Masochistic Personality Disorder: A Diagnosis Under Consideration

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In the past three decades, few diagnoses in psychiatry have had a more turbulent history than the personality disorders (1). Labels such as inadequate, emotionally unstable, and asthenic personalities entered the official nomenclature and were later withdrawn. Borderline, antisocial and compulsive personality disorders are additions that have become entrenched in the classification of mental disorders. The turmoil maintains its course with a diagnosis of Masochistic Personality Disorder under consideration to join the existing categories of personality disorders in the revised edition of *DSM-III* (*DSM-III-R*) (2).

The category of Masochistic Personality Disorder does not exist in the three earlier versions of *DSM* (3–5) or in the editions of the International Classification of Disease (ICD) (6–9). Nonetheless, the concept of masochism has a lengthy psychiatric history.

ORIGINS

The term "masochism" was first coined by Richard von Krafft-Ebing, a German contemporary of Kraepelin and Freud (10). He was an unusual thinker for his time who, like Kraepelin, is generally perceived as representing nineteenth century thought regarding the nature of psychopathology. To modern writers he is usually associated with his writings about sexual deviations. However, to his contemporaries he was a well respected psychopathologist known for his textbooks and for his rather outlandish ideas and behaviors. For instance, Krafft-Ebing believed that dementia paralytica was caused by syphilis. To prove his contention, he innoculated nine patients who had dementia paralytica with the blood from patients with primary syphilis. Since none of these patients developed signs and symptoms of syphilis, he argued that he had proven his point (11).

Krafft-Ebing used the term "masochism" to refer to persons who received sexual pleasure by having pain inflicted upon them by a member of the opposite sex. He also used the expression "ideeler masochism" (mental masochism) to designate the idea of dependence and submission yielding pleasure without the physical component (10). The root of the term was derived from the name of a

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German noble, Sacher-Masoch, who was a nineteenth century novelist. In his novels (e.g., *Venus in Furs*), Sacher-Masoch described men who gained sexual pleasure from domineering women. Sacher-Masoch first remembered feeling sexual pleasure during a childhood incident involving an aunt whom he admired. He hid himself in her bedroom closet when she surreptitiously entered the bedroom with her lover. Subsequently, her husband entered the room, surprising the pair in the act of making love. In the confusion that followed, the wife struck her husband who turned and fled. Her lover also darted away. When the aunt discovered young Sacher-Masoch hiding in the closet, she pinioned him to the floor, and beat on his posterior with her open hand. After his escape, Sacher-Masoch listened to the raging abuse and erotic whipping that his aunt directed toward her husband, who had rashly returned. Sacher-Masoch, thereafter, found himself aroused when he was struck by a woman. Although he was unmarried, he wrote novels of dominating women and men who were fascinated by these women. An aspiring German woman read one of these novels and seduced Sacher-Masoch by being a hostile, demanding, domineering woman. They married. She immediately took a lover, would lock her husband in a room, and would flaunt her refusal to behave like a conventional wife. Eventually they divorced and Sacher-Masoch married "a devoted woman" (12).

It is also worth noting that the term "sadism" was coined by Krafft-Ebing. Sadism was derived from the name of another nineteenth century noble, the Marquis de Sade, and refers to sexual excitement following the infliction of physical pain on another person (10).

Havelock Ellis, the famous sexologist of the turn of the century, argued that masochism was a naturally female approach to sexual behavior since in normal coitus, the female is the receiver and experiences some pain in the sexual act. As a result, according to Ellis, women naturally want to be dominated and often have sexual fantasies of being ravished by the objects of their desire. The male, said Ellis, is naturally sadistic. He is dominant and the inflictor of pain. For men, the natural fantasies are of authority, control, and rape (13).

DEVELOPMENT OF THE CONCEPT

Freud, like Krafft-Ebing, used masochism to refer to a sexual peculiarity. This concept of sexual masochism persists in modern psychiatric classification and is listed as a paraphilia in *DSM-III* (3). Freud, with his emphasis on sexual development in his theoretical approach to personality, speculated on masochism. He wrestled with this concept throughout his career and was never completely satisfied with his solution. As he worked out his three theories on masochism, he helped loosen the connection with sexuality (14).

