

The Surprising History of Passive-Aggressive Personality Disorder

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ABSTRACT. The history of passive-aggressive personality disorder (PAPD) reveals many things about American psychiatry, including how its use and understanding of diagnostic categories have in recent decades changed. The disorder is thus a useful litmus test for establishing whether categories in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* have undergone a type of “diagnostic bracket creep” (Peter Kramer’s term) with significant effects on the wider culture. The history of PAPD also allows us to assess whether psychiatry has encroached on routine traits and everyday practices, pathologizing behavior that was once considered normal. While the expansion of the *DSM* has generated widespread commentary and analysis, less has been written about PAPD, including how it came to be recognized and why its diagnostic parameters expanded so dramatically in each edition of the *DSM*. After tracing its roots to World War II, the essay reveals how the disorder came to be applied to ever-larger numbers of the civilian population. Original research drives the argument: previously unpublished memoranda from the American Psychiatric Association’s archive that not only reveal the back-story to the disorder’s expansion, but also cast new light on the organization’s methodology, including its practical and theoretical difficulties in differentiating normal from pathological behavior.

KEY WORDS: *DSM*, history of psychiatry, misdiagnosis, passive-aggressive, personality disorders

The history of passive-aggressive personality disorder (PAPD) offers a significant window onto broader changes in American psychiatry over the last century. Watching how the personality disorder has evolved since the Second World War tells us a lot about how the profession has characterized dysfunction, aberrant behavior, and the underlying etiology of psychiatric disorders. Passive-aggressive personality disorder more than illustrates those changes; it also reveals what happens, clinically and theoretically, when a disorder enters popular culture and comes to be known by everyday language.

Oriented almost entirely by unpublished letters and memoranda, this essay draws on a fascinating, underexplored archive at the American Psychiatric Association (APA) that captures the organization's shifting definitions of pathology and normalcy. Offering more than a simple history of PAPD, the material quoted raises larger practical and theoretical questions about diagnostic language and the associated risks of "diagnostic bracket creep" (Kramer, 1993/1997, p. 15)—questions this essay first amplifies then addresses.

Since it first appeared in 1952, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* has undergone numerous changes, some of them beneficial. No longer a thin, spiral-bound copy sold primarily to state mental institutions, it now sells in the millions, partly because schools, prisons, courts, health insurers, and mental-health professionals around the world consult it daily. However, the *DSM's* greatly expanded diagnostic role has allowed psychiatric terminology to migrate into popular culture, raising far-reaching issues about influence and meaning that deserve careful attention. It is by no means settled whether the manual has simply responded to suffering by giving patients and clinicians fresh diagnostic language, or whether it has had a more active, generative role over such matters, including over how the public now thinks about illness and distress.

To some degree, a debate about the manual's diagnostic and societal role goes back at least to 1980, when 112 new disorders swelled its watershed third edition, allowing its total number of pages to more than triple, from 134 to 494 (Healy, 1997; Kirk & Kutchins, 1992; Kutchins & Kirk, 1997). Yet since the APA's internal methods, criteria, and sometimes-rancorous discussions about these disorders came to light two years ago, when the statute of limitations on its unpublished papers expired (Lane, 2007), less has been said or known about the organization's associated difficulties in differentiating normal from pathological behavior. These difficulties sprang, we'll see, partly from the manual's attempt at being more comprehensive. "The initial task force memorandum," notes Mitchell Wilson (1993),

... clearly stated a desire to erect a high threshold for making a psychiatric diagnosis, but with the addition of new diagnostic categories, the threshold for making a diagnosis was lowered. As *DSM-III* went through its various modifications, it became more inclusive. (p. 405)

It is possible to chart the diagnostic side of this equation in rapid strokes. In 1968, the *DSM* cited 180 categories of mental disorders. By 1987, that number had grown to 292 and, by 1994, with the publication of *DSM-IV*, to over 350. In just 26 years, that is, the total number of mental disorders the general population might exhibit almost doubled. But that is just one side of the story. To offer a more complete clinical picture, it is necessary to consider the professional and lay culture from which these disorders sprang, on which the *DSM* in turn has left an indelible mark.

This essay uses PAPD to help chart and explain the manual's rapid expansion, arguing with Georges Canguilhem and other intellectual historians that

the *DSM* has dramatically—perhaps irrevocably—transformed boundaries between the normal and the pathological. For with each new edition of the *DSM*, what mental-health professionals formally and informally called pathological behavior grew exponentially. As a result, normality—an imprecise, rather tendentious category at the outset—has become an abstract ideal into which, by the *DSM*'s own reckoning, fewer and fewer people can squeeze (see Canguilhem, 1966/1991, pp. 275–87; Foucault, 2003/2006, pp. 265–95). *DSM-II* introduced a new diagnostic category for those said to have “no mental disorder” (APA, 1968, p. 127, code 318.00). Since then, the number of disorders on the books—and the number of people said to be afflicted by them—have increased enormously.

