Passive aggressive personality disorder with panic attacks as a comorbidity. The method of manipulation

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Abstract

Passive aggressive (negativistic) personality disorder lost its position among other disturbed personality disorders organized in three clusters in DSM IV. It was transferred to Appendix B and the reason for that were controversies in term of structure, content validity, co-occurring with other personality disorders, childhood experiences. In spite of losing its position in DSM classification it occurs relatively often among psychiatric patients, it should be stated that more numerous people with that type of problems do not communicate with psychiatric service at all. Those people do not realize their potential abilities of psychological and social growth, they become socially isolated. Described above case nineteen year old boy illustrates very well all those psychological and social consequences of developing that type of the personality. After the fact that he was already 19th year old, he did not complete middle school yet, he was totally socially isolated and co-occurring mild panic attack disorder, became smokescreen justifying his passivity and his withdrawal from life activity. What is significant successful medical treatment of panic attacks did not improved his life activity after that he was treated in psychiatric day hospital for four months with everyday program of psychotherapy based on school of thought transactional analysis, it helped him to change his relations with parents in the way that he started to feel responsible to some extend for them and he decided to come back to school and to continue his education. Interview with the patient after the year reviewed that he is continuing his education and his relations with his parents maintain well.

Keywords: Passive aggressive (negativistic) personality disorder, comorbidity, panic attacks

Streszczenie

Osobowość bierno agresywna (negatywistyczna) straciła w IV rewizji DSM swoją pozycję wśród zaburzeń osobowości zorganizowanych w trzech klasterach. Została przeniesiona do Apendixu B a uzasadnieniem tego były wątpliwości i brak wystarczających badań struktury, trafności treściowej, współwystępowania z innymi zaburzeniami, doświadczeń z dzieciństwa mających wpływ na wystąpienie tego zaburzenia. Mimo utraty pozycji w klasyfikacji, osobowość ta jest dość często występującym typem zaburzonej osobowości wśród pacjentów psychiatrycznych, choć można sądzić że jeszcze więcej osób z tym typem zaburzenia nie kontaktuje się z psychiatryczną służbą zdrowia, osoby te w związku z przeżywanymi trudnościami nie realizują potencjalnych możliwości rozwoju, izolują się społecznie. Opisywany przez nas przypadek dziewiętnastoletniego mężczyzny w pełni odzwierciedla wspomniane konsekwencje ukształtowania się tego typu osobowości – opisany pacjent mimo 19 lat, nie ukończył jeszcze pierwszej klasy gimnazjum, całkowicie wyizolował się społecznie, a współwystępujące zaburzenie o charakterze łagodnych epizodów lęków panicznych, stało się zasłoną dymną uzasadniającą jego bierność i brak tworzenia i realizacji planów życiowych. Charakterystyczne jest także, że pomoc lekarska w zakresie lęków panicznych nie wpłynęła na zwiększenie aktywności i planowanie celów życiowych przez pacjenta, kilkumiesięczna codzienna psychoterapia umożliwiła zmianę jego relacji z rodzicami i powolne przejmowanie odpowiedzialności za swoje decyzje i za swoje życie.

Słowa kluczowe: Osobowość bierno agresywna, współchorobowość, lęki paniczne

Lorna Smith Benjamin in her book "Interpersonal diagnosis and treatment of personality disorders" subtitled the chapter dedicated passive aggressive disorder: "Therapy is not helping" and then quoted the words of patient, who reported "I've been coming here a long time for help with my depression and nothing better. I noticed on the way in here that the parking lot's filled with doctor's Mercedes. I had over 5000$ in medical costs last year, and I don't make no 300$ an hour or drive no Mercedes. It's a big disappointment. I was really looking forward for retirement." [2].

In our case report we would like to present the patient who is only nineteen years old but on therapy session claimed with peaceful smile on his face "What I would like is retirement." As well as this quoted patient our patient had a very important reason not to be able to realize demands of everyday life – medical illness – panic disorder in his case – this was a smokescreen for his real disorder – passive aggressive (negativistic) personality disorder. This never seen by medical authorities attacks, became the reason why our patient was not able to complete school classes for seven years!

The term passive aggressive was used first in American War Department in 1945 who presented with helpless, passive resistance to the demands of the military (interpersonal) [2]. Benjamin presents the review of conceptions of passive aggressive criteria in updating DSMs, she points that DSM II passive aggressive personality disorder "reliability was disastrous", DSM III put special emphasis on oppositional features of that personality, she quotes the opinion of Millon who pointed that "definition should also include ambivalence and irritability" DSM III R added items covering this dimensions. DSM IV "added items describing ambivalence, envy, complaints of being misunderstood, unappreciated and the object of personal misfortune" (interpersonal) [2].

According to DSM IV [3] the research criteria for passive aggressive personality disorder are as follow:

A. A pervasive pattern of negativistic attitudes and passive resistance to demands for adequate performance, beginning by the early adulthood and present in a variety of contexts, as indicated by the one or more of the following:
    1. Passively resists fulfilling routine social and occupational tasks
    2. Complains of being misunderstood and unappreciated by others
    3. Is sullen and argumentative
    4. Unreasonably criticizes and scorns authority
    5. Expresses envy and resentments toward those apparently more fortunate
    6. Voices exaggerated and persistent complaints of personal misfortune.