Initially he argued that masochism and sadism were simply reverse representations of the same underlying neurotic issue. Sadism controlled hostile impulses which had become associated with sexual energy. Masochism was the introjection of these hostile impulses. Later, however, Freud argued that the

above explanation of masochism was incomplete, and the concept of the death instinct (*thanatos*) was necessary to explain the extremely painful and even destructive behaviors associated with masochism.

Freud developed his first theory on the basis of six patients described in his article, "A Child is Being Beaten" (15). Masochism appeared to be sadism which had been turned inward due to guilt from the oedipal relationship. Hence, masochism was explained as a secondary phenomenon.

Freud suggested a different explanation in "Beyond the Pleasure Principle" (16) when he introduced the concept of a death instinct. The pleasure principle does not govern everything; an early self-directed destructive impulse operates at the same time. In this theory, masochism was the primary phenomenon and sadism was the secondary transformation of the death wish away from the self toward others.

Freud's preoccupation with the concept of masochism resulted in another hypothesis. In "The Economic Problem of Masochism" (17), he defined three forms of masochism: erotogenic, feminine, and moral. By erotogenic masochism, Freud meant a biological and constitutional lust for pain. It is the basis of the remaining two types of masochism. Feminine masochism refers to normal female psychological development of which suffering is the consequence of the pain associated with childbirth, menstruation, and defloration. Freud considered this form most accessible to observation and the least mysterious. Moral masochism is the most important form in the evolution of the criteria for Masochistic Personality Disorder. In moral masochism, suffering lost its connection with sexuality. What became important was the suffering itself. According to Freud, masochistic character formation results from an unconscious sense of guilt.

MORAL MASOCHISM

The psychoanalysts who followed Freud, such as Horney, Fromm, Reik, Berliner, Menaker, and Ferenezi (18–22) developed the concept of "moral masochism." Since it is the concept of "moral masochism" which is embodied in the *DSM-III-R* diagnosis of Masochistic Personality Disorder, a brief mention of these contributions seems appropriate. Fromm wrote that normal and neurotic escape from unbearable aloneness is expressed as feelings of inferiority, powerlessness, and insignificance (19). For Horney, the tendency to devalue oneself and to be dependent represented the neurotic suffering of moral masochism (18). "A pathological way of loving" in the form of a defense mechanism or ego function was used by Berliner to discuss how masochism is expressed in interpersonal relationships (21). Menaker saw the origin of moral masochism as deriving from the early phase of symbiotic object relations. This struggle for survival caused a loss of identity and increased worthlessness (22). Reik used the term "social masochism" to refer to an attitude toward life with passive and submissive behaviors (20).

A major writer in the history of this concept was one of Freud's students, Wilhelm Reich. Reich was a brilliant young man who attracted Freud's attention during the 1920s. Freud even permitted Reich to perform analysis while Reich was still a medical student. In Reich's early writings, he developed the Freudian conception of anxiety into a broader conception of "character structure." This led Reich to disagree with Freud over the nature of masochism and also led him to attempt to blend the social theories of Marxism with the psychological theories of Freud. The psychoanalytic community attacked Reich as a communist. Reich came to the United States during the late 1930s and eventually died in jail for promoting a passive machine which he argued could trap living energy that would cure cancer (23).

In his early writings, Freud developed a distinction between the "actual neuroses" (in which disorders were associated with literal dysfunctions of the nervous system) and the "psychoneuroses" (in which anxiety, a psychological concept, is central). As his psychological theories developed, he gradually incorporated most of the conditions he had first discussed as actual neuroses under the heading of the psychoneuroses (24). Reich, the *enfant terrible* of psychoanalysis, chose the opposite direction. He argued that most neurotic conflicts were associated with actual neuroses in which sexual energy had literally been dammed up and so was being expressed by the nervous system in indirect forms. The reason for the "damming" of sexual energy, according to Reich, involved the frustrations imposed by a society that did not permit sexual freedom. In response to these frustrations Reich suggested that people would develop "character armor" to protect themselves. Thus, character structure became a repetitive, habitual pattern of responding by persons to the frustration that they had learned to expect from society. Reich argued that there were four main types of character structure which most people learned to use: hysterical, compulsive, narcissistic, and masochistic (25). (With the addition of masochistic, all four are now in the *DSM.*)