“About half of Americans will meet the criteria for a *DSM-IV* diagnosis sometime in their life” (Kessler, Berglund, Demler, Jin, & Walters, 2005, p. 593), investigators at Harvard's Medical School declared soon after updating the last National Comorbidity Survey, completed a decade earlier. By their lights, then, it would seem fitting that, over a comparable period of time, more than 67.5 million people in the United States—nearly a quarter of the country's population—had taken Selective Serotonin Reuptake Inhibitor (SSRI) medication for depression and anxiety (Healy & Aldred, 2005, p. 168).¹ These two illnesses in turn account for just a handful of the 350 disorders formally recognized by the *DSM*, for which Americans can expect medical treatment.

How a disorder is defined—including where researchers put its cut-off point—is thus a matter of diagnostic accuracy and public health, affecting the lives of millions of Americans. For that reason, it is worth examining how researchers devise and agree upon diagnostic thresholds for mental disorders. The process puts into relief the larger stakes of their deciding what constitutes normal and pathological behavior.

When researchers at the University of California, San Diego, tried to set “diagnostic thresholds for social phobia”—now considered the third-most prevalent mental disorder, after depression and alcoholism (Rettew, 2000, p. 285)—they found, quite understandably, that “precise delineation of the prevalence of ‘social phobia’ depends heavily on where the diagnostic threshold is set” (Stein, Walker, & Forde, 1994, p. 408). But deciding where to set such thresholds can raise more questions than it answers. Murray Stein and his colleagues drew from a single study—a random telephone survey of 526 urban Canadians, which asked respondents to rate their levels of anxiety for activities such as “calling someone you do not know very well,” “taking a test,” “trying to pick up someone,” and “resisting a high-pressure salesperson”—activities listed as representative on the highly influential Liebowitz Social Anxiety Scale (Liebowitz, 1993, p. 32).

Stein and his colleagues concluded that the frequency with which participants experienced social phobia ranged from 1.9% to 18.7%, depending on where his team set the threshold (Stein et al., 1994, p. 408).² That is the difference between arguing that social phobia afflicts fewer than two people in

every hundred and suggesting that as many as one in five may be at risk. Published the same year the APA decided to rename social phobia as “social anxiety disorder,” Stein et al.’s article was soon so influential and cited that it came to be considered one of the disorder’s founding documents. Yet as the team itself explained, in language more question-begging than reassuring, “By altering the threshold for interference with lifestyle or subjective distress or by restricting diagnosis to particular social situations, the rate was seen to vary by up to tenfold” (Stein et al., 1994, p. 412).

Similar vexing questions about judgment and variability apply to most disorders listed in the *DSM*, including passive-aggressive personality disorder, the focus of this essay. For the manual has not only formalized widely different types of behavior as criteria for mental disorders; it has in the process changed the way we think about such behavior. The phrase “passive-aggressive” did not exist 60 years ago; now, like “bipolar” and “obsessive-compulsive,” it is not only ubiquitous, but seen as widely accepted shorthand for a person with hostility issues. Experts weigh in on its causes, while popular websites encourage the frustrated to rail at manipulative bosses, conniving coworkers, obnoxious neighbors, and delinquent roommates, all of them given the same descriptive tag. How, then, do the term’s everyday and psychiatric meanings differ?

Although we might expect the history of PAPD to answer that question, the disorder’s origins remain as strange and open-ended as the behavior it describes. The first official document about the disorder is a single Technical Bulletin issued by the U.S. War Department just as the Second World War was coming to an end. In 1945, Colonel William Menninger voiced concern about soldiers who were shirking duty by willful incompetence. They were not openly defiant, he conceded, but expressed their aggressiveness “by passive measures, such as pouting, stubbornness, procrastination, inefficiency, and passive obstructionism.” Menninger saw their behavior as an “immaturity” and a reaction to “routine military stress” (Bulletin TB M.D. 203, dated October 19, 1945, as cited in Malinow, 1981, p. 123).

