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Cognitive Therapy for Co-Occurring Depression and Behaviors Associated With Passive-Aggressive Personality Disorder

Paula K. Yanes[1], Stephen T. Tiffany[1], and John E. Roberts[1]

Abstract

The following case study illustrates the use of cognitive therapy for treating depression that co-occurs with behaviors associated with passive-aggressive personality disorder (PAPD). Depression and co-occurring PAPD-associated behaviors present several challenges for treatment, including the transient nature of PAPD-associated behaviors and the effect of these behaviors on the effective treatment and remission of depression. Cognitive therapy was initially effective at treating depression and PAPD tendencies. As treatment progressed, dysfunctional interactions with the environment resulted in the reemergence of PAPD-associated behaviors as these behaviors were reinforced and assertive behaviors punished. With the continued use of cognitive therapy, PAPD tendencies were once again reduced and depressive status remained in remission. The present case study highlights the importance of targeting behaviors associated with personality pathology when co-occurring with depression.

Keywords

depression, passive-aggressive personality disorder, passive-aggressive associated behaviors, cognitive therapy, stress generation

1 Theoretical and Research Basis

As research on the co-occurrence between depression and other disorders has accumulated, it has become apparent that treatment-seeking clients with co-occurring depression and personality disorders tend to be the norm rather than the exception. A review conducted by Bagby, Quilty, and Ryder (2008) found that, depending on the personality disorder and type of depression examined, rates of co-occurrence between depression and personality disorders average around 50%. However, despite these high rates, it is not uncommon for clinicians to miss the presence of a co-occurring personality disorder. Clients with co-occurring Axis II pathology and depression rarely seek treatment for their personality pathology (Beck, Freeman, & Davis, 2004). In

[1]University at Buffalo, The State University of New York, Buffalo, NY

Corresponding Author:
John E. Roberts, University at Buffalo, The State University of New York, Department of Psychology, 221 Park Hall, Buffalo, NY 14260
Email: robertsj@buffalo.edu

addition, state effects of depression during an acute episode may affect the validity of a personality disorder diagnosis (Zimmerman, 1994), leading to suggestions that clinicians defer diagnosis until acute depressive symptoms have subsided (however, also see Morey et al., 2010). As a result, treating clinicians frequently disregard Axis II pathology when formulating case conceptualizations and devising treatment plans for a client presenting with depression.

Disregarding a co-occurring personality disorder when treating a depressed client could have important negative consequences. Several studies have suggested that personality disorders negatively influence treatment outcome for depression by delaying treatment response and reducing treatment response rates (e.g., Enns, Swenson, McIntyre, Swinson, & Kennedy, 2001; Newton-Howes, Tyrer, & Johnson, 2006; Reich, 2003; Shea, Widiger, & Klein, 1992). In addition, presence of a personality disorder can increase the likelihood of recurrence of depression (Enns et al., 2001). According to Hammen (1991), the maladaptive interaction between a depressive individual's personality traits and the environment serves to generate stress (specifically interpersonal stress), which, in turn, leads to the worsening of depressive symptomatology. Thus, the presence of personality pathology may act as a risk factor for future depressive episodes (Dolan-Sewell, Krueger, & Shea, 2001; Gunderson, Triebwasser, Phillips, & Sullivan, 1999) through the toxic effects of personality on the environment. Therefore, disregarding Axis II pathology could lead to a problematic roadblock for the treatment of depressed clients.

This issue may be particularly relevant for depressed clients with co-occurring personality disorders that are difficult to recognize and define such as passive-aggressive personality disorder (PAPD). According to the *Diagnostic and Statistical Manual for Mental Disorders*, 4th ed., Text Revision (*DSM-IV-TR*; American Psychiatric Association, 2000), PAPD is characterized by a pervasive negativistic attitude and passive resistance to demands that have been present since childhood and demonstrated in several contexts. Though PAPD has a long history in the personality literature, currently PAPD is not recognized as an official personality disorder according to the *DSM-IV-TR*; its official diagnostic label is a personality disorder not otherwise specified. This is partly due to concerns with its large symptom overlap with other personality disorders (e.g., Rotenstein et al., 2007) and the suggestion that it is a situational reaction to circumstances as opposed to a pervasive and longstanding personality feature (e.g., Widiger, Frances, Spitzer, & Williams, 1988). Given the difficulty distinguishing PAPD from other personality disorders and its potentially transient presentation, it is possible that this form of personality pathology may not receive adequate attention despite its potential deleterious effects on the treatment of depression.

