Clinical Dimensions of Masochism

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ABSTRACT

In this paper, I propose a general classification of masochistic psychopathology and describe relations between this clinical domain and other types of psychopathology. My main objective is to provide an outline relevant for diagnostic, prognostic, and treatment considerations of masochistic pathology. This includes descriptions of and relations among a wide variety of masochistic phenomena from the depressive-masochistic personality to extreme forms of self-destructiveness.

Ego organization, object relations, superego development, narcissistic organization, and polymorphous perverse infantile sexuality are considered as codeterminants of the levels and clinical features of masochistic pathology. Finally, the relations between masochistic pathology and negative therapeutic reactions are reexamined.

LaPlanche and Pontalis (1973) provide the briefest and, in my view, most satisfactory definition of masochism in the psychoanalytic literature:

… sexual perversion in which satisfaction is tied to the suffering or humiliation undergone by the subject.

Freud extends the notion of masochism beyond the perversion as described by sexologists. In the first place, he identifies masochistic elements in numerous types of sexual behaviour and sees rudiments of masochism in infantile sexuality. Secondly, he describes derivative forms, notably 'moral masochism,' where the subject, as a result of an unconscious sense of guilt, seeks out the position of victim without any sexual pleasure being directly involved [p. 244].

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I agree that masochism cannot be understood without simultaneous analysis of the vicissitudes of both libidinal and aggressive strivings, superego development and pathology, levels of ego organization and pathology of internalized object relations, and the extent to which normal or pathological narcissistic functions predominate (Grossman, 1986). But because of the universality of masochistic behaviors and conflicts, it is not always easy to know when masochism belongs to the field of psychopathology.

In what follows, I propose a general classification of masochistic psychopathology, and describe relations between this clinical domain and other types of psychopathology that might be confused with it. My main objective is to provide an outline of masochistic pathology relevant for diagnostic, prognostic, and treatment considerations. The classification I am proposing is based on the severity of the psychopathology.

**Masochistic Character Pathology**

"Normal" Masochism

Insofar as the price paid for the integration of normal superego functions is the disposition to develop unconscious guilt feelings when repressed infantile drive derivatives are activated, a proneness to minor self-defeating behaviors—for example, in response to what is unconsciously perceived as oedipal triumph—is fairly universal. Obsessive behaviors that unconsciously express magical reassurance against threatened activation of infantile prohibitions and their clinical correlates, such as characterological inhibitions, and, in simple terms, restrictions of a full enjoyment of life, are also ubiquitous. The tendency for realistic self-criticism to expand into a general depressive mood is another manifestation of such self-defeating superego pressures (Jacobson, 1964). In short, minor manifestations of "moral masochism" are an almost unavoidable correlate of normal integration of superego functions.
sublimatory capacity to endure pain as a price (by means of hard work) for future success or achievement also has an underpinning in this generally normal masochistic predisposition.

In the sexual realm, the normal preservation of polymorphous "perversion" infantile sexuality should permit the capacity for sexual arousal with masochistic and sadomasochistic fantasies and experiences. As I have stressed (1985a), the sadomasochistic dimension of infantile sexuality is of particular importance in maintaining the normal equilibrium between libidinal and aggressive strivings because it represents a primitive form of synthesis between love and hatred. Sexual excitement and pain become one. Therefore, to give or receive aggression in the form of painful stimuli may also signify to give or receive love in the form of erotic stimulation. It is this condensation of physical pleasure and pain that, by means of transformational processes that are still unexplored, leads to the predisposition to experience a condensation of psychological pleasure and pain as well when superego-determined accusations and attacks are directed against the self.

The Depressive-Masochistic Personality Disorder

This constellation of pathological character traits constitutes, together with the obsessive-compulsive personality disorder and the hysterical personality disorder, one of the three most frequent personality disorders of "high-level" or "neurotic" character pathology—"neurotic personality organization" (Kernberg, 1984). All these personality disorders present a well-integrated ego identity, they show nonspecific manifestations of ego strength (good anxiety tolerance, impulse control, and sublimatory functioning), and they also present an excessively severe but well integrated superego. All these patients are also able to establish well differentiated object relations in depth.

The depressive-masochistic personality disorder proper presents three dominant types of behavior (Kernberg, 1984): (1) traits reflecting excessively severe superego functioning; (2)
traits reflecting overdependency on support, love, and acceptance from others; and (3) traits reflecting difficulties in the expression of aggression.