Regarding the masochistic type, Reich noted that these persons appeared to receive pleasure from having pain inflicted upon them. However, Reich argued that just the opposite is true—these persons had learned to experience pleasure (especially love) as painful. They had learned that allowing themselves to love would place them in highly vulnerable positions which could be extremely painful. They preferred being in more submissive, somewhat painful situations since the latter were less risky. In one of his case descriptions, Reich discussed a patient who presented feeling depressed and negative about himself because this man spent most of the day lying on his stomach in bed, masturbating to the fantasy of being beaten on his buttocks. In Reich's analysis of this man, the patient remembered an event in childhood in which his father flung the boy on the bed and beat him on his rear end. Reich argued that the boy had found this pleasurable because the child was relieved that his real fear, the fear of castration, was not being enacted (25).

In summary, Reich did not study masochism as a sexual perversion but he

agreed that it arose from a sexual instinct. Reich saw masochism as secondary, not primary. He refuted Freud's death wish as an explanation and argued that masochism can be explained by the pleasure principle (25).

Since Reich's contribution on masochism and character structures, advances in psychiatry have provided new ideas to apply to the problem of moral masochism. In 1979 at the Fall Meeting of the American Psychoanalytic Association, a panel discussed current concepts of masochism and the masochistic character (26). The rationale for the panel was "that a re-examination of masochism at this time, using our present knowledge of the separation-individualization process, the nature and structural consequences of early object relations, the role in self-esteem regulation and affect development might help to clarify our understanding of masochistic phenomenon." The explanations for masochistic behavior varied among the panelists. The proposed motivating forces for these behaviors ranged from very primitive attempts to defend against and adapt to the pain of self-object differentiation to the attempt to use pain, humiliation, and failure to restore self-cohesion. The panel concluded: masochistic phenomena are universal and ubiquitous; masochism is multiply determined and serves multiple functions; pain, and perhaps masochism, can be considered along a developmental perspective; and the manifestations of masochistic phenomena appear in many forms and guises.

RELATIONSHIP TO OTHER PERSONALITY DISORDERS

All personality disorders are similar in that they involve a pattern of maladaptive, repetitious, self-detrimental behavior (27). Like dependency and narcissism, the concept of moral masochism can be regarded as a dimension that is common to some degree in all personality disorders. In *DSM-III,* some personality disorders are mutually exclusive; others, however, represent traits (e.g., narcissistic and dependent) that are present in most patients with personality disorders. The diagnostic criteria from the *DSM-III-R* definition of Masochistic Personality Disorder (Spitzer, personal communication) suggest masochistic traits fall into the latter category. The *DSM-III-R* criteria for Masochistic Personality Disorder are:

> Feelings of martyrdom and self-defeating behavior as indicated by at least six of the following:
>
> 1. Remains in relationship in which others exploit, abuse or take advantage of him or her, despite opportunities to alter the situation.
> 2. Believes that he or she almost always sacrifices own interests for those of others.
> 3. Rejects help, gifts, or favors so as not to be a burden on others.
> 4. Complains, directly or indirectly, about being unappreciated.
> 5. Responds to success or positive events by feeling undeserving or worrying about not being able to measure up to new responsibilities.

6. Always pessimistic about the future and preoccupied with the worst aspects of the past and present.
7. Thinks only about his or her worst features and ignores positive features.
8. Sabotages his or her own intended goals.
9. Repeatedly turns down opportunities for pleasure.

These clinical features overlap with other Axis II categories. Self-defeating behavior and/or martyrdom are suggested by the repetitive self-destructive acts of the borderline; the social withdrawal of the avoidant person occurs despite his desire for affection and acceptance; the dependent personality emphasizes subordination; and the passive-aggressive patient exhibits passive, self-detrimental behavior.