Given the number of fronts on which the country was fighting at the time, the stress that American servicemen endured does not appear “routine.” Yet while it is easy to grasp why the military would want to maximize efficiency, issuing a memo against “pouting” seems neither an obvious nor an effective solution. Adds Cecil Adams (2003) on *The Straight Dope* website, “If you’ve ever served in the military during wartime or for that matter read *Catch-22*, you realize that what the brass calls a personality disorder a grunt might call a rational strategy to avoid getting killed” (para. 3).

Oddly, the term did not disappear when the war ended. In fact, the armed forces found it a useful way to characterize unwanted behavior, and spent a surprising amount of time and energy over the next few years denigrating those said to exhibit it. The composite sketches they drew of “passive, henpecked Mr. Milquetoast[s]” made them look more like Norman Bates in *Psycho* than

Steve Carell's role as Michael Scott, the comically dysfunctional boss in *The Office* (Hodge, 1955, p. 87). "The passive-dependent character is a boy in man's clothes" (p. 84), Lieutenant James R. Hodge declared in a 1955 edition of the *United States Armed Forces Medical Journal*, as he steered the charge from aggression to over-reliance; "he is the child who never got away from his mother's apron strings" (p. 84) "After he is married, if he ever is ... he brings his marital squabbles home to Mamma's big bosom and embracing arms" (p. 85). Four more pages of similar invective ensue. Apparently it was simpler for Lieutenant Hodge to scorn his subordinates than consider their questioning as at times justified and even necessary. After all, the latter stance played a critical role in later—quite different—wars, such as Vietnam.

Having logged the quirks of servicemen, however, psychiatrists soon began applying the same charges virtually unaltered to civilians. As it readied the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* for publication in 1952, the APA simply copied the relevant phrases from the military memo and gave them diagnostic codes. Indeed, it adopted the same practice for a large number of behaviors and ailments, making the temporary frustration of the U.S. War Department a basis for establishing lasting pathologies in the population at large.

The *DSM* soon became the bible of mental health, quoted chapter and verse as a watertight document based on evidence, rules, and hard science—language that began to characterize the manual in the late 1970s. Given the pride attached to its criteria today, however, many lay and professional readers may be astonished to learn that its clinical and theoretical foundation was actually a group of tendentious, highly opinionated, and extremely judgmental military memos that applied to servicemen during wartime, not civilians during peacetime.

In the 1950s, unit cohesion was not the APA's primary concern; it worried more about disobedience at work and home. When the organization's first edition of the *DSM* appeared, then, conflicts in the workplace or family soon assumed new meaning: experts began calling them aggressiveness conveyed "by passive measures, such as pouting, stubbornness, procrastination, inefficiency, and passive obstruction" (APA, 1952, p. 37, code 000-x52).

The idea that such common traits as dithering and petulance could stem from a passive-aggressive personality began to take root in the culture, where the notion blossomed in such related contexts as marriage counseling.³ Indeed, by 1966, passive-aggressive personality disorder had become a common psychiatric diagnosis, accounting for more than 3% of hospitalized patients in public mental institutions and over 9% of outpatient clinic patients (Pasternak, 1974, p. 63).⁴ Given the open-endedness of the *DSM* criteria, however, the behaviors driving these statistics were far from clear. After all, a diagnosis of "stubbornness" could be made of housewives not modeled on their Stepford counterparts; and men like Willy Loman, in Arthur Miller's *Death of a Salesman*, could be labeled "inefficient" if they were struggling with their assigned (and frequently undervalued) role.

DSM-I was in fact remarkably careless in describing behaviors it considered pathological, and painted them with a very broad brush. A diagnosis of “emotionally unstable personality” could be made if the psychiatrist thought a patient exhibited too many “fluctuating emotional attitudes.” The same pathology would also make passive-aggressive personality disorder a serious diagnostic contender. Meanwhile, the *DSM* applied the term “sociopathic personality disturbance” to those deemed “ill in terms of society and of conformity with the prevailing cultural milieu,” a phrase sounding almost Orwellian today (APA, 1952, p. 36, code 000-x51, p. 38, code 000-x60).

On at least two occasions, however, the APA exercised independence from the military memos, with troubling consequences. It struck the word “*reaction*” from most conflicts, instead defining them as symptoms of “*personality*.” It also viewed these as “*pathologic*” rather than “*psychopathic*.” The American military had complained about minor military infractions tied to specific situations, but the APA soon broadcast that the businessman or housewife with a “passive-aggressive *personality*” revealed a pathologic “*trait disturbance*.” Marking a clear deviation from normalcy, their behavior was thus a syndrome that might recur if left untreated. The APA was not simply overdramatizing routine behaviors; it was relabeling them malfunctions of biology and neurology, the direction in which American psychiatry overall was heading.