1. The "superego" features of the depressive-masochistic personality are reflected in a tendency to be excessively serious, responsible, and concerned about work performance and responsibilities. These patients have a somber quality and are overconscientious. They may lack a sense of humor. They are highly reliable and dependable and tend to judge themselves harshly and to set extremely high standards for themselves. They also may occasionally, in contrast to their usually considerate, tactful, and concerned behavior, be harsh in their judgment of others, a harshness that may take the form of "justified indignation." When these patients do not live up to their own high standards and expectations they may become depressed. In more severe cases, excessive demands on themselves are matched by their tendency to unconsciously place themselves in circumstances that induce suffering or exploitation, thus unconsciously creating or perpetuating an external reality that will justify their sense of being mistreated, demeaned, or humiliated.

2. The traits that reflect overdependency on support, love, and acceptance from others also reveal, on psychoanalytic exploration, a tendency to excessive guilt feelings toward others because of unconscious ambivalence toward loved and needed objects, and an excessive reaction of frustration when their expectations are not met. These patients show an abnormal vulnerability to being disappointed by others, and they may go out of their way to obtain sympathy and love. In contrast to the narcissistic personality, who is overdependent on external admiration without responding internally with love and gratitude, the depressive-masochistic personality typically is able to respond deeply with love and to be grateful. The sense of being rejected and mistreated as a reaction to relatively minor slights may lead to unconscious behaviors geared to making the love object feel guilty. Vicious cycles of excessive demandingness,
feelings of rejection, an unconscious tendency to make others feel guilty, and consequent actual rejection from others may spiral into severe problems in intimate relations and also trigger depression connected to loss of love.

3. The "faulty metabolism" of aggression shows in these patients' tendency to become depressed under conditions that would normally produce anger or rage. Unconscious guilt over anger expressed to others may further complicate their interpersonal relations, adding to the vicious cycles described before: a tendency to "justified" attacks on those they need and feel rejected by, followed by depression and overly apologetic, submissive, and/or compliant behavior, only to be followed by a second wave of anger over the way they are treated and their own submissiveness.

All these dominant traits of the depressive-masochistic disorder correspond to the description of "moral masochism" in the psychoanalytic literature (Freud, 1916), (1919), (1924); (Fenichel, 1945 pp. 501–502); (Berliner, 1958); (Brenner, 1959); (Laughlin, 1967); (Gross, 1981); (Asch, 1985). Typically, the corresponding unconscious dynamics center on excessive superego pressures derived from infantile, particularly oedipal conflicts, and may also express themselves in an unconscious, defensive regression to preoedipal dynamics, and in general masochistic behaviors that are at a considerable distance from their infantile sexual conflicts. In other cases, however, unconscious sexual conflicts are closely related to the masochistic behaviors, so that it is particularly in the sexual realm that they manifest self-punitive behaviors as a reflection of unconscious prohibitions against oedipal impulses. These patients may tolerate a satisfactory sexual experience only when it is carried out under conditions of objective or symbolic suffering, and the depressive-masochistic personality structure may be accompanied by an actual masochistic perversion at a neurotic level (see below). In any event, it is patients with this personality structure who most frequently present masochistic masturbation fantasies and masochistic sexual behaviors without a masochistic perversion.
per se. The masochistic behaviors that directly express unconscious guilt over oedipal impulses link the depressive-masochistic and the hysterical personality disorders (Kernberg, 1985b).

**Sadomasochistic Personality Disorder**

These patients typically show alternating masochistic and sadistic behavior toward the same object. I am not referring here to the individual who submits to those above him in command and tyrannizes those who are beneath him, a social behavior compatible with various pathological character constellations. Here, the self-demeaning, self-debasing, self-humiliating behaviors alternate with sadistic attacks on the very same objects these patients feel they need and are deeply involved with.

Sadomasochistic personalities usually present borderline personality organization, with severe identity diffusion, non-specific manifestations of ego weakness (lack of anxiety tolerance, of impulse control, and of sublimatory channeling), predominance of part-object relationships, and prevalence of primitive defensive mechanisms (splitting, projective identification, denial, primitive idealization, omnipotent control, and devaluation). Within the chaos of all their object relations, the intensification of chaotic interactions with those whom they are most intimately involved with stands out. These patients usually experience themselves as victims of others' aggression, bitterly complain about the mistreatment, and adamantly justify their own aggressions toward those on whom they depend. The "help-rejecting complainer" (Frank et al., 1952) is typical of this character; the severity of these patients' interpersonal and social difficulties may lead to chronic failure at work and in social life as well as in intimate relations.

In contrast to the impulsive, chaotic, arrogant, and devaluative behaviors of the narcissistic personality functioning on an overt borderline level, the sadomasochistic personality proper has much more capacity for investment in depth in
relations with others; he shows dependency and clinging in contrast to the aloofness of the narcissistic personality.