Masochistic personality as described has several criteria in common with dependent and passive-aggressive personalities. Interestingly, before the *DSM-III-R* was written, a contemporary expert on the personality disorders, Vaillant, had suggested that the masochistic personality is a combination of the concepts of dependent personality and the passive-aggressive (27). He wrote that because of this overlap, there is little to be gained by adding another diagnostic term to Axis II. Asch (28) disagreed and stated that the current personality disorders "are inadequate to encompass the very special features of the masochistic personality."

The cogent question is: Do we need a new diagnostic category called Masochistic Personality Disorder? A preliminary study was undertaken to answer this question by having clinicians classify short case histories of patients with various personality disorders using the *DSM-III* criteria. Approximately half of these case histories were prototypes of specific personality disorders, including the masochistic personality disorder. (Remember that masochistic personality disorder is not a recognized diagnosis in the *DSM-III*.) Prototypes are highly typical cases with a high number of features associated with a category. The use of prototypes has been a recent innovation in research on the personality disorders (29,30). By studying the diagnoses assigned to the prototypes for the Masochistic Personality Disorder the following alternative hypotheses could be examined. If the *DSM-III* is inadequate and the addition of Masochistic Personality Disorder as a diagnosis is needed, the hypotheses are: a) clinicians should show low levels of agreement (poor reliability) when assigning *DSM-III* diagnoses to patients with masochistic personalities; and b) an excess of "wastebasket" categories such as Mixed, Other, and Atypical should be used. On the other hand, if Vaillant is correct, and nothing is to be gained by adding masochistic personality to the *DSM-III,* the alternative hypotheses are: c) existing *DSM-III* diagnostic categories (e.g., dependent and/or passive-aggressive) should be assigned consistently to masochistic prototypes; and d) "wastebasket" categories should not be applied to the cases seen as highly typical masochism.

PRELIMINARY STUDY

The subjects in the study were twenty clinicians, all affiliated with the University of Florida. Nine were psychiatric residents in their third or fourth post-graduate year. The remaining eleven were clinical faculty in the Department of Psychiatry. The subjects were randomly assigned to two groups.

The stimuli were ten prose case histories selected to represent the *DSM-III* personality disorders or masochistic personality disorder. Sources for the cases included the *DSM-III Case Book* (31), journal articles (32), psychiatry textbooks (12,22,33), and real cases. The five non-masochistic cases had been studied previously by Blashfield, Sprock, Pinkston, and Hodgin (32) in their study of prototypes for the various personality disorders. Three cases used in the present study were found by Blashfield et al. to be prototypes of Passive-aggressive (Case #1), Borderline (Case #2), and Dependent Personality Disorders (Case #3). The remaining two cases were not consistently diagnosed and were not prototypes (Cases #4 and #5).

The five masochistic cases were not previously studied. These cases were selected because they were plausible as prototypes for Masochistic Personality Disorder. One case was written expressly to contain the *DSM-III-R* criteria for the disorder (Case #10). Sacher-Masoch was described for another case history (Case #8); the vignette included paraphrased excerpts from his diary and "contract" with his first wife, but omitted reference to his sexual perversion (12). Natalie Shainess' questionnaire of masochistic traits was used to supplement a case she reported in her book about masochism (Case #7) (33). A psychoanalytical case reported by Esther Menaker in 1953 was selected as a representative of "moral masochism" (Case #9) (22). Finally, Blashfield, et al. in their research on prototypes had found the *DSM-III Case Book* (31) to be a good source of prototypic case histories. This book contains one vignette which the authors diagnosed as Dysthymic Disorder but said that a diagnosis of Other Personality Disorder (Masochistic) would also be appropriate. This case was included as Case #6.

All case histories were less than two-thirds of a double-spaced, typewritten page in length. Many of the case histories required editing for uniformity in length and form.

The study was performed by presenting the clinicians with directions and ten case histories (each reproduced on separate sheets of paper). Ten clinicians were asked to read the ten short case histories and assign *DSM-III* personality disorder diagnoses to these cases. They had the opportunity to list any other diagnosis that seemed appropriate. These subjects also indicated the degree of clinical certainty that other randomly selected clinicians would assign the same Axis II diagnosis as they did. A scale of 6 (extremely certain) to 0 (not at all certain) was used for the degree of clinical certainty rating. Another group of ten clinicians was provided with the same ten case histories and the *DSM-III-R* criteria for Masochistic Personality Disorder. The task for these clinicians was to

rank all the cases according to how well each represents Masochistic Personality Disorder. They were asked to place the case that most closely described masochistic personality on top, and the case least likely to represent the criteria on the bottom.