The following case presentation describes the application of cognitive therapy to a client with acute major depressive disorder (MDD) who engaged in behaviors associated with PAPD. In particular, this case study demonstrates the difficulty inherent in treating an individual with PAPD-related pathology due to the context-dependent presentation of symptoms and difficulty discriminating between client pathology and toxic environmental effects. We will first discuss the effectiveness of cognitive therapy for depression despite the presence of co-occurring PAPD-associated behaviors, then progress into a discussion of the effectiveness of applying cognitive therapy to PAPD-associated pathology. We will highlight the importance of focusing on personality-related pathology to maintain remission of depressive symptoms as well as demonstrate the context-specific nature of PAPD-associated behaviors. Obstacles to treatment related to environmental influences will also be discussed.

2 Case Presentation

Ms. X was a 48-year-old White woman who was divorced and lived with her two daughters of age 22 and 19.[1] Her 15-year-old son lived with her ex-husband. Ms. X earned her high school diploma and worked as a secretary. She strongly identified with the Protestant religion.

3 Presenting Complaints

Ms. X reported that she was seeking treatment primarily in accordance with a mandate from work that she seek counseling after being reprimanded for time and attendance problems; however, she indicated that she also desired to seek treatment for her depressed mood. She explained that her depressive symptoms began 10 weeks before presenting for treatment, soon after she received a letter of reprimand from her supervisor regarding time and attendance problems. She indicated that she had been taking time off from work to see her psychiatrist and to bring her daughters to doctor appointments. Although Ms. X initially noted that her behavior was justified and that she followed appropriate work protocol (i.e., notifying supervisor of reason for tardiness), she later admitted that her absences were excessive and evidence presented in the reprimand document supported this contention. Despite this, she argued that her behavior was not comparatively worse than her coworkers' and felt betrayed that she was "singled out" for her behavior.

As a consequence of the reprimand, Ms. X reported experiencing increasing difficulties with her supervisor and office manager. She complained that her supervisor and office manager were disproportionally scrutinizing whether she adhered to work rules, and that she was being held to unfair standards and denied certain freedoms (e.g., socializing, coffee breaks) compared to her coworkers. In addition, Ms. X reported that her work responsibilities were significantly reduced following an officewide reorganization and that the combination of being scrutinized and having less work left her feeling incompetent, inadequate, and constantly questioning herself. Ms. X explained that in response to the reprimand she decided to discontinue appointments with her psychiatrist and was not able to properly taper off her antidepressant medication. Ms. X believed that this abrupt discontinuation of medication contributed to an acute depressive episode.

4 History

Ms. X grew up with her parents and her three brothers. Though she did not report any significant difficulties in her childhood, she alluded to a childhood that was emotionally neglectful as her family did not openly communicate with each other or show physical affection. She also indicated that her parents were argumentative with each other and that her father was emotionally abusive and controlling with her mother. Though Ms. X was married for 18 years, she reported having an emotionally abusive marital relationship similar to that of her parents (e.g., excessive criticism, ignoring her needs), making it difficult for effective communication. After 14 years of marriage, she filed a court order against her husband for emotional abuse, hoping it would lead to positive changes within their relationship. Instead, her husband reacted in a more abusive manner, and 4 years later they divorced due to mutual dissatisfaction with the marriage. Ms. X neither reported having close friends with whom she socialized nor was she very close with her extended family.

Ms. X first saw a psychiatrist in response to the depression she experienced when beginning the divorce proceedings with her ex-husband. She abruptly discontinued antidepressant medication in response to her mandate (she refused to reschedule her doctor's appointments to after-work hours and therefore had to stop taking her medication); however, within 2 weeks she resumed her medication and had since continued taking it. Ms. X reported that her only other experience with therapy was during the final year of her marriage when she saw a marriage counselor. Ms. X attended individually and discontinued after 1 year because her husband refused to attend.

5 Assessment

On the basis of the Structured Clinical Interview for *DSM-IV* Axis I, Clinician Version (SCID-I; First, Spitzer, Gibbon, & Williams, 1997), Ms. X met criteria for MDD, recurrent. At the time of assessment, Ms. X reported experiencing sad mood, anhedonia, poor appetite, weight loss, trouble sleeping, feelings of worthlessness and guilt, trouble concentrating, psychomotor retardation, and fatigue. She indicated that she had been experiencing these symptoms for the past 2 months and reported having had four separate major depressive episodes in the past, all of which occurred following the termination of relationships (e.g., death of friend, parents' divorce, divorce from ex-husband, breakup with boyfriend). Ms. X's average depressive symptom severity across two intake sessions on the Beck Depression Inventory-II (BDI; Beck, Steer, & Brown, 1996) was consistent with a diagnosis of MDD (BDI = 31). Ms. X also endorsed numerous symptoms of anxiety, including increased irritability, muscle tension, and restlessness, although she indicated that these symptoms co-occurred with her depressive symptoms. She denied any current or past suicidal or homicidal ideation.