The dynamic features of these cases include severe oedipal and preoedipal conflicts, particularly, an internal dependency on primitive maternal images experienced as sadistic, dishonest, and controlling; a dangerous primitive mother exacerbates oedipal fears and condenses unconscious oedipal and preoedipal issues in these patients' behaviors much more than occurs with preoedipal regression of patients with depressive-masochistic personality and essentially oedipal dynamics.

One male patient experienced severe feelings of insecurity and inferiority toward his analyst while berating him continuously, insulting him while yet feeling depreciated and insulted by the analyst. In his relations with girlfriends, he was both extremely fearful that they might drop him for more attractive men, and extremely demanding of them for their time and attention; his separations from girlfriends were followed by pathological mourning with intense paranoid reactions alternating with a depressive sense of having been abandoned.

The lack of integration of superego functions, the reprojection of primitive superego precursors in the form of paranoid traits, and the tolerance of contradictory behaviors—in fact, the rationalization of aggressive behaviors—all illustrate the corruption of superego functions, in marked contrast to the rigid superego integration of the depressive-masochistic personality disorder.

**Primitive Self-destructiveness and Self-mutilation**

In earlier work (1975) I described a group of patients who tend to discharge aggression indiscriminately toward the outside or toward their own body. These are patients with manifest self-destructive behavior and, on psychoanalytic exploration, with severe lack of superego integration, a remarkable absence of the capacity for experiencing guilt, and the general characteristics of borderline personality organization. The most typical
examples are patients who obtain nonspecific relief of anxiety by cutting themselves or by some other form of self-mutilation, or by impulsive suicidal gestures carried out with great rage and almost no depression. These patients fall into three groups (Kernberg, 1984):

1. Patients with predominantly histrionic or infantile personality disorder, the type that also corresponds quite closely to the descriptive disorder of borderline personality disorder in DSM-III (1980). Here the self-mutilating behavior and/or suicide gestures emerge at times of intense rage attacks or rage mixed with temporary flareups of depression. This behavior is frequently an unconscious effort to reestablish control over the environment by evoking guilt feeling in others—when, for example, a relationship with a sexual partner breaks up or when parents strongly oppose the patient's wishes.

2. A more severe type of chronic self-mutilating behavior and/or chronic suicidal tendencies can be seen in patients with "malignant narcissism" (Kernberg, 1984). These are patients with borderline personality organization and a narcissistic personality disorder functioning on an overt borderline level—that is, with general lack of impulse control, anxiety tolerance, or sublimatory channeling. In contrast to the earlier group mentioned, these patients do not show intense dependency or clinging behavior, and are rather aloof from and uninvolved with others. Their attacks of rage and related self-destructive or self-mutilating behavior occur when their pathological grandiosity is challenged and they experience a traumatic sense of humiliation or defeat. In these cases the self-destructive behavior often occurs along with overtly sadistic behavior. Their grandiosity is fulfilled by their feeling of triumph over the fear of pain and death and their "superiority" over all those who are shocked and chagrined by their behavior.

3. Another type of chronic self-mutilating and related suicidal behavior is found in certain atypical, chronically psychotic conditions that mimic borderline pathology. These patients' history of bizarre suicide attempts marked by unusual degrees
of cruelty or highly idiosyncratic features may actually alert the clinician to the possibility of an underlying psychotic syndrome. Jointly, all these patients illustrate a most primitive type of self-destructiveness with conscious or unconscious pleasure connected with the pain they inflict on themselves, a severity of aggression directed against themselves that is neither centered in superego pathology (an unconscious sense of guilt) nor directly linked with erotic strivings (or at least, such erotic strivings occupy a very secondary role to that of aggressive impulses). Clinically, these patients exhibit a basic level of self-destructiveness that is dependent on the intensity of primitive aggression, primitivization of all intrapsychic structures, lack of superego development, and recruitment of libidinal and erotic strivings in the service of aggression. All these self-destructive and self-mutilating patients derive a sense of power from their diffuse destructiveness, a triumphant sense of autonomy, of lack of need of others; they show what are clinically the most blatant efforts to destroy love and relatedness, gratitude and compassion, in themselves and in others. It is questionable whether the behavior of this group of patients still may be considered as part of masochistic psychopathology in a strict sense: unconscious guilt as well as erotization of pain are usually absent.

