daily functioning, I knew that despite all her complaints and masochistic activity B could be quite controlling, directing others to do her bidding. There was a phallic aspect to her. In therapy she did things *her* way. This included using the therapeutic situation as a stage on which she could present herself as a suffering martyr (covert exhibitionism) and at the same time tenaciously demand unconditional affection from me.

I intensified my work on her masochistic character attitude by imitating her suffering, whining, melodramatic speech at every opportunity—this in order to unmask her "tragic" façade. She was Sarah Bernhardt and her therapy was a tragic performance. I asked her why she behaved this way in the treatment room when she didn't do so on the outside. She admitted feeling threatened in therapy and of being angry with me for unmasking her.

I told her to simply breathe and roll her eyes. She did not like this and kept demanding attention from me by trying to lure me into conversation. When I did not respond, she became tearful. When leaving the session she was noticeably angry. I intensified addressing her masochism by ridiculing her pitiable condition. This angered B but she wasn't able to express it. She was unrelenting in her sorrowful, mournful demeanor and her whimpering demands for affection. My persistence, however, slowly began to yield results. Although still not expressing anger directly at me, she told off her ex-husband for good. She became temporarily more independent and aggressive as she openly expressed many spiteful "No's."

Although capable of feeling anger toward me, B almost immediately turned it into self-punishment. After one session, she exclaimed histrionically, "I want to die without pain!" Because there was no expression of anger, her head felt as if it would burst. She began to

have episodes of epistaxis (nosebleeds) which provided some relief. (Her blood pressure was always normal.) She discussed her fantasy of bursting if she were touched sexually by a man. Gradually her masochistic structure came into sharper focus. She admitted that as a child she wanted to be an actress or a dancer, but she was discouraged from overt expression of these wishes. Associating with artists gave B vicarious gratification. She dressed like a bohemian and her long hair, inappropriate for her age, gave her an odd appearance. She expressed herself in devious ways and appeared obtuse and naïve. This opened her to ridicule and allowed people to take advantage of her. Furthermore, B's inordinate need for skin contact, another feature of masochism, became evident. She complained of never being touched by anyone. This was also a veiled demand to be touched (ultimately to be made to burst).

I returned to working on the upper segments. She expressed misery, grimacing, burping, choking, and finally a deeper rage. My object was to have her express as much rage as possible. In sessions, she alternated between expressing rage and being masochistic (choking on her rage). Her inability to express rage regularly intensified her sensation of inner pressure. Now her provocation of others began to manifest in full force. On one occasion she was almost mugged on the street.

It became clear from her biophysical picture that B's masochistic symptoms were associated with the build-up of emotional tension in the diaphragmatic and abdominal segments.[1] As pressure built up her gut distended and filled with gas. Her throat clamped down and so she was unable to discharge her inner tension. During this phase of therapy her burping seemed endless. Gagging produced some relief. She was completely unable to take care of her emotional needs and relied on me to provide relief. Meanwhile, she felt helplessly masochistic, like "a piece of wood."

With the continuation of diaphragmatic mobilization, including gagging, she was able to express strong shouts. This temporarily relieved pressure from the organs of the diaphragmatic segment and B felt well for a few days. Then, as the tension of rage built up and

[1]The solar plexus, the core of the biosystem, is located in the abdominal segment.

was not expressed, the abdominal pressure increased and the burping resumed. She was unable to eat. Swallowing food intensified the sensation of choking and she would burp for hours at a time, feeling miserable.

In her daily life, strong uncontrollable rage began surfacing at people at work. As her rage intensified her masochism did as well—in the form of provocativeness, suffering, self-belittlement, subtly putting me in a bad light at the end of each session, etc. It was my understanding that her capacity for biophysical expansion had been reached when she either felt beside herself (contactless) or when she experienced sensations of disintegrating. Now she began holding strongly in the small of her back and her anal sphincter. This holding reduced the burping. Conversely, when the lower back let go, the burping intensified. As B's capacity to expand increased, she again developed a pruritic rash on her legs, torso, arms, groin, and the back of her neck. Energy released from her muscular armor began getting caught at the skin surface. At this time kicking produced violent uncontrollable rages which she quickly turned inward: "I want a fast death, not a slow death."

Again her head contracted. The skin of the scalp appeared to be pulled tightly over the underlying skull. Belching accompanied her emotional intolerance of the expression of rage. Crying, a weaker emotion, which she could express, provided relief from this distressing symptom. Both crying and burping effected decompression.