Ms. X's personality profile according to the Minnesota Multiphasic Personality Inventory–Revised Edition (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) was a Spike 2 code type (Scale 2: $T = 77$), consistent with a diagnosis of MDD as individuals who respond in this manner report experiencing several depressive symptoms including sad mood and somatic complaints as well as low self-confidence and moodiness.

Though features of PAPD were partially present during the initial assessment and treatment sessions, several traits consistent with the criteria for PAPD (according to the *DSM-IV-TR*) became grossly apparent soon after Ms. X's acute major depressive episode subsided. These traits included passive resistance to complete work assignments or tasks (e.g., purposefully failing to hand in timesheets), unreasonable criticism of her supervisor and office manager (e.g., describing her office manager as too "pushy" and too controlling of her supervisor), complaints of work not being appreciated by coworkers or supervisors (e.g., stating how she consistently "gets her job done" and is yet given unsatisfactory evaluations), frequent argumentativeness with supervisor and ex-husband, enviousness toward her coworker (e.g., feeling resentment that her coworker was receiving praise for her accomplishments when she was not), and alternations between angry resistance to authority and regret for outbursts (e.g., yelling at her supervisor and making inappropriate comments followed by apologies). However, Ms. X failed to identify with a passive-aggressive behavioral style when given the communication styles worksheet from *The Assertiveness Workbook* (Patterson, 2000), and she denied meeting the specific criteria for PAPD when probed. Thus, a diagnosis of PAPD was deferred.

6 Case Conceptualization

Cognitive therapy (Beck, 1967; Beck et al., 2004; Beck, Rush, Shaw, & Emery, 1979) is an empirically validated treatment for depression that is widely used and has been adapted successfully for several disorders (e.g., Butler, Chapman, Forman, & Beck, 2006; Chambless et al., 1996, 1998; DeRubeis & Crits-Christoph, 1998). Cognitive therapy is based on Beck's (1967) and Beck et al. (1979) cognitive model which suggests that maladaptive schemas that include dysfunctional core beliefs distort one's perception and trigger erroneous automatic thoughts. These automatic thoughts generate negative affect and maladaptive behaviors. The core beliefs underlying a disorder are thought to be deeply ingrained and relate to the self, the world, and the future. Thus, treatment focuses on modifying underlying maladaptive beliefs and distorted automatic thoughts.

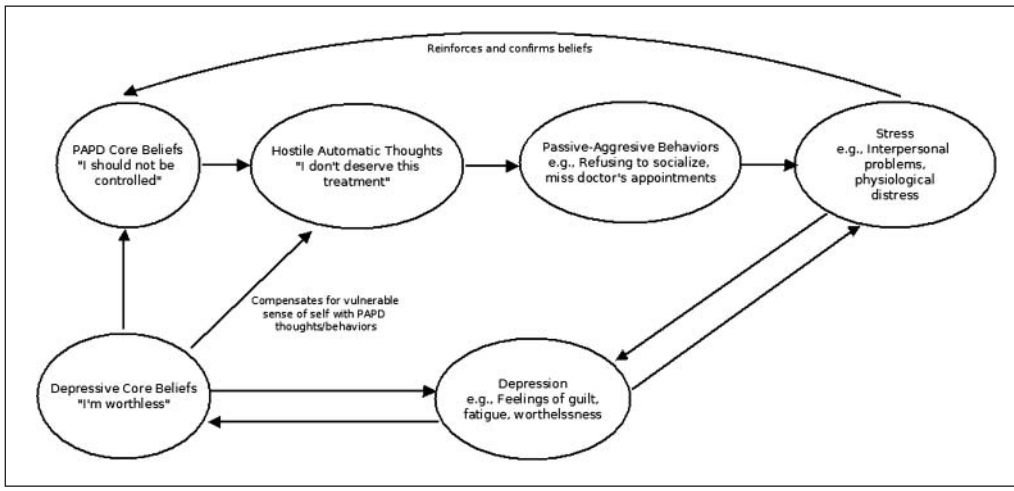

Figure 1. Diagram illustrating the relationship between passive-aggressive beliefs and behaviors, stress, and depression
Note: PAPD = passive-aggressive personality disorder.

