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Research Paper

When Pain becomes Personality: Revisiting Sado-Masochistic Personality Structure

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ABSTRACT

The current case report is an exploration of a traditional diagnostic entity of sado-masochistic personality disorder. It contributes to the discourse by demonstrating process of conceptualization and emphasizing utility of projective tests when objective tests don't yield adequate results. MMPI 2 RF, TAT, the Rorschach and SCID-5 interview schedule were used and a psychodynamic lens was used to conceptualize the case. Eclectic approach was used for therapy; however, it didn't generate impactful outcomes. Important outcome was learning to revisit earlier classificatory systems to deepen conceptual learning and clinical thinking.

Keywords: *Sado-Masochistic Personality, Psychodynamic, Assessment, Therapy*

The current diagnostic systems of DSM-5 and ICD-11 don't recognize sado-masochistic personality as a diagnostic entity. Also known as a self-defeating personality disorder, it was proposed as a part of DSM-III in 1980 and discussed in the appendix of DSM-III-R but never formally introduced into the manual (Khess & Simlai, 2018). Yet, the complexities of the current case, challenges us to revisit and critically reflect upon the conceptual boundary of this construct.

Mr. RB, a 20-year-old unmarried Hindu male, presented in the out-patient department of Central Institute of Psychiatry, Ranchi with complaints of repetitive thoughts of dirt and contamination, repetitive sexual thoughts and images, aggressive behaviour and self-harm behaviour for the last 4 years. Relevant background information suggested conduct traits in childhood including bullying other children, physically hurting younger sister by pushing her off the terrace and pelting stones at neighbours and threatening to bang head against wall as emotional manipulation. The patient was also a survivor of sexual abuse at the hands of a neighbor during his adolescence, which the family has no knowledge of. In the last four years, he developed contamination and sexual obsession after watching a friend's unhygienic behaviour. It progressed to internet searching and self-diagnosis of obsessive-compulsive disorder (OCD). Online content about OCD related self-harm led to deliberate and planned self-harm behaviour which he found pleasurable and identity-affirming. He would engage in deliberate mutilation of his arms and face. He had mutilated his arms so severely that it appeared like an intricate network of spider webs. His facial scars were

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reportedly inspired by the 'Joker' from Christopher Nolan's 'Dark Knight Rises'. Feelings of guilt related to sexual content and watching pornography further intensified his self-harm. He was also preoccupied with the idea of undergoing multiple body modification surgeries. He believed the surgeries would give him an opportunity to be more successful as a youtuber and filmmaker and give further opportunity for self-mutilation. After the death of father, who was dependent on alcohol and a source of familial violence, he displayed no remorse. Rather, he demanded all of father's insurance money to spend on his hobbies. He would blackmail his mother to give fifty thousand rupees to order film cameras, pianos and face masks every month. Refusal to indulge led to physical assault on the mother. During this time, his younger sister was also diagnosed with obsessive compulsive disorder and borderline personality disorder.

Clinical Findings and Conceptualization

The major challenge was to conceptualize the case and the findings of the assessment. The Minnesota Multiphasic Personality Inventory 2 Restructured Form was invalid due to over-reporting of symptoms (Ben-Porath & Tellegen, 2011). The Rorschach Inkblot Method suggested that he exhibited an avoidant coping style with impaired reality testing and mediational dysfunction, leading to distorted perceptions and unconventional behaviours. He showed exaggerated self-involvement, low self-awareness, and expressed needs for closeness in atypical ways. His interpersonal relationships were maladaptive, shaped by unmet emotional needs and a disregard for social norms. Personality features reflected persistent cognitive and emotional peculiarities (Exner, 2003). The Thematic Apperception Test suggested needs of autonomy, affiliation, intraggression, rejection and succorance. Major conflicts were autonomy vs dominance, affiliation vs loss, rejection vs succorance, id vs superego, intimacy vs isolation and life vs death. The major defenses were wishful thinking, turning against self, idealization and devaluation and acting out (Murray, 1943). Through multiple interviews and administration of Structured Clinical Interview DSM 5 PD, he appeared to meet criteria for narcissistic personality, borderline personality and antisocial personality disorder according to the existing classificatory system (American Psychiatric Association, 2013). Few poignant experts from the interviews translated into English:

- "My internal anger, trauma, tragedy, sadness, guilt and suicidal thoughts give me peace and strengthen my moral values"
- "During my childhood, I used to imagine that my family dies in a car accident and that thought gave me peace and I hoped it would come true"
- "I want to unleash the anger towards others onto myself"
- "I like injuring myself. I plan out ways to hurt myself. I plan to have many body altering surgeries and then cut myself again. I like seeing the shocked faces of others when they see me. These injuries and scars are my identity".

The difficulties faced during the assessment phase of the case paled in comparison to the substantial challenges of the psychological management. Mr. RB had previous experience with counselling. In his words, he 'wanted therapy at any cost and as frequently as possible.' He would attend up to 4 sessions per day at private practice. The urgency stemmed more from the desire to 'show off his personality in a space he knows he will be entertained' rather than a need stemming from experienced difficulties.