RESULTS

Rank Order Ratings

The initial goal was to determine if any of the five case histories intended to represent Masochistic Personality Disorder were reasonable prototypes. A decision was made that the mean rank order score should be less than 3.6 in defining a prototype. This value is equal to the mean of rank order scores for all five masochistic cases. Three cases (Cases #8, #9, and #10) are below 3.6 and are clustered together with a mean of 2.8. These three cases are prototypes for Masochistic Personality Disorder as defined by *DSM-III-R* criteria. The three cases documented as prototypes of borderline, dependent, and passive-aggressive in the previous research were rated as clearly not masochistic.

The results from this part of the study are shown in Table 1 which illustrates the mean rank order scores. A score of one indicates the case which most closely represents Masochistic Personality Disorder. Ten, which is the highest possible score, means the case is very dissimilar to the masochistic personality criteria.

Classification using DSM-III Criteria

The next task was to ascertain if the three clear masochistic prototypes were confidently classified using *DSM-III*. Listed in Table 2 are the intended or correct diagnoses, the degree of clinical certainty ratings, and the assigned diagnoses and their frequencies. Masochistic prototypes received a larger number of diagnoses (mean 5.7) than the control prototypes (mean = 2.3). This indicates that the reliability with which clinicians can classify masochistic patients using the *DSM-III* categories is substantially lower than its overall reliability for personality disorders. In addition, the three masochistic prototypes received more wastebasket diagnoses (mean = 4.0) compared to control prototypes (mean = 0.3). No specific *DSM-III* category was used by a majority of clinicians for any masochistic prototype. Because the diagnoses assigned to the masochistic prototypes were scattered (i.e., low reliability) and received an increased number of wastebasket labels, the data are consistent with hypotheses "a" and "b." Thus, the results imply that patients with masochistic personality characteristics are not adequately classified by *DSM-III*.

The degree of clinical certainty ratings tended to be lower for masochistic prototypes (mean = 3.7) than for prototypes of other personality disorders (mean = 4.5). This trend indicates that the clinicians were less confident of their diagnosis for the masochistic cases using the *DSM-III* system.

DISCUSSION

The *DSM-III* has had a major impact on clinical psychiatry and the training of psychiatric residents in this country (34). Recently, an American Psychiatric Association (APA) Work Group has proposed a revised version of this classification; the revised system will be called the *DSM-III-R*. In general, this revision is not greatly different than the *DSM-III*. Most changes concerned the diagnostic criteria used to define various mental disorders. However, three new disorders were proposed for inclusion in this classification, including Masochistic Personality Disorder. A recent article in *Psychiatry News* reported that the proposed addition of Masochistic Personality Disorder triggered controversy when presented to the American Psychiatric Association Board of Trustees (35). One group wants to abandon the diagnosis completely; another faction would like to simply change the term. Spitzer, speaking for the Work Group, maintains that Masochistic Personality Disorder needs to be recognized. Conferences are scheduled in the near future to debate this issue.

The current study is timely. The major goal of this study is to provide some evidence about the need for including "moral masochism" as a category in the classification of personality disorders. The results of this study did suggest that the inclusion of Masochistic Personality Disorder would be a useful addition. Without the presence of this diagnostic category, clinicians were unable to consistently classify case histories of patients who had the personality characteristics associated with masochism. This finding is contrary to the expectations of Vaillant (27) who had suggested that patients engaging in self-defeating behaviors could be subsumed under the diagnoses of Dependent Personality Disorder and Passive-Aggressive Personality Disorder.

Although suggestive, this study only provides preliminary evidence regarding the inclusion of masochistic personality as an official mental disorder. One obvious limitation to this study is the sample of clinicians. First, the size of the sample was small, precluding the use of any statistical tests of relevant hypotheses. In addition, the clinicians sampled were all in the Department of Psychiatry at the University of Florida. Although we clinicians at this setting pride ourselves for our broad and representative views of the mental health field, obviously this sample may not represent the views of all American psychiatrists.