It is hypothesized that Ms. X may have developed core beliefs related to PAPD and depression due to early childhood experiences. Her parents' "hands-off" parenting style may have contributed to negative core beliefs such as "I'm unwanted" and "I'm not good enough." Simultaneously, her parents' lack of involvement may have also left Ms. X unaccustomed to, and unaccepting of, any type of controlling or demanding behavior, leading to PAPD-related core beliefs, including "I should not be told what to do" and "rules will constrain me." One possibility is that the PAPD-related core beliefs formed as a defensive response to her negative depressogenic core beliefs; that is, to defend against beliefs that she does not deserve to be loved or is deficient, the client developed protective counteractive beliefs suggesting that she deserves special treatment (e.g., "Others should not question me") and that deflect a sense of deficiency from self to others (e.g., "I can't depend on anyone because they are untrustworthy").

Although these PAPD-related beliefs may serve the function of deactivating or countering depressogenic core beliefs, their effect on behavior, cognition, and the environment may ultimately activate the very depressogenic beliefs the client was attempting to subvert. According to the cognitive model, PAPD core beliefs activate hostile automatic thoughts in response to daily situations. These passive-aggressive thoughts may lead the individual to generate life stress through their negative interactions with others and their environment, which ultimately may trigger depression and the activation of depressogenic core beliefs (see Figure 1). For example, Ms. X reported that a new office manager within the company was "too controlling" and unfairly scrutinizing Ms. X. As a result, Ms. X experienced thoughts such as "I have no rights" and "I don't deserve to be treated this way." She indicated that these thoughts made her resentful and influenced her decision to no longer socialize with friends at work and to stop attending psychiatrist visits. These two factors in turn directly contributed to her depressive episode as she experienced a reduction in social support, increased beliefs of low self-worth and self-efficacy, and increased physiological distress due to her abrupt discontinuation of antidepressant medications.

Originally, passive-aggressive core beliefs may have developed in response to the development of depressive core beliefs. These passive-aggressive core beliefs may remain active as a defense against reverting back to depressogenic thinking. In response to daily situations, the

passive-aggressive core beliefs may activate hostile automatic thoughts, which in turn may lead to passive-aggressive behaviors that cause stress. The activation of stress may lead to the experience of depression as well as reinforce latent passive-aggressive core beliefs. Depressive symptoms in turn may generate additional stress as well as reinforce depressive core beliefs. The activation of core beliefs may once again activate the cycle through defensive passive-aggressive thoughts and behaviors.

Treatment Plan

As Ms. X's primary complaint was her depressed mood, her initial treatment plan focused on targeting the maladaptive automatic thoughts and core beliefs influencing her negative mood and maladaptive behaviors using cognitive therapy. She would be taught to recognize and monitor her cognitions, particularly when experiencing an increase of negative effect. Once automatic thoughts were identified, treatment would focus on examining the validity of the thoughts and labeling possible cognitive distortions. Treatment would then progress to identifying faulty assumptions and core beliefs and applying similar cognitive restructuring techniques. To help Ms. X understand the relationship between her thoughts and her behaviors, activity monitoring would also be assigned. Once this connection had been established, treatment would focus on changing the maladaptive behaviors that maintain her depression and begin incorporating behaviors that are pleasurable and adaptive (e.g., activating her to leave her bed and engage in more socializing activities).

Three months into the treatment, when Ms. X's depressive symptoms had subsided, her PAPD traits became readily apparent. Therefore, the treatment plan shifted from cognitive therapy for depression to cognitive therapy for PAPD (Beck et al., 2004), which is similar in structure to cognitive therapy for depression in that dysfunctional passive-aggressive thoughts and assumptions are monitored and identified, thoughts are then labeled as cognitive distortions and modified through cognitive restructuring, and finally the cognitive schema and core beliefs are restructured. By identifying these cognitive distortions, it is suggested that changes in affect and behavior would occur, specifically a reduction in anger and passive-aggressive behavior. To assist with the modification of passive-aggressive cognitions, self-monitoring would be used to identify maladaptive thoughts and to demonstrate their effect on problematic behavior patterns and acerbic affect. Other specific techniques would be incorporated to assist with emotional management and expression, including assertiveness training, anger management, and social skills and communication training.

7 Complicating Factors

Mandated Treatment

Ms. X was mandated by her employer to receive psychological treatment as a result of her time and attendance problems at work. Mandated treatment suggests that Ms. X lacked intrinsic motivation to attend therapy, a potential barrier to successful treatment progress and outcome. Clients who are mandated to treatment are generally more resistant to treatment and have less motivation to change, leading to several problematic treatment behaviors such as failure to complete homework assignments, showing up late to sessions or not at all showing up, excessive argumentativeness with the therapist, and failure to form a strong therapeutic alliance (Snyder & Anderson, 2009). To address these concerns, treatment collaboration was emphasized to assist the client to become involved and invested in treatment. Specifically, the client's feedback was consistently solicited and active listening techniques used to engage the client and elicit cooperation. These

techniques proved effective. Initially, Ms. X was reluctant to engage in treatment and complete homework assignments, but after the initial assessment and treatment sessions, she indicated that she enjoyed "having someone who really listened" to her concerns and she increased her engagement in treatment.