Further strong kicking briefly produced a look of sadism in her eyes for the first time. She was beginning to make genuine contact with her intense hostility. She wrote the following letter which was full of bitterness, self-pity, and theatrics:

> Yes, I hate. I hate every living thing I have come in contact with and that includes you. Because every living thing I have ever come in contact with has hated me. They hate my needs, my desires, my interest, my sympathy, my energy. You withdraw from me when I meet you outside the therapy room and I become confused, but of course that is the nature of the relationship so I bear it and then you ask questions. With the others I know it is pure hatred but with you it is putting together and tearing apart. So be it. What else is there for me but to

digest the only truth I have? I have lived in hatred, I was born of hatred, bred in hatred, worked in hatred, married in hatred. Yes, life equals hate and I finally admit it and know it for the truth. I have finally achieved reality—hate. Thank you for staying by me till this ultimate moment of truth.

With an increased ability to tolerate rage, B experienced strong throbbing in her upper segments and expressed some anger verbally: She really didn't know why she was coming to therapy. When I questioned her further about this, she admitted to being angry with me but claimed that she "blacked out" and so was unable to say more.

At this time she developed abdominal pain accompanied by intermittent rectal bleeding. I referred her to an internist. A barium enema revealed a polypoid lesion in the transverse colon. Surgical exploration revealed a benign adenoma with no evidence of malignancy. She made an uneventful recovery.[2]

After surgery and recovery, she continued to experience pains across her abdomen. I mobilized this segment and had her kick to encourage expansion and to relieve some of her abdominal tension. This was followed by stronger expressions of rage and an abatement of her burping.

Again, she became mired in her masochistic complaints. Dwelling on her pain, she said, "I am one big mass of pain." However, she was in better touch with her inner hatred and felt it building up within her. Again her belching intensified. It was difficult for her to keep any food down.

B then had a dream in which a wall in her house cracked. This corresponded to a softening of her thoracic armor. As her respiratory excursions became fuller, her burping decreased and her work capacity improved. She was also able to experience some pleasure in her work. This was followed by a castration dream: She is walking with a loose sandal, which falls off. The association between her pleasurable work experience and the castration dream was unmistakable.

As B became more expanded, she stoically vowed that she would never again allow herself to be degraded. However, she again clamped

[2]The benign tumor was another manifestation of the undischarged emotions that were centered in her abdomen.

down. She became constipated and began burping. My attempts to elicit anger were unsuccessful. Full of emotional tension, she appeared ready to burst. She was unable to eat, and developed epistaxis and intense abdominal pain. I continued my efforts to decompress her from various parts of her body (back, chest, jaw, hips). With the expression of misery she was able to obtain temporary relief.

I also furthered work on her masochistic structure. I told her to cut her long hair and to dress more appropriately. She was reluctant to show herself in a stylish manner. When I again focused on her whining, pathetic voice, B became frightened and kept her anger hidden. Following a brief period of expansion, she again developed fantasies of bursting. She exclaimed: "I want to be ripped open." She was able to obtain some relief with deep crying but soon clamped down in her chest. That week she called me from home to tell me she was having chest pains radiating to both arms. I told her to immediately call for an ambulance to take her to the hospital. EKG revealed electrocardiographic changes consistent with a lateral wall myocardial infarction. B's hospital course and recovery were unremarkable.

When she returned to therapy B described the right side of her chest as being "full of pain," which radiated to her throat. I focused on relieving pressure in her chest, since this had become the segment which held the most tension. Direct biophysical work elicited crying which relieved her pain.

Expression of her misery provided relief but also led to a deeper fear of expansion. She held her breath to counteract expansion, but this produced increased pressure in her chest and led to more masochistic behavior. She succeeded in alienating a female friend by acting provocatively toward her. Despite my attempts to clarify her behavior, she refused to assume any responsibility for what she had done. Instead, B righteously accused me of misunderstanding her and of siding with others against her.

I therefore returned to decompressing her biophysically. She was able to express some misery and anger, which produced relief. I asked her to be more precise about what she meant when she said that she felt pain. She replied that it was not pain but rather feelings that she was experiencing as painful. In other words, she distorted any emotion or sensation and experienced it as pain.

She felt that a terrible rage was surfacing accompanied by a feeling of utter loneliness. She began dwelling on her childhood and considered the possibility that she may have been illegitimate. This would explain why B was treated like a pariah by her entire family and would account for her dazed and lost expression. She recalled that as a child her father regarded her with utter contempt. I told B that she now acted like a pariah in the same way that her family had treated her. I pointed out that to date she was still unable to accept gifts. She responded with a rationalization that the gifts proferred were not ones she wanted.

