Passive aggressive personality disorder – behavioral pattern – two cases report

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Abstract

Passive aggressive (negativistic) personality disorder lost its position in three clusters of disordered personalities in DSM IV. This was due to controversies connected with dimensions, co-occurrences, and prevalence of this personality disorder in the general population. In clinical practice, this type of disturbed personality remains an important problem. In our practice, prevalence of this disordered personality or its features seems to be quite significant. Somatic disorders commonly diagnosed in patients with passive aggressive personality disorder are one of common methods of manipulation and should explain their negativistic approach that commonly veil the clinical symptoms of these patients. Common problems connected with the described personalities are abnormal structures of families commonly functioning without a father, as it was taken place in both described patients. Overprotective mothers were not able to establish the upbringing forms that could correct the disturbed development of the personality of the patients. They accepted parasitic-claiming way-of-life of their children. Moreover, in this case, the mother of described girl accepted inversion of their circadian rhythm and as a result functioning of the patient in the growing social isolation.

Keywords: passive aggressive personality disorder

Streszczenie

Osobowość bierno-agresywna utraciła w DSM IV swoje miejsce pośród głównych typów zaburzeń osobowości, ze względu na niejednoznaczności lub brak wystarczających danych dotyczących wymiarowości tego zaburzenia, współchorobowości, częstości występowania. W praktyce klinicznej ten typ osobowości pozostaje jednak istotnym klinicznie problemem. W naszej praktyce częstość występowania tego zaburzenia lub jego elementów wydaje się być bardzo znacząca. Częste choroby somatyczne diagnozowane u osób z zaburzeniem bierno agresywnym i które są jedną z częstszych form manipulacji, którą posługują się ludzie z tą osobowością, mają uzasadniać bierność i roszczeniowość i wielokrotnie przesłaniają istotę kliniczną problemów tych ludzi. Częstym problemem wiążącym się z rozwojem opisywanej osobowości są nieprawidłowe struktury rodzin bardzo często funkcjonujące bez ojca tych osób, tak jak to w przypadku obojga opisywanych w tej publikacji pacjentów miało miejsce. Nadopiekuńcze matki nie potrafiły stworzyć warunków wychowawczych korygujących nieprawidłowy rozwój osobowości u opisywanych pacjentów. Akceptując nie tylko ich roszczeniowy i pasożytniczy tryb życia, ale także jak w przypadku opisanej pacjentki godząc się na odwrócenie rytmu dobowego i funkcjonowanie pacjentki w coraz pełniejszej izolacji społecznej.

Słowa kluczowe: osobowość bierno-agresywna

Introduction

The Oxford Textbook of Psychopathology says that "no epidemiological studies that have yet examined the prevalence of this (passive aggressive (negativistic)) disorder as currently conceived in DSM IV" [1]. The same source shows the results of studies on prevalence of passive aggressive personality disorder among the patients who are diagnosed with personality disorders – the results show – one publication 0%, another 2%, 5%, 8%, 10%, 12% and even 52%. Probably diagnostic limitations of DSM III criteria for passive aggressive personality disorder, which excluded any type of comorbidity with other disturbed personalities, artificially lowered prevalence rates [1]. "This restriction was eliminated from DSM IIIR and it could be diagnosed along with other personalities" [1]. Our observations support those mentioned results which show quite common prevalence of that type of personality disorder. These patients go through their life with the burden of this disturbance. They can't realize their intellectual potential, they are separated from society by set of features which create this type of personality. Formerly (in DSM III) the passive aggressive personality disorder belonged to core types of disturbed personalities, but because of the fact, that the diagnostic criteria are not precisely described and recognized by majority of clinicians and there are still a lot of questions concerning "structure, content validity, overlap with other personality disorders and relations to validating variables such personality traits, childhood experiences, and clinically relevant correlates" [2]. The epidemiology of passive aggressive (negativistic) personality disorder was withdrawn from mainstream list of disturbed personalities and relegated to the appendix of fourth edition

of DSM. It should be mentioned, that "even though passive aggressive behavior continues to play an important role in several theories of personality disorders" [2]. A very large study conducted by experienced American psychiatrists and psychologists confirmed "that the construct is unidimensional, internally consistent, and reasonably stable. Furthermore, passive aggressive personality disorder appears systematically related to borderline and narcissistic personality disorders. They exhibit sets of personality traits, childhood experiences consistent with several theoretical formulations, dysfunctions, substance abuse disorders, and history of hospitalizations" [2].

