Moral Masochism and the Self-defeating Personality Disorder

Summary of Doctoral Dissertation Research

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When a person suffers physical or emotional pain, punishment, humiliation, and abuse, two responses are typical and understandable: an effort to escape, and a tendency to try to avoid similar outcomes in the future. The concept of masochism has arisen to account for behavior in which such ordinarily painful and unpleasant experiences do not result in these expected responses.

Masochism has been a concept of notable clinical and theoretical interest to psychoanalytic practitioners since the inception of psychoanalysis at the turn of the century. Within the psychoanalytic literature, the concept itself has undergone a complex evolution from a specific to a more general use, and perspectives on the etiology and treatment of masochism have been elaborated in ways that have paralleled the development of new trends in psychoanalytic theory. More recently, the controversy surrounding the inclusion of a "Self-defeating Personality Disorder" (SDPD) in DSM-III-R (APA, 1987), has called the concept of masochism to the attention of non-psychoanalytically oriented mental health professionals as well (e.g., Caplan, 1987; Franklin, 1987; Rosewater, 1987; Walker, 1987). The purpose of my presentation is 1) to give a brief historical overview of the concept of masochism and 2) to discuss several key areas of confusion which bear on the controversy over masochism and the SDPD.

Masochism as a psychological concept was first considered by Krafft-Ebing (1900) in his investigation of deviant sexual behaviors. He focused on masochism as a sexual perversion in which erotic pleasure is obtained by the passive acquiescence to, or even seeking out of, brutal and humiliating responses from another. The term had been culled

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from the name of the Austrian writer, Leopold von Sacher-Masoch, whose novel, *Venus in Furs* (1870) describes in florid detail the sexual and psychological subjugation actively sought by the male protagonist.

Beginning in 1905 with *Three Essays on the Theory of Sexuality* (1905), Sigmund Freud began to explore the dynamics of masochism and its counterpart, sadism. In a series of theoretical and technical papers written over the next 20 years, his observations were made from several evolving perspectives. To summarize, Freud began by viewing masochism as a secondary phenomenon derived from a primary aggressive drive which had, for various reasons, turned inward. In this view, masochism was really sadism directed toward oneself. In *Instincts and Their Vicissitudes* (1915), Freud pointed to the tendency of all instincts to alternate with their opposites, and observed that in clinical practice sadism and masochism typically co-existed in the same individual, although either might predominate and even function as a defense against the other. In a paper entitled *A Child is Being Beaten* (1919), Freud stressed the role of unconscious guilt in the development of masochism.

With the publication in 1920 of the highly speculative and theoretical *Beyond the Pleasure Principle* (1920), Freud introduced his so called "dual instinct theory", thereby enlarging his concept of the "life instincts" and postulating the existence of a "death instinct". This shift "beyond the pleasure principle" led to a reconsideration of the nature and origins of masochism which Freud most clearly explicated in the last of his major writings on the subject, *The Economic Problem in Masochism* (1924).

In this paper, Freud differentiated between three types of masochism: erotogenic, feminine, and moral masochism. While the earlier view of masochism as sadism turned inward was retained, it was relegated to a secondary position. The most elemental form of masochism, according to Freud, results from a fusion of the death and life instincts which is then directed toward the self. To put it another way, while Freud had previously conceptualized masochism as sadism turned inward, he now conceptualized sadism and masochism turned outward. Freud termed this "erotogenic" masochism and conceived of

it as providing the physiological substratum that makes possible an association of pleasure and pain. Erotogenic masochism is not a clinical form of masochism, but rather a metapsychological construct providing a conceptual underpinning for the clinical manifestations of feminine and moral masochism.

"Feminine masochism" was Freud's term for the masochistic sexual perversion. The term itself has led to some confusion and unfortunately has often been misconstrued as meaning the "masochism of women". In fact, what Freud actually discusses under this heading is the essence of the masochistic sexual perversion in men, which he views as an unconscious fantasy of being placed in a characteristically female position. It should be remembered that in the context of his theory of bisexuality, Freud used the term "female" to indicate passive and "male" to indicate active with the understanding that both trends are found in men and women alike (Freud, 1905). Feminine masochism is possible for any human being regardless of gender.

The third, and most observed form of masochism, Freud termed "moral masochism". It was here that he extended the notion of masochism beyond the scope of overt sexual behavior and laid out the theoretical foundation for subsequent discussions of the masochistic character.