After another round of edits in the late 1960s, the same “traits” became “deeply ingrained maladaptive patterns of behavior,” which according to *DSM-II* were usually “life-long” and “determined primarily by malfunctioning of the brain” (APA, 1968, pp. 41–42, code 301). The APA was at this point close to saying that passive-aggression and all other mental disorders were permanent, even innate conditions. The manual’s second edition also deleted the word “*reaction*” from all remaining psychiatric categories. As a result, diagnoses such as *schizophrenic reaction*, which previously had referred to sporadic psychiatric incidents, were transformed almost overnight into full-blown *schizophrenia*, even if the person’s symptoms were rare and not especially violent.

This bold stroke amounted to a major shift in approach: it changed the very meaning of illnesses for clinicians and patients, and eliminated the dynamism or struggle of the patient’s *reaction*. Illnesses began to define people rather than surfacing as an aspect of their personality, and symptoms were not merely an expression of unease tied to specific conditions. They were maladaptive problems that psychiatrists must treat and that society in general should fear.

To passive-aggressive personality disorder, in particular, *DSM-II* added two rather ominous sentences that greatly increased the likelihood of misdiagnosis:

This behavior commonly reflects hostility which the individual feels he dare not express openly. Often the behavior is one expression of the patient’s resentment at failing to find gratification in a relationship with an individual or institution upon which he is over-dependent. (APA, 1968, p. 44, code 301.81)

Not only had the *DSM* outlawed pouting, then; it left large numbers of people with ungratifying jobs vulnerable to a psychiatric diagnosis, too.

While it is difficult to believe that these judgments could be disseminated in a manual of mental disorders whose reach and authority was increasingly global, of greater embarrassment to American psychiatry is that *DSM-III*, appearing in 1980, did not always improve on them, as is commonly supposed, but often made a bad situation worse. Robert L. Spitzer, chair of its task force on “nomenclature and statistics,” wrote that the new edition would at last be evidence-based and rule-driven, forming a “classification system that would reflect our current state of knowledge regarding mental disorders” (Spitzer, Sheehy, & Endicott, 1977, p. 1). But after several years’ discussion, the group—pathologizing at least one of the behaviors it exhibited—thought it appropriate to add “dawdling and ‘forgetfulness’” to the disorder’s possible symptoms (APA, 1980, p. 329, code 301.84).

To an extent far greater than its contributors and editors care to admit, *DSM-III* is a flawed, often tendentious document. It tells psychiatrists that a symptom of “schizoid personality disorder” is whether the person seeking their assistance is “humorless or dull.” Associated features of that mental disorder can include being “not with it” or “in a fog” (APA, 1980, p. 310, code 301.20). Meanwhile, those with histrionic personality disorder “crave novelty, stimulation, and excitement” as they “act out a role, such as the ‘victim’ or the ‘princess.’” Those with narcissistic personality disorder “might be more concern[ed] about being seen with the ‘right’ people than having close friends,” and so on (APA, 1980, p. 313, code 301.50, p. 316, code 301.81). Still, the meetings and memos that generated these diagnoses are, if anything, even more troubling.

When the Personality Disorders committee met to redefine passive-aggressive disorder (or PAP, as the psychiatrists themselves began to call it), one committee member, Donald Klein, pushed to make the illness encompass “resistance to demands for *increased activity*” (Klein, as quoted in S.E. Hyler, personal communication to R. Spitzer, October 31, 1977). The colleague who opposed him, Steven E. Hyler, did so largely on the basis that Klein evinced similar traits: “I do not interpret Doctor Klein’s remarks as stubborn, negativistic, or intentionally inefficient,” he wrote. “They are much too direct and should probably be classified as oppositional [defiant disorder]” (S.E. Hyler, personal communication to R. Spitzer, October 31, 1977).

Hyler was not unique in pathologizing colleagues who disagreed with him. At one particularly tense moment over the criteria for avoidant personality disorder, Spitzer asked Klein: “Does the reference to ‘hypersensitivity to rejection’ get too close to Hysteroid Dysphoria for your personal comfort?” (R. Spitzer, personal communication to D. Klein, February 27, 1978).

As surprising as it sounds, we are likely in Hyler’s debt that indirectly stated doubts about a manager’s competence are not signs of mental illness. But Hyler’s colleagues did not reject Klein’s recommendation completely; they modified it so the “essential feature” of PAP became, in the words of *DSM-III*, “resistance to demands for *adequate performance*; the resistance is expressed indirectly rather than directly” (APA, 1980, p. 328, code 301.84). Hyler also made clear that it would be fine to say that a person with the disorder

displayed two of these qualities: “indecisiveness [*sic*], lack of assertion, [and] lack of self-confidence.” Indeed, he concluded, in parentheses, “perhaps only one of three is sufficient” (S.E. Hyler, personal communication to R. Spitzer, October 31, 1977).