In more general terms, looking at this entire group of masochistic character pathology, we might say that, as we move toward the more severe pole on this spectrum, we find a gradual decrease of superego integration and of superego participation in the consolidation of masochistic pathology, and an increase of primitive and severe aggression together with primitivization of object relations and defensive operations. Erotism also fades out at this polarity of the masochistic spectrum.

**The Syndromes of Pathological Infatuation**

Chasseguet-Smirgel (1985), in disagreeing with Freud (1921pp. 111–116) that in the act of falling in love the ego is depleted
of libidinal cathexes (which are invested in the love object as a replacement of the ego ideal) points to the enrichment of libidinal investment of the self of the person in love. Particularly under normal circumstances, a love object is either abandoned in a process of mourning when it does not reciprocate the subject's love, or, when love is consolidated in a reciprocal relationship, this very reciprocity enhances the self-esteem of the lovers. The difference between normal falling in love and a masochistic pattern of falling in love is precisely that masochistic personalities may be irresistibly attracted to an object who does not respond to their love. In fact, the unconscious selection of an object who is clearly unable or unwilling to respond to love characterizes masochistic infatuations, and constitutes a "high level" of this kind of pathology.

It is important to differentiate such impossible love affairs from masochistic sexual perversion, in which a love object provides sexual gratification in the context of physical pain, debasement, and/or humiliation. Although both patterns may coincide, more often this is not the case. The description of sexual masochism by Sacher-Masoch in *Venus in Furs* (1881), from which the word *masochism* actually derives, corresponds to the writer's relation with his first wife, and later with his second wife as well. It exemplifies typically perverse practices in the context of a stable relationship with a loved object.

To sacrifice oneself and all interest in life for someone who does not reciprocate (dramatically illustrated in Heinrich Mann's novel, *The Blue Angel*, of 1932) may constitute a major, singular aspect of a personality structure that, in other respects, does not fulfill the characteristics of the depressive-masochistic personality disorder. To the contrary, the dramatic self-sacrifice, the abandonment of all previous commitments and engagements, the ease with which an entire life pattern seems to be brushed aside in the pursuit of the idealized, unavailable love object may impress the clinician as presenting almost narcissistic features in the neglect and sacrifice of all others except the love object, the total self-involvement of the afflicted individual, his
apparent lack of commitment to preestablished values and engagements. In fact, the patient presenting such pathological infatuations manifests a sense of narcissistic gratification and fulfillment in the enslavement to an unavailable object. There is an unmistakable pride in the image of oneself as the greatest sufferer on earth, dynamically related to the narcissistic gratification of being "the greatest sinner" or "the worst victim."

At this level of pathological infatuation, the love of the unavailable object indeed represents the submission to the egoideal aspects of the superego that were projected onto the object, and the painful and unsatisfactory love fills the individual with pride and emotional intensity. This constellation may also be present in patients with hysterical personality structure, whose masochistic involvement with unavailable love objects is the price paid for the unconscious oedipal meanings of all sexual interests, as, for example, the woman who can fall in love only with men who mistreat her. In other cases, it is not an unavailable love object but a clearly sadistic one who has to be chosen.

The arrogant rejection of all who would interpose themselves between the patient and his or her self-sacrificing love affair may impress the observer as narcissistic, but, in my view, reflects normal infantile and not pathological narcissism. The masochistic patient's sense of superiority ("I am the greatest sufferer of the world") refers to the specific area of suffering, but not to all other areas of the patient's life.

One female patient, for example, maintained an unsatisfactory relationship with a sadistic, largely unavailable man, and at the same time was able to maintain stable relations in depth with other friends and social acquaintances, as well as commitments to her work and family and cultural interests. In the transference, her critical and belittling behavior toward any analytic effort to point to the self-demeaning aspects of the relation with this man corresponded, at a deeper level, to her effort to maintain the psychoanalytic relationship as unsatisfactory.
because of unconscious guilt feelings over oedipal longings for the analyst.

At a second, more severe level of pathological infatuation, the opposite development has taken place, namely, a severely masochistic pursuit of an impossible love relation while all the patient's other object relations are narcissistic. For example, one patient, a young lady of considerable charm and beauty, mercifully denigrated and devaluated men and was interested only in pursuing a man who was physically attractive, socially prestigious, wealthy, or powerful—attributes she hoped to acquire for herself through the man. Rejection by such a man would trigger deep depression in her, suicide attempts, or denial that he had rejected her. She even went so far as to deny his lack of interest to the extent of erroneously interpreting, over a period of many months, any conventional friendliness from him as a sign that their relationship had a future.