Another potential issue with this study concerns an implicit assumption in its design. Basically, the results from this study suggest that, *if there are a large number of patients who present with the personality characteristics associated with masochism,* then the current list of personality disorders in the *DSM-III* is not sufficient to classify these individuals. This study contains no evidence regarding the prevalence of the personality characteristics (self-defeating behavior, pessimism, avoidance of pleasure, etc.) which are associated with masochism. However, the consistent and reasonably large literature on "moral masochism,"

especially in the psychotherapy literature, suggests that these personality characteristics have sufficient prevalence in standard clinical practice to warrant the provisional inclusion of masochism in a classification of the personality disorders.

The final point concerns another issue which has been implicit in this paper, but which needs to be addressed explicitly. Under what circumstances should a new disorder be included in an official classification of mental disorders? In this regard, Feighner, Robins, Guze et al. (36), in their classic paper on diagnostic criteria for 15 disorders, suggested that there were five phases necessary for the validation of a diagnostic category. These phases were clinical description, laboratory studies, delimitation from other disorders, follow-up studies, and family studies.

The first step in validating a diagnosis is to describe the clinical features of the disorder. Recognition of masochism as a personality constellation became widespread after work by Sigmund Freud in the first two decades of this century. Freud's description of moral masochism and Wilhelm Reich's conceptualization of character structure laid the groundwork for describing the essential features of this disorder. Since these contributions, psychoanalysts have used the concept of moral masochism to predict the course and outcome of therapy with these patients. Descriptions of the treatment of masochistic character indicate that a negative therapeutic response may occur, that these patients often are resistent to insight oriented therapy, and that a full blown transference neurosis should be avoided (14,22,37). The consistent and considerable literature which has evolved regarding the masochistic personality suggests that clinicians see this category as descriptively useful. Moreover, this study found the case history written to include the *DSM-III-R* criteria for this disorder rated as being the most masochistic of ten case histories (including a case history of Sacher-Masoch for whom the disorder was named). This finding suggests that the *DSM-III-R* criteria are a descriptively valid presentation of what clinicians mean by this diagnostic concept.

In the case of masochistic personality, the remaining four validity phases proposed by Feighner et al. have not been addressed. In fact, most of the personality disorders recognized in the *DSM-III* have little or no evidence concerning these last four phases. The majority of the research evidence regarding any of these disorders is descriptive. The clear exception is the Antisocial Personality Disorder. Concerning this disorder, genetic studies, follow-up studies and cross-sectional studies have been performed (27). When introduced into an edition of the *DSM,* a wide psychoanalytic literature existed on Narcissistic, Borderline, and Dependent Personality Disorders, but little more than descriptive information was available. Only now, for instance, are family studies of the popular concept of Borderline Personality Disorder beginning to appear in the literature. If the same standards that were applied for the inclusion of the above disorders in the *DSM* are applied to the concept of

masochistic personality, then the lack of information regarding the last four phases of diagnostic validation should not prohibit its tentative addition.

Some psychiatrists fear that introducing masochistic personality would stigmatize women and reinforce a critical view of women (35). Like the concept of the Histrionic Personality Disorder and the Dependent Personality Disorder, the concept of the Masochistic Personality Disorder has sexist overtones and connotations. These are discussed in a recent article (38) in the *American Psychologist* by Caplan ("The Myth of Women's Masochism"). She attacks the notion that women are "naturally" masochistic and provides a detailed criticism of the approach to masochism represented in the writings of many of the psychoanalysts. In her article, she quotes a case history by a contemporary psychoanalytic writer discussing the masochistic personality. This case gives a feel for the sexist overtones to the use of this label.

> There were also some indications that she felt herself to be abused and exploited by those with whom she had business or professional relationships: her physician who had prescribed a birth control pill was blamed for causing a malignant growth which was discovered in her breast, the mechanics who repaired her car defrauded her in ways to which she passively acquiesced, and merchants sold her goods which she frequently felt were not as represented. Occasionally she sought legal opinion about her rights but rarely proceeded to litigation.