Passive-Aggressive Personality Pathology

The transient nature of PAPD made it difficult to officially diagnose the client with a personality disorder. Ms. X's PAPD-associated behaviors presented themselves in context-specific situations, specifically in interactions with individuals whom she perceived as controlling, overbearing, and inflexible (e.g., her ex-husband, office manager, and supervisor). Therefore, it was necessary to conduct a functional analysis of her passive-aggressive behavior (e.g., track her daily activities paying special attention to situations where her behaviors could be defined as passive-aggressive and resulted in emotions of anger and frustration) and relegate cognitive therapy to specific situations that would trigger her PAPD-associated behaviors. This inability to apply PAPD-related cognitive techniques to all situations meant that a necessary component of treatment was to teach the client to monitor the specific situations where PAPD-associated behaviors were problematic and to practice cognitive techniques when those circumstances arose.

8 Course of Treatment and Assessment of Progress

Beginning Sessions: Cognitive Therapy for Depression (Sessions 1 to 10)

Initial treatment with Ms. X began with cognitive therapy for her depression. Goals for treatment were to decrease her depressive symptoms, increase mastery of her work performance, and increase positive activities. Therefore, treatment began with a functional analysis of Ms. X's activities where she was asked to track her activities and rate her mood as a result of each activity (Sessions 1-2). As a result, Ms. X was able to recognize the effect her decreased social behavior had on her mood at work, and she quickly reengaged in socializing activities. Initially, Ms. X failed to complete her homework assignments to go for walks and attend bible study classes, giving excuses such as it being too cold outside or not having time. However, she was able to acknowledge that these were excuses that reflected her ambivalence, and after a discussion of the benefit of performing these activities, she eventually successfully engaged in them. In addition, Ms. X began to socialize at work and engage in her work duties. As a result of her increased activation, Ms. X reported an improvement in her mood and greater satisfaction with herself.

In addition to the functional analysis, Ms. X was introduced to the cognitive model of depression and educated about her depression (Session 2). She was taught the relationship between her emotions and thoughts and learned how to identify them. Ms. X began to monitor her thoughts, the majority of which were related to the core beliefs of "I'm useless" and "I'm incompetent." In addition, she catastrophized about the welfare of her daughters and ruminated about beliefs that she was being excluded at work. Though she was successful at identifying possible distortions in her thoughts, she had difficulty restructuring her thoughts into alternative interpretations. Regardless, as the initial sessions progressed (Sessions 3-10), she improved her ability to recognize her distorted thought processes and, though she required assistance, was able to successfully restructure her distorted cognitions when they occurred.

Between her second and third treatment sessions, Ms. X demonstrated a significant improvement in her mood with a 19-point drop in her BDI score (from 31 to 12) and a 4-point drop in her Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988; from 8 to 4), and another dramatic decrease in BDI (8 points) and BAI (2 points) scores between her third and fourth

treatment sessions. Given this dramatic and quick drop in depression and anxiety symptoms, it is possible that her improvements were unrelated to treatment; however, Ms. X independently commented that her increased engagement in work and socializing with coworkers caused an improvement in her mood, and that understanding the effect her cognitions had on her mood helped her to change the way she felt about herself. As cognitive therapy for her depression progressed (Sessions 6-10), her depressive symptoms remained low (BDI scores ranged between 1 and 2). However, as Ms. X's depressive symptoms subsided, she increasingly complained of problems at work. Ms. X reported being frequently late for work, but she did not see it as a problem despite having been reprimanded for it in the past. She also indicated that a fellow coworker whom Ms. X had trained began getting recognition and attention that she once received and expressed resentment that she was required to seek assistance from this individual when she felt she could handle the work independently. In addition, she reported a confrontation with her supervisor where she acted inappropriately because her behavior was questioned and she felt she was being controlled. The combination of her personality pathology becoming more problematic and our conceptualization that Ms. X's PAPD-associated behaviors would put her at risk for relapse into depression indicated that treatment should shift to focus on her personality-related pathology.