Freud described moral masochism as a derivative form of masochism where the subject, because of an unconscious sense of guilt, seeks out a position of victim or suffering, without any sexual pleasure being directly involved. Moral masochism describes not a sexual perversion (which may or may not be associated), but rather a pervasive pattern of personality functioning in which the subject unconsciously seeks people and circumstances which bring emotional suffering, defeat, and injury.

Since Freud, newer psychoanalytic theories have offered etiological reviews of this extensive literature may be found in Brenner (1959) and Stolorow (1975). However, before turning to the function of masochism, let us look briefly at how the concept of

masochism has been dealt with in the Diagnostic and Statistical Manual of mental Disorders. (APA, 1980, 1987).

In the debates and conferences leading up to the 1990 publication of the DSM-III, the proposal on the part of some clinicians to include a Masochistic Personality Disorder was overridden by the preference of the DSM Task Force to include self-defeating and pessimistic behavior under the axis I affective Dysthymic Disorder. "Masochism" was included only as a sexual perversion (Freud's feminine masochism). The clinician treating a patient with pervasive masochistic characteristics had the option of diagnosing such a person under "Other Personality Disorders" and noting the presence of masochistic personality traits. However, there were neither agreed-upon criteria for inclusion nor suggestions for differential diagnosis.

Many clinicians were dissatisfied with this situation and recommendations for including a Masochistic Personality Disorder continued (Simons, 1987). In 1983, the Work Group to Revise DSM-III began and extensive literature review as well as several conferences in which potential criteria were discussed and debated. In 1985, a Masochistic Personality Disorder was included in a draft of the proposed DSM-III-R. This generated considerable professional and public controversy. Some opponents of the diagnosis, particularly those rendering a feminist critique, did not disagree that self-injurious behavior patterns exist, but rather offered explanations which emphasized the primacy of socio-cultural factors over psychological factors (Caplan, 1987; Rosewater, 1987; Walker, 1987). Others, particularly those with non-psychoanalytic theoretical orientations, objected to a clearly psychoanalytic diagnosis in what was allegedly an atheoretical diagnostic manual. The compromise emerging from the controversy was the change of the diagnostic name to the Self-defeating Personality disorder and the decision to move the SDPD from the main body of the text to an appendix entitled "Proposed Diagnostic Categories Needing Further Study". Here the SDPD is introduced as:

A pervasive pattern, in a variety of contexts, of self-defeating behavior, beginning by early adulthood. The individual may often avoid or undermine pleasurable

experiences, be drawn to situations or relationships in which he or she will suffer and prevent others from helping him or her (APA, 1987, p. 371).

The presence of at least 5 of the descriptive criteria listed must be present to make the diagnosis. The DSM text notes that this disorder has been called the Masochistic Personality Disorder, but the name has been changed "to avoid the historic association of the term "masochistic" with older psychoanalytic views of female sexuality and the idea that a person with this disorder derives unconscious pleasure from suffering" (p. 371).

This brings us to the important issue of pain and pleasure in masochism, an area where clarification is essential. There are two points I would like to make. The first concerns the semantic confusion that surrounds the terms *pleasure* and *pain.* The notion that these subjective states are dichotomous and mutually exclusive often seems to be a source of confusion in the minds of those who find the concept of masochism baffling or simply objectionable. That is, it seems nonsensical and absurd to suggest that someone gets "pleasure" out of "pain". However, this apparent paradox begins to dissolve when we consider that both terms can be applied to different qualities or levels of experience. On the simplest level, for example, there is a distinction between physical sensation and state of mind. Pain and pleasure can be experienced at either level or there can be various mixtures in which elements of pain coincide with elements of pleasure. Consider the marathon runner whose body is racked with physical pain at the end of a 26-mile run, but whose mental state is one of pleasure, perhaps elation, at having gone the distance. Given our own everyday mixed feelings, it should not surprise us that pleasure and pain need not be mutually exclusive. Given what we know of the complexity of the human mind, and the multitude of ways in which events can be given interpretive meaning, it should not surprise us that pain and pleasure may co-exist in ways that lay beyond awareness.

Having commented on the semantic confusion, my second and more important point remains. The DSM introduction to SDPD unfortunately overemphasizes the link between pleasure in pain in masochism. This both reflects, and unwittingly preserves simplistic

misconceptions concerning the ways in which contemporary psychoanalytic clinicians conceptualize the dynamics of masochism.