Not surprisingly, when any of these men did reciprocate the patient's love, within weeks she was devaluing him as she had devaluated all the other men in her life. In fact, the growing awareness of this pattern led her to search for even more unavailable men and to set up, unconsciously, a situation in which she would be rejected, so that her investment in the "ideal man" would continue unchallenged. In all her other object relations she presented typical features of a narcissistic personality disorder.

Here we find the projection not of a normal ego ideal onto the unavailable love object, but of a pathological grandiose self, with an effort to consolidate a relationship that unconsciously would confirm the stability of the patient's own grandiosity. On analytic exploration, these masochistic love affairs of narcissistic personalities may represent an unconscious effort to consolidate a symbolic integration within the grandiose self of the characteristics of both sexes by means of establishing a symbiotic unit with the idealized object.

In these latter cases the relation to the idealized love object typically reflects a condensation of oedipal and preoedipal issues,
the idealized positive oedipal love object and the superimposed sadistic yet needed preoedipal love object as well. Cooper (1985) has drawn our attention to the combination, in clinical practice, of narcissistic and masochistic character features. While I disagree with his proposal that these two character constellations correspond to basically one type of character pathology, and think he underestimates the differences between normal infantile and pathological narcissism in these patients, I believe the syndrome of pathological infatuation does require a careful evaluation of both its masochistic and narcissistic features.

**Masochistic Sexual Behavior and Perversion**

Masochism as a sexual perversion is characterized by the restrictive, obligatory enactment of masochistic behavior to achieve sexual excitement and orgasm (Freud, 1905); (Laplanche and Pontalis, 1973). Masochistic behavior may include the need for experiencing physical pain, emotional suffering, self-debasement, and humiliation. There are levels of severity of the sexual perversion that parallel the levels of severity of masochistic character pathology already referred to.

**Masochistic Perversion at a Neurotic Level of Personality Organization**

Sexual masochism at this level typically takes the form of a "scenario" enacted in the context of an object relation that is experienced as safe. Typical unconscious dynamics centering on oedipal conflicts include the need to deny castration anxiety and to assuage a cruel superego in order to obtain sexual gratification that has incestuous meanings. The unconscious scenarios also include enactment of conflictual identifications with the other sex and identification with a punishing, sadistic incestuous object. The "as if" quality of the sexual scenario, its play-acting quality is common to all perversions at the level of
neurotic personality organization (Kernberg, 1985a). The sexual perversion may include symbolic enactment of primal-scene experiences, such as the oedipal triangle in the form of a ménage à trois, in which the masochistic subject is forced to witness sexual relations between his love object and a rival as a precondition for sexual intercourse and gratification.

Masochistic perversion usually but not necessarily involves a partner. There are masochistic forms of masturbation in which the individual ties himself up and watches himself in a mirror while experiencing pain as a precondition for orgasm, and masturbation fantasies may have an obligatory masochistic quality. At a deeper level, of course, the actual presence or absence of an object is less important than the fact that all sexual behavior implies an object relation; the manifest characteristics are less important than the conscious and unconscious fantasies that reflect the obligatory structure of the perversion. Usually the perverse scenario is spelled out in great detail by the individual himself, and the repetitive and strict enactment of that scenario is a source of powerful reassurance against unconscious anxieties as well as a precondition for sexual pleasure and the capacity to achieve orgasm.

**Sexual Masochism with Severely Self-destructive and Other Regressive Features**

In contrast to the typically circumscribed masochistic scenario that is part of a containing or protective object relation, has a play-acting quality, and corresponds to a neurotic personality organization, are situations that seem devoid of such safety features, and have an open-ended quality of danger that may lead to mutilation, self-mutilation, and even accidental death. These masochistic situations are typical for patients with borderline personality organization.

One patient with a masochistic homosexual perversion demanded being tied up by men he met casually in bars frequented by sadomasochists. He provoked these men into
serious fights in which he was physically hurt. On several occasions he had been threatened at gunpoint and robbed while engaging in such casual sexual encounters. This patient presented a narcissistic personality with overtly borderline features.

Another patient, a woman in her early twenties, was able to experience sexual excitement only when prostituting herself to much older men or to black men in dangerous neighborhoods (the patient was white and upper middle class). This woman was aware that the potential danger to her life was one source of excitement in such encounters. She also suffered from a narcissistic personality with infantile and masochistic features.

A third patient was able to achieve orgasm only if her arms were seriously twisted during intercourse so that she suffered exquisite pain and fear of a dislocation or fracture; she also prostituted herself at the request of her sadistic (and antisocial) boyfriend. This patient presented masochistic and infantile features and a borderline personality organization.