Middle Sessions: Initial Treatment of Cognitive Therapy for PAPD (Sessions 11 to 40)

At this point, Ms. X and her therapist mutually agreed that treatment would shift to focus on her PAPD symptomatology. The goal of treatment was to increase assertive and appropriate behaviors and cognitions, and decrease passive-aggressive tendencies. Ms. X was introduced to the difference between passive, aggressive, assertive, and passive-aggressive behavioral styles, and though she failed to recognize her own behavior as passive-aggressive, she eventually endorsed several passive-aggressive traits (e.g., fearing authority, having resentment toward others, unexpressed anger, failing to follow rules). The cognitive model for PAPD was introduced, highlighting her tendency to make assumptions without evidence for her beliefs. To assist her in recognizing passive-aggressive beliefs, Ms. X continued to monitor her automatic thoughts in response to emotions such as anger or frustration. Due to the difficulty she had with restructuring her beliefs, she was given the homework assignment to ask the opinions of others for their interpretation of events and why they interpreted things as such; in addition, she was asked to bring emails and copies of correspondences into treatment sessions to objectively reread them and highlight any misinterpretations she might be making. This evidence also helped the therapist to determine the extent to which the complaints were exaggerated and the result of her distorted perception. Although direct communication would have allowed a test of her cognitive distortions, Ms. X refused to confront or communicate with others citing excuses such as "it wouldn't matter" or "I don't trust them or what they say." Regardless, due to the continued questioning of beliefs in session, Ms. X eventually became accustomed to recognize that her beliefs may be inaccurate and would often begin a discussion of her interpretations with the statement, "I know I may be making an assumption, but. . . ."

In addition to a direct examination of her distorted cognitions and beliefs, Ms. X was taught to understand the effect that her distorted passive-aggressive cognitions had on her behavior. For example, Ms. X refused to take notes at a meeting, stating that she believed it was "stupid." After identifying beliefs such as "being told what to do means I'm being controlled," she was able to recognize that her belief was inaccurate and that her resulting behavior was inappropriate and was likely to lead to a confrontation with her supervisor. Ms. X also was taught the effect that her cognitions had on her emotions, specifically the emotion of anger. She discussed how her early childhood beliefs that her feelings were not validated often led her to have angry outbursts and through cognitive restructuring was able to see that others were not always trying to invalidate her feelings.

Once Ms. X was able to successfully apply the cognitive techniques to her distorted passive-aggressive cognitions, the focus of therapy switched to training in skills to further reduce passive-aggressive behaviors. These included communication and interpersonal skills training, assertiveness training, and anger management. Anger management skills were first introduced, as Ms. X admitted to frequently experiencing frustration and anger during confrontations or in response to cognitions. Therefore, Ms. X was given several techniques to assist her control her anger, including breathing and relaxation techniques, counting, distraction, and self-soothing statements. Once Ms. X learned how to effectively control her angry emotions, she was taught assertiveness skills. Ms. X was continually challenged to openly communicate her emotions and express herself. Though initially she could only directly communicate through emails and letters, she eventually became more confident and through the practice of role-playing was able to directly discuss problems with others. Communication and interpersonal skills were also taught such that Ms. X learned how to appropriately express her emotions using "I" statements (e.g., saying "I feel that I may be able to figure this out on my own" instead of "you don't need to tell me what to do") and how to recognize and avoid the use of certain words that could offend others (e.g., calling things "stupid" or using extreme statements like "you never/always do this").

After having progressed through all the skills training, Ms. X reported having only occasional minor difficulties at work for several months in a row. Ms. X's depressive and anxious symptoms continued to be assessed, with little change in her low BDI and BAI scores.

Later Sessions: Continued Cognitive Therapy for PAPD (Sessions 41-90)

After a period of infrequent passive-aggressive behavior, Ms. X reverted into old passive-aggressive behavioral patterns starting with the filing of a grievance against her office manager. Ms. X indicated that she was upset that her office manager was reviewing her time sheets and questioning her lunch hours. Though Ms. X admitted that she had inconsistently taken time for lunch, she explained that she was doing it purposefully to demonstrate that she was being "watched." Ms. X refused to directly discuss the issue with her office manager, being deterred due to both a failed previous attempt and the belief that she would be "treated like an idiot." Despite a thorough discussion regarding possibly distorted thinking and negative consequences for her behavior, Ms. X filed the grievance, as she felt that doing otherwise would be "backing down." After the grievance hearing, Ms. X was partially rewarded for her behavior as her office manager agreed to allow Ms. X's supervisor to deal directly with Ms. X. However, Ms. X was required to forfeit a pay raise as a result of her behavior.