The years since Freud have witnessed the development of new psychoanalytic theories which can be broadly categorized as ego-psychology, object-relations theories, and self-psychology. At times these theoretical perspectives have included, or run in counterpoint to, Freud's drive/structural model. At other times they have been presented as opposing alternatives.

Nevertheless, the concept of masochistic character has endured. On a phenomenological level, there appears to be widespread agreement among these various schools that "masochistic character" is a viable, common, and important diagnostic syndrome which can be described in terms of a pervasive, primarily unconscious, pattern of seeking suffering. However etiological explanations vary in focus and are often in disagreement. The disagreement has to do with why and in what way suffering offers something to the person.

While Freud himself moved beyond the pleasure principle in using the concept of the death instinct to explain masochism, the metapsychology of the death instinct has been largely ignored by a large portion of subsequent Freudians. Instead, the emphasis has been primarily on the function of moral masochism in alleviating unconscious guilt. By contrast, object relations theories have emphasized that the masochistic personality suffers from an attachment disorder in which a pathological mode of loving serves to maintain object ties (e.g., Berliner, 1958). Self-psychologists have emphasized the narcissistic function of masochism in maintaining self-cohesion and boundaries (e.g., Stolorow, 1975). Others have noted the complexity of masochistic phenomena and stressed the importance of an integrative approach (e.g., Brenman, 1952).

I would like to offer my own impression from a reading of the literature that the notion of the masochistic person is seeking and finding pleasure in painful suffering is inadequate, misleading, and does an injustice to the complex views advanced by

contemporary theorists. Such a simplistic association of pain and pleasure in masochism exists more in the minds of critics who have failed to read the literature carefully (e.g., Caplan, 1985). It would be more representative of current perspectives to say that masochists seek gratification in their suffering, with the *caveat* that the word "gratification" be understood as short hand for a variety of complex psychological operations.

Having considered the psychological functions of masochism, the final point I wish to discuss is the differentiation of masochistic suffering from other suffering. Suffering is an intrinsic part of all psychopathologies. The search for relief from such suffering is, of course, a primary motivation for patients seeking psychotherapy. However, for the term masochism to be meaningful and useful, I believe there needs to be a crucial distinction drawn between the suffering which accompanies psychopathology in general, and that which is uniquely "masochistic". While the masochist may be said to seek suffering, not all suffering is masochistic. The key to this is an appraisal of motivation.

One can imagine a continuum of suffering which focuses on the motivation of the sufferer. On one end of this continuum is externally generated suffering in which motivation is irrelevant. An example would be the suffering that results from being fired from a job because of economic recession. In the middle of the continuum is what we might call “neurotic suffering". Here the suffering is a byproduct of other motivations, and not an end in itself. That is, the sufferer's attempts to cope with conscious and unconscious difficulties are maladaptive insofar as they result in secondary consequences which lead to emotional suffering. An example would be fired from a job for drinking. Finally, on the other end of the continuum would be the motivation to suffer because it is necessary for gratification. Here our sufferer drinks to be fired. While the interplay of internal and external reality is not so neatly separated, this continuum is perhaps useful in helping us conceptualize three potential sources of suffering, only the last of which can be meaningfully considered "masochistic".

If an appraisal of motivation is the key to identifying masochistic suffering, it is understandable that the concept of masochistic personality hits a stumbling block in its translation into the SDPD of the DSM-III-R. The DSM is intentionally atheoretical and, in general, excludes etiology from discussion. Regarding the SDPD, the authors state that a number of theories cognitive, social learning, as well as psychoanalytic, have been offered to explain self-defeating behavior. Thus, the problem arising from the psychoanalytic perspective is that the atheoretical stance of the DSM precludes any mention of motivation, and, as I have argued above, this is the key to differentiating masochistic suffering from other forms of emotional suffering.

Addendum: Doctoral Research

The addition of the SDPD resulted from long-standing recommendations by psychodynamic clinicians to include a Masochistic Personality Disorder in DSM nomenclature. The unusual placement in the appendix and the change of names (from "Masochistic" to "Self-defeating") reflect both the controversial pre-publication opposition to the diagnosis and the DSM's stated intent of categorizing disorders in a descriptive manner which avoids reference to functional etiology.

Even though the term "masochistic personality" is widely encountered in the psychoanalytic literature and clinical settings, the absence of formal criteria leaves open to question whether substantive agreement exists concerning the diagnostic features. Further complicating matters is the fact that in discussing cases, psychodynamic clinicians typically distinguish between the level of descriptive symptomatology and the more inferential level of dynamic explanation. To address these issues, my doctoral research, completed in 1988, attempted to clarify the ways in which psychodynamically oriented clinicians conceptualize the masochistic personality by developing two prototypes consisting of characteristic features at both the descriptive and functional level.