In these and similar cases the sexual perversion breaks out of the "as-if" or play-acting frame, and may bring about an authentic threat to the patient's survival; these cases reflect a severe pathology of object relations. In other cases there is no self-mutilating behavior proper, but a bizarre quality of sexual activity in which undisguised anal, urethral, or oral contents color the masochistic pattern, giving it a primitive, pregenital quality. One patient had the following preferred mode of sexual relation with his wife: in order to be able to achieve orgasm through masturbation, he had her sit on a specially constructed toilet that permitted her to defecate on his face while he was watching her. This patient had severely paranoid personality features in addition to a sadomasochistic personality structure.

Another patient's preferred mode of masturbatory gratification was to wade in a local brook in an area so muddy that he sank knee-deep in the mud while masturbating in the water. He did this at night in order to avoid being observed by neighbors. This patient also presented borderline personality organization,
with paranoid, schizoid, and hypochondriacal personality features, and rather extreme social isolation.

All these cases have in common (1) strong, primitive aggressive impulses; (2) severe pathology of object relations; (3) a predominance of preoedipal conflicts and aims in the sexually masochistic scenario; and (4) lack of integration of superego functions. These patients also revealed confusion of sexual identity, so that homosexual and heterosexual interactions were part of their sexual life, with the masochistic scenario representing its primary organizing feature. In my view, these cases illustrate, at the level of severely regressive sexual masochistic perversion, the general deterioration of superego structure and object relations, and a predominance of primitive aggression, together with dynamic regression to anal conflicts in which the differentiation of sexes and object relations deteriorate jointly (Chasseguet-Smirgel, 1984); (Kernberg, 1986).

**Extreme Forms of Self-mutilation and Self-sacrifice**

The most severe level of masochistic sexual perversion may be illustrated by patients who are intent on self-castration as part of a religious ritual or a submission to an idealized, extremely sadistic primitive object. I have not personally seen any of these cases, except patients whose self-mutilating wishes and behavior were part of clearly psychotic pathology. I would also place some borderline patients with self-mutilating behavior that has an erotic quality at this level; for example, patients who bite and swallow their buccal mucosa or their finger nails, or who are engaged in chronic self-mutilation of fingers and toes, or whose masturbatory behavior is linked to self-mutilating damage inflicted on their genitals. The patients I have seen with these characteristics presented the syndrome of malignant narcissism, that is, a narcissistic personality with severely paranoid, antisocial, and ego-syntonic sadistic features (Kernberg, 1984). This group pretty much overlaps with the characterologically self-destructive, impulsively suicidal, self-mutilating group.
mentioned earlier. The major difference resides in the chronic, repetitive, erotized self-mutilating behavior that impresses one as more insidious and bizarre than the explosive self-destructive crises of the group mentioned earlier. The erotization of pain and self-mutilation usually has acquired the meaning of a triumph over life and death, over pain and fear, and, unconsciously, over the entire world of object relations. These patients usually have poor prognosis for psychotherapeutic treatment.

In summary, I propose to include the following constellations, which I have described before, as part of a clinical grouping of masochistic syndromes. At a neurotic level of personality organization: (a) depressive-masochistic personality disorder, (b) masochistic infatuation, (c) masochistic perversion; at a borderline level of personality organization: (a) sadomasochistic personality disorder, (b) sexual masochism with generally self-destructive and/or other regressive features, (c) extreme forms of self-mutilation and self-sacrifice.

Some Implications of the Proposed Clinical Grouping of Masochistic Syndromes

The description of clinical constellations related to masochism points to the broad spectrum of pathology that may rightly be classified under this heading, and to the various structural and psychodynamic preconditions that codetermine the clinical features and the severity of each of these syndromes.

One major and obvious dimension is the universality of sexual masochistic features as part of the sexual life at all levels of normality and pathology, a point I have stressed earlier (Kernberg, 1985a), (1986). The relation between erotic masochism and aggression, both in their intimate connection in sadomasochistic fantasies and behavior and in the crucial function of the severity of aggression in codetermining the clinical form of masochism, points to a basic dynamic of instinctual conflicts at all levels of psychopathology: the mutual interplay and recruitment of libidinal and aggressive features.
At milder levels of masochism aggression is recruited at the service of erotism; at severer levels of masochism, erotism is recruited at the service of aggression; at the most severe level of masochism, erotism fades out altogether and leaves the field to what seems to be an almost pure culture of aggression.

The quality and degree of superego integration appears as an additional central organizing aspect of masochism, not only in the gradual transformation of erotic masochism into moral masochism, but in providing a frame for both erotic and moral masochism that clearly differentiates higher-level masochistic pathology with good superego integration from lower-level syndromes with severe superego pathology.

