Depressive and Self-Defeating Patients

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Depressive personality does not equate with depressive illness

- It is a more chronic, low-grade tendency toward feeling guilty or inadequate, feelings that go with cognitions explaining painful life experiences in terms of personal malfeasance or failure. One can have a depressive personality and never have had a significant depressive episode.
In fact . . .

- It appears to be the most common personality type among psychotherapists (Hyde, 2009)
Depression versus normal grief:

- **In normal grief states:**
  - There is a clear loss or rejection.
  - The world seems bad or empty.
  - The painful feelings come in waves; between the waves there is normal mood.

- **In depressive episodes:**
  - The precipitant may be unclear.
  - The self seems bad or empty.
  - The painful feelings are chronic and unremitting.
  - There is no sense of a capacity to improve one’s mood (cf. Seligman’s “learned helplessness”)

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Depressive and self-defeating personality disorders are not in the DSM or the ICD taxonomies

- The decision not to include them, despite evidence that depressive-masochistic personality (Kernberg, 1984) is the most common kind of personality disorder, resulted from political rather than scientific factors.
- The *Psychodynamic Diagnostic Manual*, which tries to reflect both accrued clinical experience and research, does have a category for depressive personality styles and disorders, with hypomanic and self-defeating variants.
Diagnosis for clinical purposes

- Dimensional rather than categorical
- Inferential rather than reified
- Contextual rather than isolated
- Integrated rather than artificially “co-morbid”
Depressive/masochistic affect

- Psychological pain
- Distress and a sense of grief without a clear object
- Guilt and/or shame
- Self-hatred (Fairbairn’s “moral defense”)
- At the level of brain activity, activation of Jaak Panksepp’s PANIC (separation/attachment) system
Depressive and Masochistic Cognition

- “When I experience a rejection, loss, or disappointment, I conclude it is because there is something wrong with me.
- Early childhood experience that sets the stage for depressive psychology may include the inference, “Mother is gone. It must be my fault. I was bad or insufficient in some way.”
- In masochistic psychology, the inference is more like, “Mother is gone. It must be my fault. I was bad or insufficient in some way. But maybe if I keep demonstrating how hurt or needy I am, she will return.” Thus, attachment is predicated on suffering (cf. Martha Stark’s “relentless hope”)
Depressive and Masochistic Defenses

- Introjection
- Turning against the self
- Idealization of others
- Identification with the aggressor

- In masochism, acting out and “victim entitlement”
Two subjective experiences of depressive psychology (Blatt, 2008)

**Anaclitic (self-in relationship)**
- Shame
- Sense of being empty of anything valuable.
- Relationship itself is therapeutic and reduces symptoms quickly.
- Danger of losing gains at the end of a therapy.

**Introjective (self-definition)**
- Guilt
- Sense of being full of badness, evil.
- Therapy takes longer and must include focus on cognitions about one’s “faults.”
- Improvement may continue after the end of treatment.
Transference in depressive patients

- They attach quickly and may convey a sense of trust and hope.
- They tend to idealize the therapist, but not in an empty way: they appreciate good qualities in the therapist that are real.
- They are alert for criticism and rejection from the therapist.
- They try to please, and they try not to “bother” the therapist.
- They are frightened of any negative feelings or attitudes toward the therapist.
Countertransferences to depressive patients

- They are likeable and evoke natural sympathy.
- The introjective type may be perfectionistic and be admirable as a result.
- Both types may induce warmth and genuine concern, though the self-hatred of the introjective person can become tedious, as can the passive dependency of the anaclitic one.
- Both depressive types may eventually evoke a sense of futility that mirrors the patient’s despair.
- It is sometimes easy to enjoy the patient’s idealization and not notice opportunities to explore his or her negative experiences of the therapist.
Treatment implications: Depressive patients

- Because of their tendency to attach easily, they work well in therapy.
- Anaclitically depressive patients may be helped by normalizing conversations about their sensitivity to attachment and separation. They may need either significantly long treatments, so that they can internalize the therapist’s attitude, or specific psychoeducation about separation when in shorter therapies.
- Introjectively depressive patients need confrontation of their underlying automatic cognitions.
- “Supporting the ego” versus “attacking the superego.”
- Both need to become comfortable with critical and hostile feelings toward the therapist; otherwise, they will end treatment thinking they were lucky to go to such a wonderful person – without experiencing improvement in their own self-acceptance.
Self-defeating (masochistic) patients: Subtypes

- **Introjective self-defeating patients** have been called “moral masochists” or Millon’s (1995) “aggrieved pattern” of personality.
- **Anaclitic self-defeating patients** have been called dependent or narcissistic-masochistic patients (Cooper, 1988).
- There is a more **paranoid version of masochism** that Nydes (1965) called the “paranoid-masochistic character.”

Importance of appreciating the difference between normal altruism or surrender, developmentally appropriate self-sacrifice, and masochistic submission (comparable to differences between grief and depression).
“Normal Masochism” (Adaptive Altruism)

Like all psychopathology, self-defeating patterns are extreme versions of normality.

- Altruistic self-sacrifice is evolutionarily important to the survival of the human species. Parenting mammals will put the welfare of their children ahead of their individual welfare; we are biologically equipped for such sacrifices.

- C. G. Jung: Masochism as a perversion of the normal need to worship or venerate

- Helena Deutsch: Masochism as a normal and inevitable part of mothering

- Emmanuuel Ghent: Masochistic submission as a perversion of the normal need to surrender to something larger than the self
Unconscious motives behind self-defeating behavior (Reik, 1941)

- **Provocation** (“Let’s get the suffering over with”)
- **Appeasement** (“I’m already suffering, so please don’t hurt me”)
- **Exhibitionism** (“Pay attention! I’m in pain!”)
- **Deflection of guilt** (“Look what you made me do!”)
Masochistic Clinical Presentations

- The “Isn’t it awful?!” presentation, in which the adolescent attempts to enlist you in lamenting a context of victimization that is taken as a fact of life.
- Indications of the patient’s pleasure in frustrating clinical efforts to help, like the slight smile in reporting, “That medicine didn’t work either . . .”
- Emphasis on the role of others in wounding the person and recruitment of the therapist to feelings that he or she deserves special compensations for a difficult history (“victim entitlement”)

Countertransferences to self-defeating patients

• Initially, deep compassion, based on the person’s having been realistically victimized
• Also, early in treatment, masochistic feelings (expressed in behaviors such as reducing the fee, seeing the patient at inconvenient times, being available by telephone at all hours)
• Usually later, irritable, sadistic feelings, including hostility, exasperation, lack of compassion.
Treatment implications for self-defeating patients

- Don’t exemplify masochism
- Don’t be too sympathetic (it can reinforce the schema that attachment is based on the patient’s suffering)
- Don’t take on the patient’s anxiety (masochistic patients off-load it on the therapist, and they need it to motivate change)
- Confront the underlying fantasy that if the therapist really understands the patient’s pain, psychological progress will happen without the person’s personal effort.

These therapeutic stances tend to evoke anger in the patient, which is important to welcome and work through as a corrective to the person’s internal conviction that only the suffering self is welcome to others. Important to be accepted with one’s darker, more aggressive side.
Thank you!

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