Hyler’s contribution to the *DSM* fortunately was modest. Five months earlier, he had penned a memo recommending the inclusion of ailments as vague as “chronic complaint” and “chronic undifferentiated unhappiness” disorder on the basis that a person suffering from the second of these “often present[s] a very sad face,” and a person experiencing the first inflicts their “persistent and consistent complaining ... in a high-pitched whining fashion which is especially noxious to the listener” (S.E. Hyler, personal communication to R. Spitzer and the *DSM-III* Task Force, May 10, 1977).

In describing “chronic complaint disorder,” Hyler elaborated further on his rationale:

To be included in this category are persons who heretofore were known by the synonyms: “kvetch,” “scootch,” “noodge,” and just plain “neurotic.”

An episode of acute complaining is usually elicited by the question: “How are you?” The pathognemonic response is, “Don’t ask.” The response complaints are of a general nature and include such diverse topics as the weather, the energy crisis, taxes, or the previous evening’s track results

Associated features in this disorder include an outlook on life which is characterized as pessimistic. ... There also appears to be an ethnic association with this disorder in that it is found predominantly in persons of Eastern-European ancestry. In these cases, the pathognemonic expression becomes, “Oy vay, don’t ask.” (S.E. Hyler, personal communication to R. Spitzer and the *DSM-III* Task Force, May 10, 1977)

Hyler’s diagnostic zeal might well elicit the same response from readers. But Spitzer was more diplomatic in forwarding the proposal, merely adding in his cover letter, one hopes with irony: “Enclosed are draft versions of two new disorders for possible inclusion in *DSM-III*... It is gratifying to see that the methodology that we have so painstakingly developed for the ‘traditional’ disorders, applies equally well to disorders yet awaiting discovery” (R. Spitzer, personal communication to the *DSM-III* Task Force, May 10, 1977). Thereafter, the proposal seems to have generated only bemused or stony silence.

To its credit, the Advisory Committee on Personality Disorders initially questioned the inclusion of PAP in *DSM-III*, arguing that the latter seemed tied more to situational patterns than personality traits—a symptom of military origins it clearly had outgrown. The committee’s skepticism might have derived from Michael Fielding’s insistence that experts could spot the disorder by such pathological signs as when a patient “feels misunderstood” while displaying a “negative attitude (chip on shoulder)” (M. F. Fielding, personal communication, May 11, 1978) or by Ivan Elder’s advising them from Tuscaloosa’s Veterans

Administration Hospital that the “passive-aggressive is *both* too demanding and too dependent,” before he listed, as an example of such behavior, “a child ‘tak[ing] his (her) marbles home’ after the other kids refuse to play ‘her (his) way’” (I. Elder, personal communication to R. Spitzer, March 14, 1978).

But Erwin R. Smarr, a psychiatrist on the Assembly Liaison Task Force, was not happy about removing the illness from the *DSM* and urged Spitzer’s committee to reconsider. Drawing on his own experience with veterans, he insisted the afflicted would “certainly be rightly amazed if psychiatrists could not even recognize that such a pattern existed” (E.R. Smarr, personal communication to R. Spitzer and H. Jaso, November 4, 1977). In a curious twist, then, patients themselves were said to be crying out for continued recognition of behavior that does not, in this case, seem at all passive-aggressive.

Spitzer was at first noncommittal to this objection, conceding, “There has been no outpouring of enthusiasm from this Committee for the inclusion of this category. For some existential reason,” he added, “on this matter, I have no personal beliefs other than to exclude the category would certainly cause a lot of bad feeling from this Committee” (R. Spitzer, personal communication to the Advisory Committee on Personality Disorders, November 9, 1977). But as Spitzer concluded, he wound up siding with Smarr and pushed for continued adoption of the disorder:

As you can see from the enclosed letter from Dr. Smarr, a member of the Assembly *DSM-III* Task Force, he and his group are quite insistent on including this category in *DSM-III*. ... [As] Don [Klein] has noted, we have a lot of categories in *DSM-III* of questionable validity, and I don’t think that we should object to trying this category out in the Field Trials. ... I therefore urge that we include this category in the[m] ... and see how often it is used. If any of you have strong objections to my gentle twisting of the Advisory Committee’s collective arm (arms?), please let me know. (R. Spitzer, personal communication to the Advisory Committee on Personality Disorders, November 9, 1977)

The rationale for extending the life of a disorder first introduced to pathologize stubborn soldiers came down to saying that it was not considerably weaker than a host of other illnesses “of questionable validity.” Still, Spitzer’s team had only agreed about large numbers of them because interested parties had greeted their discussion with comparable assurances and appeals.