The general level of ego organization, whether borderline or neurotic, colors both the quality of object relations that constitute the matrix for masochistic fantasies and behavior, and the extent to which sexual masochism may be contained within an integrated love relation.

Finally, the consolidation of a pathological grandiose self as part of a narcissistic personality structure determines completely different idealization processes from those of normal narcissistic functioning in the context of an integrated tripartite intrapsychic structure. Erotic idealization that reflects the projection of the ego ideal produces very different results from erotic idealization that reflects the projection of a pathological grandiose self.

In short, ego organization, object relations, superego development, narcissistic organization, and the extent of integration of polymorphous perverse infantile sexuality codetermine the level and clinical features of masochistic pathology. The psychodynamics of the oedipal constellation, including castration anxiety and incestual conflicts, are central in moral masochism and masochistic perversion in neurotic personality organization; the condensation of these conflicts with pathologically dominant preoedipal conflicts centering around preoedipal aggression are related to the more regressive conditions of all the codeterminants of masochistic syndromes.
The clinical syndromes I have summarized illustrate how, at the extremes of the spectrum, the concept of masochism dissolves into other diagnostic and psychodynamic considerations. Thus, for example, the normal tolerance of pain (in hard work, postponement of gratification, acknowledgment of one's own aggression) as part of sublimatory efforts is no longer masochism in a strict sense; the erotic excitement with milder forms of pain, playful debasement, and humiliation as part of normal sexual interactions contains so many functions and developmental features that the term masochism no longer says anything specific about such behavior. At the other extreme, the self-destructive and self-defeating effects of borderline and psychotic psychopathology may no longer warrant the term masochism either: in such cases self-destructive aspects may be present, but hardly any erotization of pain and even less moral masochism. It is true that Freud (1920), (1924), (1937) linked masochism with the hypothesis of the death instinct, so that, in his view, primary masochism represents the origin of early forms of self-destructiveness; but the equation of masochism and self-destructiveness at the most severe levels of psychopathology dilutes the specific meaning of masochism.

Another dimension that limits the boundaries of the concept of masochism is that of normal and pathological narcissism. Masochistic surrender provides narcissistic gratification; the depressive-masochistic personality obtains narcissistic gratifications from the sense of being unjustly treated and is implicitly morally superior to the object. The self-punitive price paid for sexual gratification or for success or creativity also provides approval from the superego and, by the same token, an increase in self-esteem. Insofar as the normal and the neurotic superego regulate self-esteem by self-directed approval or criticism, masochistic behavior patterns have important functions in neurotically maintaining self-esteem and, in metapsychological terms, in assuring the ego's narcissistic supplies. But then, all neurotic character formations have such a narcissistic function; there is no unique linkage here between masochism and narcissism. The
self-idealization in fantasy linked to masochistic infatuations may be considered a particular example of this narcissistic consequence of an underlying masochistic structure.

In contrast, at the more severe level of pathological infatuation described, the projection of the pathological grandiose self creates a narcissistic aspiration that has self-defeating qualities and impresses the observer as profoundly masochistic. Yet here the masochism restricted to one object relation is essentially a reflection of narcissistic psychopathology reflected in all the other object relations of the patient, and does not have the deeper, specific functions of moral masochism and pleasure with pain.

I have described (1984) negative therapeutic reactions, typically found in patients with severe masochism. I defined negative therapeutic reaction as a worsening of the patient's condition, particularly as reflected in the transference, at times when he is consciously or unconsciously perceiving the therapist as a good object who is attempting to provide him with significant help. I suggested three levels of negative therapeutic reaction: (1) that derived from an unconscious sense of guilt, typical for depressive-masochistic personalities; (2) that derived from the need to destroy what is received from the therapist because of unconscious envy of him, which is typical of narcissistic personalities; and (3) that derived from the need to destroy the therapist as a good object because of the patient's unconscious identification with a primitive, sadistic object who requires submission and suffering as a minimal condition for maintaining any significant object relation.

In the light of the findings presented in this paper, I would now restate that the first and mildest level of negative therapeutic reaction, namely, that derived from an unconscious sense of guilt, is indeed typical of depressive-masochistic personality structures and may also emerge in the course of the psychoanalysis of a masochistic perversion at a neurotic level. In contrast, the second and third levels of negative therapeutic
reactions are more complexly related to other types of masochistic pathology.