Caplan points out that it is difficult to find evidence of masochism in the above description. The behavior of this woman can be explained by other means; for instance, being angry at a merchant may be appropriate and reasonable, rather than representing some underlying need of a woman to feel abused. It is worthwhile noting that of the concepts in the *DSM-III* classification of personality disorders which have sexist overtones, three focus on stereotypes of women while only one (antisocial) has a masculine stereotype (although a case might be made for the compulsive as a second masculine stereotype).

Spitzer (35) has argued that women will not be given the diagnosis of masochistic personality more than men (this matter will surely become the object of empirical study). Spitzer expresses the belief that many of the term's historical connotations (e.g., unconscious enjoyment of pain) no longer apply. Nonetheless the proposed addition has triggered protests, debate, and study.

A final issue regarding the concept of masochism is the relationship between theory and classification. The authors of all three editions of the *DSM* have consistently argued that their classifications are atheoretical, a claim which has been chided by others. In this regard, it is ironic that with the addition of masochism, all four of Reich's concepts will be included in *DSM-III-R*. As a result, the *DSM-III-R* classification of personality disorders will appear as being derived from one of the most radical theorists in the history of psychoanalysis.

More generally, one explanation for the recent turbulent history of personality classification is the lack of any clear organizing principle. For instance, if personality disorders are to be included on the basis of considerable clinical description with little or no systematic evidence, a case could be made for the inclusion of the popular "Type A" personality. Also, if masochistic personality exists, why shouldn't there be a parallel category called the "Sadistic Personality Disorder" to describe persons who need to be in control? In short, to prevent Axis II from being expanded *ad infinitum,* the classification of personality disorders needs an operational framework to organization and expansion. Setting a minimum standard such as requiring a proposed diagnosis to meet at least two of Feighner's phases (e.g., clinical description and delimitation from other disorders) before entering the official nomenclature would diminish the turmoil and provide empirical justification for changes. In the case of Masochistic Personality Disorder, the pilot study suggests that this category *may* indeed be useful. However, further evaluation using scientific criteria for validity of diagnostic categories is needed before its inclusion in the *DSM* can be logically justified.

TABLE 1

Mean Rank Order Ratings for Ten Case Histories According to How Well Each Represents *DSM-III-R* Criteria for Masochistic Personality Disorder.

Case	Rank Order Rating (mean for 10 subjects) (1-closely describes; 10-does not represent)
1	8.3
2	7.9
3	6.8
4	8.3
5	5.7
6	5.4
7	4.2
8	3.0
9	2.8
10	2.6

TABLE 2

Degree of Clinical Certainty Ratings, Assigned Diagnoses and Their Frequencies for 10 Subjects.

Case	Intended Diagnosis	Certainty Rate 0-Low; 6-High	Assigned Diagnoses	Frequency
1	Passive-Aggressive*	4.5	Passive-Aggressive	8
			Antisocial	1
			Compulsive	1
2	Borderline*	4.4	Borderline	9
			Mixed	1
3	Dependent*	4.6	Dependent	9
			Compulsive	1
4	Passive-Aggressive	3.8	Passive-Aggressive	4
			Dependent	3
			None	1
			Atypical	1
			Narcissistic	1
5	Dependent	3.4	Dependent	4
			Mixed	2
			None	1
			Passive-Aggressive	1
			Atypical	1
			Histrionic	1
6	Masochistic	3.6	Avoidant	3
			Mixed	2
			Dependent	1
			Compulsive	1
			Passive-Aggressive	1
			Schizoid	1
			None	1
7	Masochistic	3.6	Dependent	5
			None	1
			Avoidant	1
			Passive-Aggressive	1
			Mixed	1
			Atypical	1
8	Masochistic*	3.6	Atypical	3
			Mixed	2
			Other (Masochistic)	2
			Dependent	1
			Schizotypal	1
			None	1
9	Masochistic*	3.5	Dependent	4
			Avoidant	2
			Passive-Aggressive	1
			None	1
			Other (Inadequate)	1
			Atypical	1
10	Masochistic*	3.9	Mixed	3
			Dependent	3
			Avoidant	2
			Passive-Aggressive	1
			None	1

* = Prototype

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