Soon after, Ms. X reported inappropriately "blowing up" several times at her supervisor and coworkers as well as failing to follow rules with regards to appropriate office procedures. Eventually, Ms. X was given a work performance evaluation that negatively assessed her personality and professional conduct. Ms. X refused to directly discuss her concerns with her supervisor, stating that she did not trust her and was afraid of her. Ms. X filed another grievance against her office manager and supervisor, and though she agreed that the grievance may be an act of revenge, she denied conscious awareness of acting for that purpose. Though Ms. X's behavior was positively reinforced as she felt that her opinion was successfully heard at the grievance hearing, she also experienced a negative consequence: her office manager noticed that she took too many notes and printed too many emails which Ms. X was using as evidence for grievance hearings. Thus, Ms. X was given directives to refrain from printing and copying unless given permission to do so. Ms. X continually ignored this directive due to it being "stupid," leading to two notices of discipline being written. Due to the sudden increase in passive-aggressive thoughts and behaviors, Ms. X's treatment focused on the harm that her cognitions were having on her and her work environment, specifically her core beliefs regarding the need to break rules to remain satisfied at her job and that "if they just left me alone I'd be fine." Ms. X was shown how her

behavior affected other coworkers around her, as she increasingly had days when her coworkers clearly avoided her and refused to speak to her. In addition, a discussion regarding the purpose of following the rules and how it would benefit her and help her meet her goals (e.g., office manager would stay away) was continually brought up as well as the possibility that she could lose her job. These techniques in combination with being reprimanded for not following her directives resulted in Ms. X once again reducing her passive-aggressive behavior.

Individuals with personality pathology may require protracted treatment to successfully address the problem (Beck et al., 2004). Therefore, Ms. X continues to attend treatment sessions despite no longer being mandated to do so. As her office manager was eventually removed from her position, current treatment sessions focus on how to prevent the same behavior and cognitive problems with a new office manager as well as with her ex-husband. Her BDI scores have remained low (range = 0-2), which perhaps is a reflection of the effect of treatment on her personality pathology and the less stress she experiences on a daily basis as a result.

9 Managed Care Considerations

Ms. X's treatment was provided through an outpatient clinic with a sliding-scale fee. Therefore, no managed care issues were raised as a result of her treatment.

10 Follow-Up

Ms. X is currently still undergoing treatment. Thus, follow-up is not applicable.

11 Treatment Implications of the Case

Compared with other personality disorders, little research has been conducted on the construct of PAPD and treatment of the disorder. Though this dearth may be related to the controversy over the validity of the diagnosis (Fine, Overholser, & Berkoff, 1992), this is little consolation to the 52% of treating clinicians who, according to a national survey, reported seeing a client with PAPD (Westen, 1997). Thus, though PAPD is currently not a formal personality disorder according to the *DSM-IV-TR*, clinicians are frequently faced with this disorder and its associated behaviors with little precedence on how to treat it. Adding to the treatment issues of PAPD pathology is the fact that it is often co-occurring with Axis I pathology such as depression (Bagby et al., 2008) and may be difficult to detect when initially presented with depressive symptoms. Implications for treatment of the client are significant, as PAPD-associated behaviors may interfere with the effective treatment of depression and act as a diathesis for future depressive episodes.

Several potential problems could have prevented successful treatment of Ms. X's depression and co-occurring personality pathology. Her presentation as a mandated client initially contributed to her lack of engagement in treatment; however, the use of collaborative techniques suggests that these issues do not need to interfere with the success of treatment when addressed appropriately. In addition, perhaps as a result of addressing the PAPD-associated symptomatology, the client did not experience a relapse of her depressive symptomatology despite previous recurrent episodes; this case highlights the importance of addressing underlying personality pathology to prevent future depressive relapses. Furthermore, it became evident that the client's social-occupational environment played a significant role in the reemerging of her PAPD tendencies. Ms. X's attempts at direct assertive communication were at times ineffective and negative,

making it difficult to convince her of the benefits of direct communication. In addition, her passive-aggressive attempts were often rewarded as she received the response she was seeking without having to risk direct confrontation. This made it difficult to challenge and alter the client's dysfunctional beliefs. This case points to the prominent role that the social environment can play in the maintenance of PAPD pathology and suggests that cognitive therapy needs to pay particular attention to the influence of these factors in the treatment of personality pathology.

12 Recommendations to Clinicians and Students

This case highlights the importance of identifying and treating personality pathology co-occurring with depression. Although some research has suggested that the assessment of personality during acute episodes is not effective (e.g., Hirschfeld et al., 1983), a recent study (Morey et al., 2010) contradicts this notion. Given the importance of personality dysfunction as a potential impediment to treatment and its role in case conceptualization, it would be prudent to conduct a thorough assessment before the start of treatment using an instrument with diagnostic capabilities such as the Schedule for Nonadaptive and Adaptive Personality, Second Edition (SNAP-2; Clark, Simms, Wu, & Casillas, IN PRESS).