When the APA brought out a revised version of the third edition in 1987 aimed at tightening the diagnostic criteria of several hazily summarized disorders, the “essential features” of passive-aggressive personality disorder became, if possible, still cloudier than before. In the manual’s words:

When an executive gives a subordinate some material to review for a meeting the next morning, rather than complain that he or she has no time to do the work, the subordinate may misplace or misfile the material and thus attain his or her goal by passively resisting the demand on him.

These people become sulky, irritable, or argumentative when asked to do something they do not want to do. They often protest to others about how unreasonable the demands being made on them are, and resent useful suggestions from others concerning how to be more productive.

Under the heading “impairment,” the manual added:

These people are ineffective both socially and occupationally because of their passive-resistant behavior. For example, because of their intentional inefficiency, job promotions are not offered them. A housewife with the disorder may fail to do the laundry or to stock the kitchen with food because of procrastination and dawdling. (APA, 1980/1987, pp. 356–57, code 301.84)

The manual concludes: “Often individuals with this disorder are dependent and lack self-confidence. Typically, they are pessimistic about the future but have no realization that their behavior is responsible for their difficulties” (p. 357).

The APA’s problems were not limited to faulty reasoning and questionable examples; imprecision was another blemish. In the passage above, “passive-aggressive” behavior morphs unaccountably into “passive resistance”—a move perhaps due to carelessness or deliberate sleight of hand, but troubling either way. Passive resistance has a dignified history, dating at least to 18th-century Irish dissidents bandying together to reject British Home Rule. The Quakers and eventually Mohandas K. Gandhi adopted a similar name for their strategies. Consequently, it is bewildering to see *DSM-III-R* declare, in 1987, that such behavior is a disorder typified by such routine traits as “fail[ing] to do the laundry or to stock the kitchen with food because of procrastination and dawdling.”

Despite the greatly increased scope of the disorder, several psychiatrists voiced concern that it was still too “narrowly focused” (T. Millon, personal communication to the Advisory Committee on Personality Disorders, June 28, 1978). Others thought it “too situation specific,” presumably wanting more locations referenced than just the office, the home, and—in *DSM-III*—the club. Their concern was such that the *DSM-IV* task force considered deleting the disorder altogether. Others thought that rash, however, and pressed for a compromise. After Theodore (Ted) Millon, a consultant on the *DSM-III* task force, recommended renaming the disorder, arguing that “terms such as ‘oppositional personality disorder’ or ‘negativistic personality disorder’ capture the flavor of these patients more clearly,” his colleagues agreed to “Negativistic (Passive-Aggressive) Personality Disorder” and moved the illness to *DSM-IV*’s appendix, shorn of its diagnostic code.

For some time, as he notes in accompanying essays and books, Millon’s concern about how to diagnose passive-aggressive people with “introverted personalities” had not been heeded. In June 1978, he wrote that his colleagues needed to

... make more reference to [such people’s] characteristic behavioral apathy, their lack of vitality, their deficits in ... spontaneity [*sic*], their inability to display enthusiasm or experience pleasure, their minimal introspectiveness

and awareness of self, as well as their imperviousness to the subtleties of everyday social life. I think our description and our diagnostic criteria [for PAPD] would be strengthened if we included these personality dimensions that clearly signify the disorder. (T. Millon, personal communication to Advisory Committee on Personality Disorders, June 28, 1978)

It may seem odd to accuse introverts of “minimal introspectiveness,” yet this is not the most puzzling issue about Millon’s work.⁵ Pushing strongly for PAP to be expanded still further and renamed “Negativistic (Passive-Aggressive) Personality Disorder,” he was certain his suggestions would hit the mark and “enrich the descriptive material we have”:

I would suggest some of the following: frequently irritable and erratically moody; a tendency to report being easily frustrated and angry; discontented self-image, as evidenced in feeling misunderstood and unappreciated by others; characteristically pessimistic, disgruntled and disillusioned with life; interpersonal ambivalence, as evidenced in a struggle between being dependently acquiescent and assertively independent; the use of unpredictable and sulking behaviors to provoke discomfort in others. (T. Millon, personal communication to the Advisory Committee on Personality Disorders, June 28, 1978)

Millon’s memo circulated two years before *DSM-III* was published in 1980. Even so, perhaps because his definition was so loose, however, as to encompass just about anyone, the *DSM-IV* task force waited 13 years before it paid much attention to his concerns. In 1991, however, the *DSM-IV* task force had a change of heart. Perhaps worn down by Millon’s advocacy or simply uncertain whether to abandon or expand PAP, it decided in its *Options Book* to list the symptoms of Millon’s “Negativistic Personality Disorder” alongside those of PAP, to see which should prevail.