Regarding the second level, the negative therapeutic reaction owing to unconscious envy of the therapist, it is indeed typical of patients with narcissistic personality structure, but may also develop in patients with sadomasochistic personalities whose unconscious sense of guilt over being helped is reinforced by their resentment of the therapist who is free from the destructive and self-destructive potential that these patients cannot escape from. I would therefore suggest that negative therapeutic reaction resulting from unconscious envy is not as specifically linked to narcissistic pathology as I suggested earlier.

Regarding the most severe types of negative therapeutic reaction linked to the experience of a primary love object as simultaneously a destructive one—so that love can only be expressed as destruction—this would seem to me an essential dynamic of the most severe cases of masochistic pathology I have described, both in terms of diffuse self-destructive behaviors that have characterological implications, and primitive sexual masochistic perversions with dangerous—even life-threatening—primitivization of aggression. In earlier work and based on Jacobson's (1964) description of superego development, I have referred to the following "scenario" as responsible for these patients' pathology of object relations and of superego development:

… (1) the experience of external objects as omnipotent and cruel; (2) a sense that any good, loving, mutually gratifying relationship with an object is frail, easily destroyed, and, even worse, contains the seeds for attack by the overpowering and cruel object; (3) a sense that total submission to that object is the only condition for survival and that, therefore, all ties to a good and weak object have to be severed; (4) once identification with the cruel and omnipotent object is achieved, an exhilarating sense of power
and enjoyment, of freedom from fear, pain, and dread, and the feeling that the gratification of aggression is the only significant mode of relating to others; and (5) as an alternative, the discovery of an escape route by the adoption of a completely false, cynical, or hypocritical mode of communication, an erasing of all judgment that implies a comparison between good and bad objects, and negation of the importance of any object relation or successful maneuvering in the chaos of all human relations [Kernberg, 1984, p. 299].

I have also found Fairbairn's (1943) idea of the setting up of a "moral defense against bad objects" in the form of an intrapsychic transformation of internalized relations with bad primary objects a helpful, alternative formulation of this state of affairs. In fact, Jacobson's (1964) description of early levels of superego development and Fairbairn's description of the vicissitudes of the internalization of bad objects have striking correlations—once one goes beyond semantic barriers and leaves aside their basic metapsychological incompatibilities. Fairbairn (1943) states:

In becoming bad he is really taking upon himself the burden of badness which appears to reside in his objects. By this means he seeks to purge them of their badness; and, in proportion as he succeeds in doing so, he is rewarded by that sense of security which an environment of good objects so characteristically confers. To say that the child takes upon himself the burden of badness which appears to reside in his objects is, of course, the same thing as to say that he internalizes bad objects. The sense of outer security resulting from this process of internalization is, however, liable to be seriously compromised by the resulting presence within him of internalized bad objects. Outer security is thus purchased at the price of inner insecurity; and his ego is henceforth left at the mercy of the

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band of internal fifth columnists or persecutors, against which defenses have to be, first hastily erected, and later laboriously consolidated [p. 65]. Insofar as the child leans toward his internalized bad objects, he becomes conditionally (i.e., morally) bad vis-à-vis his internalized good objects (i.e., his superego); and, insofar as he resists the appeal of his internalized bad objects, he becomes conditionally (i.e., morally) good vis-à-vis his superego. It is obviously preferable to be conditionally good than conditionally bad; but, in default of conditional goodness, it is preferable to be conditionally bad than unconditionally bad... It is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil... In a world ruled by the Devil the individual may escape the badness of being a sinner; but he is bad because the world around him is bad. Further, he can have no sense of security and no hope of redemption. The only prospect is one of death and destruction [p. 66].

I realize that these excerpts hardly do justice to the complexity of Fairbairn's ideas, but I trust they illustrate an alternative model to mine that attempts to clarify severe, primitive developments in the transference. In any event, the dominance of early sadistic superego precursors, an essential feature of the most severe levels of masochistic pathology, has devastating effects on all subsequent internalization of object relations. In these patients' internal world, and therefore in their perceptions of their interpersonal reality, one is either extremely powerful and ruthless or one is threatened with being destroyed or exploited. If good object relations are in constant danger of destruction by such malignant forces, they may be devalued because of their implicit weakness. In this way primitive superego pathology and pathology of all other internalized object relations reinforce each other. The activation of these sadistic superego precursors in the transferences of the more severe types of masochism within the total spectrum explored is reflected
in sadomasochistic relations with the analyst that determine the most severe types of negative therapeutic reactions. The patient needs the therapist to be bad as a primitive defense against otherwise diffuse and dangerous aggression; but this very badness of the therapist threatens the patient with the inability to receive anything good from him. The analyst's persevering interpretation of this regressive level of transference is of crucial importance in helping patients to overcome severely regressive masochistic psychopathology.

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