B then had a most terrifying dream in which she called for her mother. The profound significance of this dream did not become apparent until much later. In retrospect, it indicated that strong expansive impulses were being mobilized. The dream expressed, for the first time, B's longing for her mother and the terror of being open to her.

At this time she joined with a younger male friend in a business venture and loaned him a very large sum of money to finance the deal. Her ostensible reasons for lending such a huge amount was that she wanted to have some fun in her life and also wanted her money to work in a more positive way, instead of idly collecting interest.

As the relationship with her young friend developed, despite the fact that he was half her age, in typical fashion B began to expect more from him emotionally than he was willing to give. Slowly, the same pattern of unconditional giving and the toleration of abuse and thoughtlessness began to emerge. Her allegiance was soon shared by myself and this young man, causing her ambivalence toward me to surface. She began expressing her doubts and reservations about therapy to him just as she discussed with me how she was being victimized by his thoughtless behavior. She never spoke directly to either of us about what angered her.

Then a deeply buried layer of hatred slowly began emerging toward people in her life. In order to prepare her for the full intensity of this rage, I went back to work on her ocular segment and showed her how she tenaciously clung to people with her eyes. Making her aware of this expression enabled her to let go. This resulted in her feeling more movement in her body, which I encouraged her to tolerate. She was able to see how easily she fixated on

people both with her eyes and with her excessive talking.

In her daily life B still experienced the behavior of her business partner toward her as abusive. Although feeling angered by him, she acted masochistically by behaving stupidly, and incurred his anger.

Despite all my efforts, she steadfastly refused to see her part in the problem that was slowly beginning to emerge and threaten her close relationship with him. I told her that behind her excessive demand that others unconditionally accept her behavior was an attempt to provoke them to anger. With this end accomplished she could justifiably hate the world secretly while suffering overtly. Her rage finally was uncontainable, and she began expressing it to her partner. At first she spoke up rationally, and this relieved her tension considerably. Then, she stoically resolved not to take any "abuse" from him and to become independent of everyone. When she did this in a hostile and rejecting manner their relationship became strained.

I continued to encourage expansion through biophysical mobilization of her legs, especially the adductors of the thighs. This produced increased respiration, and her respiratory movements passed through her diaphragm without producing burping. She stated that she felt that she was becoming "unglued."

She had a dream: She was in a room whose walls had old paint peeling off them, and she was painting herself into a corner. This indicated that B was finally giving up her armor ("walls peeling") but found this intolerable (feeling cornered). Again, her masochism returned in full force. She expressed a fear of the dark and of being hurt. She stated that her puffed out chest was to make her like a blowfish so she would not be swallowed by others.

A pain in her right arm became intense. When I pressed on the muscle, an explosive rage was elicited with forceful hitting. This outburst was the strongest that she had ever expressed, and she felt the most relief thus far. For the first time she actually left the session smiling. She looked optimistic and said that she felt better than she had ever felt in her life.

She was handling herself better in daily life and talked to her partner rationally about the financial aspects of her investment. She now recognized that she had blindly put her life savings into this business venture and in an attempt to protect her interests, she hired an

attorney. In therapy, her anger was easily mobilized. She had strong urges to strangle a sheet and also to hit. When upset, her voice sounded legitimately angry, no longer a whimpering whine.

B began feeling a strange new sensation in her chest. She had no dyspnea (shortness of breath) or radiating pain, and a cardiac workup was negative. Now the rage in her chest was coming through deeper and stronger. She was easily stirred up by events in her life and lost her illusions about people. Her rage at the world continued to intensify and was expressed consistently. She lost her muddled look and gave the appearance of being clear and realistic. In all the years of treatment, I never saw her look as strong, as expanded, as in control of her life as now. No one seeing her would have dared "start up" with her.