Millon’s lists were so open-ended that they included “expresses envy and resentment toward those apparently more fortunate” and “claims to be luckless, ill-starred, and jinxed in life; personal content is more a matter of whining and grumbling than of feeling forlorn and despairing” (APA, 1991, R17). It was as if Hyler had managed to resurrect his proposal for “chronic complaint disorder.”

The published version of *DSM-IV* ended up combining the lists while scaling back some of Millon’s more extreme criteria. The spirit and language of his 1978 memo nonetheless remain. For instance, the *Options Book* includes as potential symptoms: “(2) complains of being victimized, misunderstood, and unappreciated by those with whom he or she lives and works”; and “(5) communicates a pervasive mix of angry and pessimistic attitudes toward numerous and diverse events (e.g., cynically notes the potentially troublesome aspects of situations that are not going well)” (APA, 1991, R17).⁶ Remarkably, only the latter was cut from *DSM-IV*; all the other options remained, including the final clause of “(8) alternates between hostile assertions of personal autonomy and independence, and acting contrite and dependent” (APA, 1991, R17).

The consequence of these startling suggestions and revisions is that *DSM-IV*—in its appendix—gives the loosest definition yet of the illness:

These individuals ... may be sullen, irritable, impatient, argumentative, cynical, skeptical, and contrary. ... Because of their negativism and tendency to externalize blame, the[y] often criticize and voice hostility toward authority figures with minimal provocation. They are also envious and resentful of peers who succeed and who are viewed positively by authority figures. These individuals often complain about their personal misfortunes. They have a negative view of the future and may make comments such as, "It doesn't pay to be good" and "Good things don't last." (APA, 1994, pp. 733–734.)

This astonishingly broad description of negativity, appearing in the most trusted and praised edition of the *DSM*, is the culmination of years of research and discussion in neuropsychiatry and psychopharmacology. Yet the disorder's relegation to the manual's appendix has not put an end to discussion about whether it remains a bona fide illness. Although Thomas Widiger (2003) has declared, without much regret, that PAPD "may already be on the path to extinction" (p. 98), many believe it could be rehabilitated if it were slightly redefined. "By renaming and relegating PAPD to the Appendix," assert Scott Wetzler and Leslie C. Morey (1999), "the *DSM-IV* work group may have sounded its death knell. ... [But] although it may be difficult to differentiate PAPD from other personality disorders, this is a shortcoming common to all personality disorders. It may not be a ringing endorsement," they concede, "but one can only conclude that PAPD is no less valid than other personality disorders" (p. 57).

One could in fact draw very different conclusions, including that such frank admission about the disorder's definitional problems is tantamount to suggesting that *all* personality disorders be reviewed and perhaps even eliminated from the *DSM*. But few, if any, psychiatrists would agree to that. In a 1992 essay on the disorder's "diagnostic validity," for instance, Mark Fine, James Overholser, and Karen Berkoff agreed that the disorder looked more promising when viewed from a "dimensional rather than a categorical perspective," but most of their recommendations boiled down to arguing that the disorder be recognized by nouns that alliterate: "rigidity, resentment, resistance, reactance, and reversed reinforcement" (pp. 470, 478).

That was over a decade and a half ago, however, and few have heeded their advice. The disorder looked set to languish indefinitely in the manual's appendix. As recently as 2007, however, a team on the East Coast boldly asserted "The validity of *DSM-IV* Passive-Aggressive (Negativistic) Personality Disorder" and lamented, "the diagnosis has never gained international acceptance" (Rotenstein et al., 2007, p. 30). Even as they concede the disorder has been controversial, they argue that it could be revived in altered (negativistic) form, to take its place once more among the *DSM*'s other personality, mood, and anxiety disorders.

To do that, the authors focus on the disorder's "long history" without acknowledging its many twists and turns, including that the disorder recently acquired a new name and has been expanded almost beyond recognition

(Rotenstein et al., 2007, p. 28). What they contribute, though, is fresh “empirical data” about a disorder that oddly has lacked much of it (p. 30).