An additional assessment issue with clients who present with PAPD is the absence of appropriate measures to assess ongoing treatment success and outcome. Ms. X's treatment progress was continually monitored using the BDI and BAI. Though these measures were successful at monitoring symptoms during her depressive episode, they were largely uninformative during the treatment of her PAPD-associated behaviors. Several alternative self-report measures might have been more appropriate given her personality pathology. These include measures that assess emotions related to anger (e.g., how frequently during the week did the person become angry, how strong was the anger), the frequency of certain behaviors (e.g., checking off how often assertive and/or passive communication occurs on a daily basis, how often rules are followed or broken, or how many arguments the individual has in a week), and the strength of passive-aggressive beliefs (e.g., rate how strongly they believe that they are being misunderstood or controlled by others, that others are more fortunate than them, or that they do not need to follow the rules).

The role that specific contextual environmental factors play in the presence of PAPD pathology require that the clinician pay particular attention to whether PAPD-associated behaviors are truly a result of personality pathology or a myopic reaction to a dysfunctional environment. One way in which this may be differentiated is to ask the client to bring objective evidence into the session. Ms. X was asked to bring in copies of emails and performance letters, and was asked to ascertain the reactions from other coworkers to help the clinician determine whether the client's perception of the situation was accurate or distorted due to personality pathology. This proved to be instrumental in her treatment and helped the clinician recognize the role that the environment played in her problematic behaviors.

Although the formation of a strong therapeutic alliance is a key component of successful treatment across different presenting problems (Horvath & Luborsky, 1993), it may be even more important and potentially challenging in the case of personality pathology, such as PAPD (Beck et al., 2004). Ms. X presented with two possible barriers in forming a strong therapeutic alliance before treatment: (a) She was mandated to seek treatment, thus lacking intrinsic motivation to attend and (b) treatment could provide a venue for playing out passive-aggressive beliefs given her problems with authority figures and resentment over feeling controlled. Contrary to expectations, Ms. X did not resist treatment and instead appeared to genuinely be engaged and enthusiastic. Factors that may have contributed to the formation of a strong and positive therapeutic alliance included the therapist's genuine and positive regard for the client, the full collaboration with the client throughout the treatment, the therapist's use of caution when confronting

the client about her passive-aggressive traits, the use of active listening skills, and the frequent validation of the client's feelings.

Overall, the current case highlights the challenges inherent in treating clients with comorbid Axis I and Axis II pathology, and the importance of focusing on personality pathology if future depressive episodes are to be prevented. The case also points to the interplay between conflicting sets of cores beliefs (e.g., worthlessness and entitlement) and how they can lead to the generation of stress, which in turn reinforces the maladaptive beliefs and triggers depressive episodes.

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Note

1. To protect the privacy of the client described in this report, all identifying information and certain descriptive details have been changed.

Bios

Paula K. Yanes, MA, is a 5th-year graduate student working toward her PhD in clinical psychology at the University at Buffalo, the State University of New York. Her research interests include affect regulation and avoidant coping responses (e.g., overgeneral autobiographical memory), and their relationship with depression.

Stephen T. Tiffany, PhD, is a professor in the Department of Psychology at the University at Buffalo, the State University of New York, where he is the director of clinical training and head of the Clinical Psychology Program. He holds an Empire Innovation Distinguished Professorship at the University at Buffalo. He conducts research on drug craving, the causes of drug dependence, the diagnosis of dependence, adolescent

drug use, and the interaction of biological and psychological factors in the control of addictive behaviors. He was awarded the American Psychological Association Distinguished Scientific Award for early career contribution to psychology in 1993. He is on the editorial boards of several journals, including *Experimental and Clinical Psychopharmacology*, *Journal of Abnormal Psychology*, *Nicotine & Tobacco Research*, and *Psychological Science*. He has served on several National Institutes of Health (NIH) scientific review panels and has received numerous research grants from NIH and national foundations.

John E. Roberts, PhD, is an associate professor in the Department of Psychology at the University at Buffalo, the State University of New York. He received his doctoral degree from the University of Pittsburgh and his research interests lie in the role of psychosocial factors in the onset and course of depression and health-related behavior among HIV+ individuals. He is an associate editor of *Cognition & Emotion* and *Cognitive Therapy and Research*, and he serves on the editorial boards of *Personality and Individual Differences* and *AIDS Patient Care and STDs*.