In the first phase, 13 clinicians selected from the aforementioned psychodynamic theoretical orientations wrote two descriptions of the masochistic personality using

psychodynamic concepts for the first and behavioral-descriptive terms for the second. The clinicians were asked to describe the important characteristics of the masochistic personality in the domains of drives and wishes, superego functioning, ego functioning, object relations, and sense of self. A group of judges then reduced the clinicians' narratives to basic ideas and determined which ideas were mentioned independently by at least four of the 13 clinicians. A second sample of 34 clinicians then rated each of these prototypic features, along with the eight SDPD criteria from DSM-III-R and four irrelevant or "dummy items" (chosen at random from other DSM-III-R personality disorders) according to its importance in making a differential diagnosis of masochistic personality.

Ten psychodynamic and 11 descriptive features were developed in the first phase of the study. These features were mentioned by at least four (and as many as nine) of the 13 clinicians with the majority being mentioned by five to six clinicians. These results are significant in identifying an important area of consensus in diagnosing masochistic personality.

Clinicians in the second phase then rated these two groups of features and the SDPD criteria as equally important in making a diagnosis of masochistic personality (as expected the "dummy" items were rated significantly lower). The SDPD criteria from DSM-III-R received the highest mean rank, followed by the descriptive prototype features, and the psychodynamic prototype features. The fact that the clinicians found the SPDP criteria to be as clinically relevant as the descriptive and psychodynamic features generated by their colleagues lend to support to be the face validity and clinical validity of the SPDP as a diagnosis that accurately reflects the psychodynamic concept of masochistic personality.

Qualitatively speaking, there was considerable overlap between the descriptive features in the study and the SDPD criteria. In the descriptive prototype, five of 11 features had corresponding SDPD criteria. Among the eight SDPD criteria, four had corresponding features in the descriptive prototype.

Since one of the intentions of this project was to generate descriptive features that could be compared qualitatively to the DSM-III-R criteria for SDPD, an important result is that several features were identified which are not currently included in the SDPD diagnosis, but which were ascribed importance by the clinicians sampled here. An example is “Experiences self as powerless victim of unfair abuse and mistreatment at the hands of others.” This feature was considered highly relevant by the clinicians in this study and was ranked higher than seven of the eight SDPD criteria. Two other descriptive features, “Excessively depreciates, denigrates, blames, and criticizes self”, and “Low self-esteem and feelings of worthlessness” also had no corresponding DSM criteria. The first of these was rated third in importance among the 11 descriptive features ranking it higher than six of the eight SDPD criteria. The second feature was ranked sixth in the descriptive prototype, although rated lower than most of the SDPD criteria.

Taken as a whole, these results suggest that, from the psychodynamic perspective, the criteria for the Self-defeating Personality Disorder could be strengthened in reflecting the masochistic personality by the addition of three similar features.

It is interesting to note that this study did not develop corresponding features for several SDPD criteria which would seem to reflect well the literature on masochism. Two examples are: 1) "Following positive personal events (e.g., new achievement) responds with depression, guilt, or a behavior that brings about pain (e.g., an accident)”; and 2) “Fails to accomplish tasks crucial to his or her personal objectives, despite demonstrated ability to do so (e.g., “helps fellow student write papers but is unable to write his or her own).” Another SDPD criterion with no corresponding feature is: “Rejects or renders ineffective the attempts of others to help him or her.” These first two SDPD criteria are reminiscent of Freud’s depiction of “those wrecked by success”, and the third might be considered an operational definition of the “negative therapeutic reaction” often described in the literature with regard to treatment of masochistic patients. The fact that these aspects of the masochistic personality have been attended to in the literature, and yet not by clinicians in this study, should underscore both the complexity of the clinical

syndrome itself, and the need for further research to investigate the diagnostic usefulness of all these criteria with actual patient populations.

In summary, this study, 1) identified ten psychodynamic and 11 descriptive features constituting an area of consensus concerning characteristics of the masochistic personality, 2) lends support for the psychodynamic face validity of the SDPD, and 3) identified several new important features not included in the DSM describing a sense of victimization, excessive self-denigration and feelings of worthlessness.

**References for this and all other presentations are listed on a separate PDF*