I told her that there was still a great danger that she could turn her anger inward in a self-destructive manner. I had no idea of the extent to which my warning would come true. Soon afterward, and for no apparent reason, she felt victimized again and, with the wrath of a woman scorned, she hurled her full fury at her business partner. She railed for entire sessions at his shabby, contemptuous treatment of her. She realized that she had expected too much from him and that she should have known all along that he was unwilling to make the same emotional commitment to her that she had made to him. Now, she also included me as part of the world that was against her. Her masochistic obtuseness was present in full force. She said I no longer understood her or could be of any help to her. She simply could not see how she was once again setting the world up to victimize her. Her own aloof and contemptuous (defensive) attitude regarding the financial world put her above such a realization. She simply wanted to "do good" with her money. She totally ignored her contribution to the problem: Her secret expectations of love from her business partner and her unrealistic belief in the power of her money to win him over. I became part of the world that did her such a terrible injustice. In her typical victimized role, B stated that she no longer had any illusions about either of us ever giving her what she so desperately longed for. It was now clear that her involvement in the business venture had been, in large measure, a grand provocation.

As I had foreseen, B succeeded in turning her aggression inward which, finally after years of difficult work, had become directed out-

ward. She had once again become the pathetic victim. On the positive side, she was completely free of her masochism for a brief time. If she had been capable of maintaining this level of functioning, therapy would have made a permanent and drastic alteration in her structure. Unfortunately, B was not capable of sustaining this degree of health. Nevertheless, therapy was successful from the standpoint that it enabled her to tolerate the greatest degree of biophysical expansion her structure would permit and her general mobility had greatly increased compared to the state she was in prior to treatment.

Discussion

This case illustrates many of the typical features encountered in the medical orgone therapy of the masochistic character. Although the initial clinical diagnosis was manic depressive character, the correct diagnosis of masochistic character, which requires that *all* the traits of masochism be present, was not made until later because a cardinal trait—a tendency to torture and provoke others—was not conspicuous early in therapy. In retrospect, however, there were many clues pointing to the correct diagnosis. Her frequently placing herself in the role of victim, her biophysical appearance of being ready to burst, her extreme intolerance of pain, her accusing look, were all present at the beginning of therapy and were suggestive of the diagnosis of masochism. However, it was only when she felt secure enough in her relationship with the therapist that her provocativeness gradually made its appearance—and even then not at first with the therapist, but in her other relationships. Once this trait was observed and the diagnosis made, thorough consistent work on her masochistic structure was possible.

Another trait that was not conspicuous was a chronic sense of being cold and a need for physical warmth. However, from an emotional standpoint she did require an inordinate amount of love and attention; that is, emotional warmth. Diagnostically, this characteristic satisfied the criterion of needing physical warmth. The prominent clinging expression observed in her ocular and oral segments were actually in the service of her anal (not oral) unsatisfied impulses for closeness and warmth. This behavior is similar to that of the

passive feminine character and is why she responded with fear and not anger when the clinging attitude from these segments (teeth clenching, holding on with her eyes) were addressed.

Also, to satisfy criteria for the diagnosis it is sufficient for the patient to display moral masochism instead of an actual masochistic perversion. The wish to have intercourse with the father (therapist) and the release of sexual tension become distorted into a desire to be beaten (masochistic perversion) or humiliated (moral masochism). Recall the frequent masochistic oedipal dreams of this patient from the very onset of therapy.

The patient appeared to seek humiliation and failure from the therapist. But this was also an attempted provocation. Her masochistic behavior was actually a wish for sexual release and, by substituting a milder punishment (humiliation, degradation) for the dreaded fear of castration,[3] a defense against punishment and anxiety. The provocation, by also placing the therapist in a bad light, satisfied the patient's reproach: "See how badly you treat me. See how miserable I am." This behavior serves the exact same function in the character as the sexual masochistic perversion by maintaining the chronic contraction and providing some relief. It will be recalled that this patient actually had masochistic fantasies of bursting while fantasizing being touched sexually by a man.

The question arises: Why did this patient withdraw at the end of therapy exactly when the greatest change in her structure was about to occur? In this connection, her dream just prior to her business venture with the young man was of greatest significance. It indicated that a deep layer of expansion was about to take place as expressed by the emergence of deep longing for her mother. This dream was experienced as terrifying and was a direct manifestation of her biophysical intolerance of expansion. It was immediately following this dream that the patient initiated the disastrous business enterprise. In retrospect, this action was in large part a well-executed provocation that was so cleverly choreographed it escaped detection until it was too late.

[3]The masochist experiences the melting pre-orgastic genital sensations as the dreaded fear of castration.

Also, in conclusion, it should be emphasized that in the end phase, masochistic symptoms are a defense not against sadistic impulses but against overpowering pre-orgastic sensations.

REFERENCES

1. Reich, W. *Character Analysis*, trans. by T. Wolfe, third edition. New York: Orgone Institute Press, 1949.