For many reasons, in our opinion, the passive aggressive personality disorder (negativistic disorder) is a real clinical, therapeutic, and social problem, that should be introduced to the future classification of mental disorders. In our clinical practice, the passive aggressive personality disorder, is in some cases seen and diagnosed in a very early stages. Probably because of the familial and social problems that are connected with the negativistic forms of behavior. It is interesting that in later stages, those persons usually disappear as a separate diagnostic group of disordered personality people. Probably because of the fact that parasitic mode of life, in later stages of life is more common and typical for many others personality disorders and other mental disorders. On the other side passive aggressive personality disorder is associated with increased risk of [2] other personality disorders (narcissistic, borderline) increase of substance use, anxiety disorders, depression. There is no doubt that in some cases we can observe the comorbidity of the mentioned above mental disorders with passive aggressive personality disorders. There is limited data concerning the comorbidity of this personality with disorders from Axis I, the publications suggest links with mood disorders – dysthymia and major depression [1]. Oppositional Defiant Disorder (ICD 10 93.1) diagnosed according to ICD 10, can predict the passive aggressive personality disorder in the later stages of life.

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

A. A pervasive pattern of negativistic attitudes and passive resistance to demands foe 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
7. Alternates between hostile defiance and contrition [3].

Passive aggressive disorder

As we mentioned above the intensity of passive aggressive personality features differs in various people suffering of that type of abnormal personality. Most commonly this personality features can be diagnosed from adolescence in the intentional passive resistance to the educational or other life plans or other routine tasks , sometime also in the aggressive way.

These tasks are typically introduced by parents, commonly, by the father. They complain of any duties that normally people fulfill, they demand others do their duties for them sometimes in aggressive way. They complain of being victims of their families or other social establishment. They resist of realization of their duties in a variety of ways: open resistance of fulfill the duties, or by delay, or perform just as is. They do not strive for independent life, they manipulate the surrounding people, to continue parasitic way of life.

They perform the following maladjustive reactions: aggressive, dysphoric sometimes hypochondriac. The manipulations of suicidal behaviors or very seldom suicidal behaviors.

Case 1 report

Patient 19 year old male, who was raised by his mother and grandmother, experienced his Father leaving the family when the patient was two years old. According to his mother the patient did not pay much attention to school activities and duties from very early on, however his IQ was within the norm. The patient did not do any home duties, he searched for reasons that he should be treated in a special way.

This 19 year old male often claimed to be ill (the doctor diagnosed him with Gilbert syndrome), next he claimed also that he is anxious because it is possible that people could laugh of him, he can meet aggressive people outside the house, or he can be contaminated with HIV and so on. As a result of these statements, he refused to attend school, so he received home instruction for both middle and high school.

Due to his mother's initiative and concern, he graduated high school. She often worried that the patient had no plans for future education and for a more independent way of life. During the interview the doctor discussed with the patient's the possible forms of the future education that could prepare him to independent way of life – the reaction of the patient was very emotional and even aggressive he stated that he is an ill person and can not

fulfill the suggested forms of activity and that it is the real harm to him. From there the patient emotionally refused any further discussion with the therapist and abruptly left the consulting room. With respect to his relationship with his mother, he was assertive and demanding and dominative. His mother took the submissive attitude to his avoiding of any activity, and felt completely helpless in this situation.

Case 2 report

A 15 year old female patient, MW, is the only child in the family. She was brought-up by both her mother and grandmother due to her parent's divorce; the father has limited parental rights. The patient has negative attitude in front of her father and she does not stay in contact with him. Since 13 years of age, the patient refused to realize her educational requirements by rather expecting special treatment. In the previous academic year she had individual schooling and was established under the care of psychological and pedagogical counseling while altogether she tried minimizing academic institutional contact as much as possible. For approximately six months, the patient did not do any routine activities in the home and claims that she did not attended school "because the girls were unfriendly to me, I am irritated when someone clings to me, they dictated me what I should do and how should I behave."

In addition, over the past few months the patient experienced a circadian rhythm reversal. She sleeps during all day, and during the night she is active, her mother accompanies her, although during the day she must work out of the house. The mother makes a true effort to be have a good relationship with her daughter by willingly making every concession to each of her daughter's request. The patient consciously altered her circadian rhythm to be free from any school obligations. She literally has no future plans and is absolutely confident that someone else, her mother, will organize the remainder of her life for her. The IQ of the patient was within the norm and there is no evidence for any other mental disorders other than passive aggressive personality disorder. In this case, we should highlight that the patient's relationship with the mother was quite extreme and there is no doubt that mother was overprotective. These behavioral challenges created an environment where the patient made no effort to change her passive and negativistic attitude in life.

A common thread among both of these cases where that, in both cases the families were incomplete and the patients were brought up without fathers in the home.

References

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