Alternates between hostile defiance and contrition. Presently passive aggressive personality disorder is included to DSM IV in appendix B. The transfer of this personality from core types of disturb personalities to appendix was caused by controversies "including its structure, content validity, overlap with other personality disorders, and relations to validating variables such as personality traits, childhood experiences, and clinically relevant correlates" [4]. There is very limited research concerning co-occurring passive aggressive disorder and Axis I disorders – New Oxford textbook of psychiatry [5] points major depression, dysthymic disorder, anxiety disorder, hypochondriasis. There is as well comorbidity of this personality with other personality disorders [6] – histrionic, borderline, obsessive compulsive, dependent, narcissistic [5] self-defending, sadistic [8] antisocial [7]. Research confirms genetic and environmental factors in etiology of this personality [4]. The course of passive aggressive personality disorder is a field for future research, treatment of this personality disorder is an open field for research – the systematic studies of psychotherapy of this disorder are rare, fluoxetine seems to be helpful in reducing passive aggressive symptom in depressed patients.

Case report

Patient J.T. 19 years old, is a middle school student, and is only child in the family, the parents are divorced, but they cooperate well in care for their son. The onset of patient's mental disorders was in 15th year of his age, in form of the panic attacks, very mild in intensity and frequency (during his treatment in young people ward he never presented any attack as well as in our day care center). Patient was treated in outpatient treatment, in private consulting rooms, psychotherapy and pharmacotherapy were in use, the target of treatment was anxiety disorders. Despite treatment, the patient did not realized school requirements; he did not do any routine home activities, although his intellectual abilities were in normal range. The parents though that it is due to his anxiety problems that were not properly treated. The total passive attitude to life problems and demanding special rights for him were treated as a consequence of the anxiety disorder. In 19th year of his age the patient was hospitalized in a psychiatric young people's unit and was treated with paroxetine. The treatment was effective concerning the panic attacks. The parents realized after a while that the successful treatment of panic attacks did not changed at all the patient's attitude to everyday life, he was equally as before demanding, negativistic, concentrated on his own problems, claiming the special position in his family and refusing coming back to school. He was also completely indifferent towards his future life problems. He always stressed that what is important for him is only here and now situation. Because of that the patient was admitted to our outpatient psychiatric day hospital, were he was treated mostly by the psychotherapy, psychoeducation and pharmacotherapy with paroxetine. We diagnosed him as passive aggressive personality disorder and panic attacks as comorbidity problem. The treatment was continued each day for another four months. During first weeks, he participated in individual and group psychotherapy in rather passive way, when his problems were discussed he defended his decisions of refusal to come back to school and continue his education in assertive and even ironic way. He did not take into account any other points of view but himself, in spite of that, his relation with the other group members was correct and after some time even friendly. After some time he tried to engage in group dynamics in other patients problems and at the same time, he revealed no insight concerning his own problems in terms of actual situation and future perspectives. He was not at all concerned of the fact that been nineteen years old is still the student of the first

class of the middle school, whereas his both parents were highly educated and took top professional positions in society. Long term structured psychotherapy focused on the change of his script of life gradually changed his psychological and family situation by improving his insight and diminishing the manipulative and negativistic approach to parents. At the same time he became more realistic in assessing his present situation and planning the future. What should also be mentioned is that using the state of health as a method of manipulation of family members is rather typical and quite common in this personality disorder.

The other group members in majority older than him were very much interested in his situation and in group discussions expressed their opinions in a very friendly way. The patient continued the psychotherapy, but did not change his mental condition for about three months. After that as we mentioned before, the situation was slightly changing. First he changed his attitude to his parents by expressing that because they are responsible for him he is also to some extend responsible for them. Next, he joined actively discussions concerning his future life plans and particularly coming back to school education. Than he decided to discuss his future education with the school teachers, finally he decided to start again with school education and to change in practical way his activity at home. The positive results of this therapy were obtained after four months of the psychotherapy conducted by teem of psychotherapists (a psychiatrist, two psychologists and the occupational therapist). What also should be taken into consideration as we mentioned before, is that both parents of the patient's however divorced, cooperated well with psychotherapists and supported patient in his way to more mature and responsible conducting of his life. The psychotherapy was based on transactional analysis school of thought. Interview with the patient after the year reviewed that he has completed the middle school and is continuing his education and his relations with his parents maintain well.

The recent events in big cities of England, where numerous young people in a very aggressive way, demonstrated their dissatisfaction of their social status (points 2,3,4,5 of DSM IV definition) whose prime minister of UK Cameron called as those who think that the world owes them, but is not, proved among others the importance and validity of the diagnoses of passive aggressive personality disorder and need for introducing it for future international classification.

References

1. Bradley R., Shedler J., Westen D. Is the appendix a useful appendage? An empirical examination of depressive, passive-aggressive (negativistic), sadistic, and self-defeating personality disorders. J. Pers. Disord., 2006; 20(5): 524-540.
2. Smith Benjamin L. Interpersonal diagnosis and treatment of personality disorders. New York; Guilford Press: 2003.
3. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington DC; American Psychiatric Association: 1994.
4. Hopwood Ch.J., Morey L.C., Markowitz J.C., Pinto A., Skodol A.E., Gunderson J.G., Zanarini M.C., Tracie Shea M., Yen S., McGlashan T.H., Ansell E.B., Grilo C.M., Sanislow Ch.A. The Construct Validity of Passive-Aggressive Personality Disorder. Psychiatry, 2009; 72(3): 256-267.
5. Gelder M., Andreasen N., Lopez-Ibor J., Geddes J.R. New Oxford Textbook of psychiatry Second Edition. New York; Oxford University Press: 2009.
6. Masiak M. Zaburzenia osobowości w ujęciu klinicznym. Wykłady Sekcji Psychologii KUL – Lublin: 1990.
7. Morey LC. Personality disorders in DSM-III and DSM-III-R: Convergence, coverage, and internal consistency. A. J. Psychiatry, 1988; 145: 573-577.
8. Millon, T., Radovanov, J. Passive-aggressive (negativistic) personality disorder. In W. Livesley (Ed.), The DSM-IV personality disorders: Diagnosis and treatment of mental disorders. New York, NY; Guilford Press: 1995 pp. 312-325.

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