Therapeutic Intervention

Literature on treating a sado-masochistic personality suggested no particular modality for treatment, hence, an eclectic approach was taken. The team after much deliberation decided

to begin therapy with the aim of motivating him to stop self-harm and understanding his patterns. A total of approximately 20 sessions were conducted. Early on in therapy, the process of therapy being a collaborative process was discussed to which he had agreed. Through behavioural contracting self-harm behaviour management was initiated which the patient readily followed. The major challenge posed to be his insistence on spending his excessive money and preoccupation with surgeries. Each session followed a recurrent pattern of the patient presenting a specific idea regarding his need for surgeries and need for spending money, and the therapist and co-therapist attempting to introduce alternative perspectives while validating what could be reasonably validated of his ideas. Although the patient appeared to agree superficially, he consistently reverted to the same maladaptive patterns of behaviour and idea. Following each session, he would indicate that he intended to act according to his own judgment, irrespective of therapeutic input. However, he was still willing to come to therapy and was always punctual for the sessions as it provided him a free space to share his ideas. Over the course of the sessions, marginal improvement was seen in his self-harm behaviour. Unfortunately, self-harming behaviour resurfaced around the 18th session, while issues related to aggression, body modification surgeries and excessive financial expenditure persisted throughout the therapeutic process. After the 19th session, the therapeutic process was reviewed. Feedback was once again provided, emphasizing that therapy cannot be shaped solely according to his preferences, as it is intended to be a space of mutual collaboration. He was encouraged to reflect on whether he would be able to engage in and adhere to this process of collaborative work. At the conclusion of 20 sessions, the patient chose to discontinue therapy, expressing dissatisfaction that his perspective was not being acknowledged and that the therapeutic approach was overly focused on promoting changes he was unwilling to accept.

DISCUSSION

This case illustrates the challenges of working with an individual with a personality disorder. The core challenge at hand was conceptualizing the case, and keeping the patient engaged in a collaborative relationship that yielded effective results.

Understanding this case from a psychodynamic viewpoint, based on overall history, interviews and assessments relates that at the core of his psychic organization lies a deeply internalized belief that *physical suffering pales in comparison to emotional pain*, which he has endured chronically. This emotional pain has become fused with his sense of identity, such that *his self-esteem is organized around his perceived capacity to endure suffering*. He appears to be an extreme form of *hedonic reversal*, whereby, the ordinary experience of pain is not experienced as burden but as something pleasurable and gratifying that grants him moral or existential value and meaning. He often endures hardship with a conscious or unconscious hope that it serves a "greater good," whether in the form of redemption, love, or acceptance (McWilliams, 2011).

His early object relations appear to have been marked by unresponsive or punitive caregivers, leading to internalized disappointment, unexpressed rage, and unmet dependency needs. In an effort to maintain attachment to these internalized objects, he has *turned his aggression inward*, a hallmark defense mechanism in masochistic personality structures. This manifests as chronic self-sacrifice, self-denial, and emotional self-lashing. At times, he engages in *exhibitionistic acting out* drawing attention to his pain or endurance not necessarily for sympathy, but to demonstrate his ability to tolerate pain without breaking, thus reinforcing a narcissistic identification with suffering (McWilliams, 2011).

He is often drawn to relationships with individuals who validate or idealize his capacity to endure suffering. These relationships serve a dual purpose: they preserve his sense of specialness and strength (through suffering), while also allowing him to replay early relational disappointments. He struggles with guilt, but rather than processing it directly, he employs *deflection*, often framing his pain as being caused by external forces or unjust others. This protects him from feeling the shame associated with being vulnerable or "needy" (McWilliams, 2011).

His narcissistic traits stem from early and repeated experiences of relational disappointment, particularly with caregivers who may have been withholding, inconsistent, or emotionally unavailable. As a result, he has developed a fragile sense of self, created not through genuine self-love, but through *the performance of suffering*. He could not admit remorse or weakness easily, as doing so would expose a shameful dependency he learned early on must be disowned to retain dignity and connection (McWilliams, 2011).

One of the main factors that are a pre-requisite in therapy is high patient motivation and the ability to form a relationship with the other (Karasu as cited in Kaplan & Sadock, 2009). Due to his history of impaired interpersonal connections, the concept of a mutually collaborative relationship where ideas and concerns of both parties are discussed and reflected appeared to be foreign to him. He had been used to one-sided transactional relationships where he was present to acquire benefits from the other or vice versa. Additionally, his motivation for therapy lied in him viewing it as a tool for his exhibitionistic desires and tendencies, where he could make a show of his self without being judged. He did not have any desire for health, cure or long-term gains. Thus, the foundation of the therapeutic relationship was unstable and could be a factor contributing to the feeble results it yielded. Moreover, the case presented with high degree of complexity, requiring advanced therapeutic skills. Despite being under supervised practice, the case highlighted the limits of experience of the therapist and need for further refinement of therapeutic skills.

CONCLUSION

Greatest insight from this experience would be conceptualizing the case from the psychodynamic perspective. A comprehensive review of the patient's history through the dynamic lens proved instrumental in identifying the underlying behavioural patterns. As a beginner professional, it was a welcome challenge to understand the significant utility of projective tests in facilitating insight into intrapsychic conflicts. Therapy proved to be the biggest hurdle which despite many attempts didn't yield favourable results. Nevertheless, they served as an opportunity to deepen theoretical understanding and enhance therapeutic skills, particularly in building alliances with challenging patients. Though not formally recognized as sadomasochist personality anymore, the current diagnostic system would classify the current symptomatology as a mixed personality disorder comprising of borderline personality, narcissistic personality and antisocial personality. However, given the current scenario, revisiting earlier classificatory frameworks remain valuable, not for diagnostic application, but as a means to deepen conceptual understanding and inform clinical thinking.

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Conflict of Interest

The author(s) declared no conflict of interest.

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