At first blush, the new data look impressive. The authors draw from a sample of 1,200 psychiatric outpatients at Rhode Island Hospital, and affirm that, of these, 35 participants (3.02%) “met criteria” for Passive-Aggressive (Negativistic) Personality Disorder (NEGPD). Most of the patients were white; over half of them were women; and almost half of them were married.

Among the many pages of data that follow are impressive tables that itemize “convergent and divergent validity coefficients for Negativistic Personality Disorder criteria,” as well as “Axis II Comorbidity in Patients with and without Negativistic Personality Disorder.” All this would seem to point to the disorder’s appropriate resurrection. When listing the criteria in question, however, the authors’ language changes dramatically, becoming far more colloquial and idiomatic. Since the authors must adopt *DSM-IV* criteria, they are forced to include “[feels] misunderstood and unappreciated”; “[experiences] envy and resentment”; and “[regrets] personal misfortune” among their arguments for re-designating PAPD/NEGPD an official mental disorder. To that end, when trying to draw bold pointers from their data, the authors’ arguments become more perplexing than compelling: “The data showed that ‘complaints of being misunderstood and unappreciated’ and ‘sullen and argumentative’ were the most correlated to the NEGPD criteria set. Additionally, the item ‘voices exaggerated ... complaints of personal misfortune’ was the most diagnostically efficient” (Rotenstein et al., 2007, p. 38). But why would it not be? It must be, after all, one of the most common complaints around.

Psychiatrists may wince over these and other quoted passages, insisting that PAPD has finally been shorn of diagnostic cachet so there is no point dredging up its unillustrious career. Some persist, however, as the authors above do, in saying that skepticism, petulance, procrastination, and kvetching about bad luck really are symptoms of a bona fide mental illness and should be formally recognized as its valid criteria. Further, as the difficulty in setting diagnostic thresholds for social anxiety disorder made clear, a close study of almost any disorder in the *DSM* would yield the same indeterminate results, leading us to wonder yet more about the cut-off point between normalcy and pathology. In recording what happened to passive-aggressive disorder, then, I am not only presenting a window onto a significant, largely unexamined chapter of American psychiatry; I also wish to document the APA’s profound difficulties in differentiating normal from pathological behavior.

This is not a trivial problem when the organization’s manual is invoked daily around the world, with dramatic consequences for millions of lives. These difficulties and their knock-on effects also lead us to question how much faith we can or should place in the next *DSM* task force, which is now meeting to assemble the next edition of the manual, *DSM-V*. According to early reports (including from Spitzer himself), the *DSM-V* group is likely to add “apathy,” “compulsive buying,” and “internet addiction disorder” to the diagnostic manual.

If *DSM-IV* is anything to go by, perhaps we should anticipate that “It doesn’t pay to be good” and “Good things don’t last” will return as their distinguishing symptoms. Either way, the history of many *DSM* disorders suggests that they are more open to doubt and investigation than the task forces creating them have realized or acknowledged.

Notes

1. Healy and Aldred’s data end in 2002, three years before Kessler’s replicated survey. Their final tally would likely be greater still if it extended until 2005.
2. Kessler and his colleagues put the combined percentage for any anxiety disorder at an eye-popping 28.8, but calculated that social phobia alone afflicts fewer than Stein’s upper-ceiling—that is, 12.1% of the population (roughly one person in eight; see Kessler et al., 2005, p. 593).
3. See, for instance, McGee and Kostrubala (1964) describing one patient:

Psychological testing ... suggested that he would like to relate to women in a passive-dependent manner but saw them as aggressive, destructive, and controlling. This did not deter him from other attempts to establish a passive-dependent relationship with women. The diagnosis was that he was a passive-aggressive personality, passive-dependent type. (p. 81)

4. Pasternak’s essay does not appear in the second edition of this collection, cited earlier for Malinow’s essay.
5. See, for instance, his *Disorders of Personality*, in which he argues there’s likely a “biological” reason passive-aggressive people exude “a capricious impulsiveness, an irritable moodiness, a grumbling, discontented, sulky, unaccommodating, and fault-finding pessimism that characterizes their behaviors.... Even in the best of circumstances,” he despairs, “they always seem to seek the ‘dark lining in the silver cloud’” (Millon, 1981, pp. 252, 246).
6. Compare these with the research criteria published for “Passive-Aggressive Personality Disorder (Negativistic Personality Disorder),” in the appendix of *DSM-IV* (APA, 1994, p. 735). The phrasing is almost identical.

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