DEPENDENT PERSONALITY DISORDER

Some people are overly dependent, unable to make decisions on their own, needing frequent advice and reassurance, and alienating those around them with neediness and clinging insecurity. Studies show that when dependent personality traits become rigid and inflexible they can have myriad negative effects on social and occupational functioning (Bornstein, 1993, 2005). When dependency is both intense and pervasive, adversely affecting many different aspects of a person's life, it may indicate the presence of dependent personality disorder (DPD).

Evolution of the DPD Diagnosis

Because excessive dependency has pronounced negative effects on adjustment, problematic dependency has been formally recognized in virtually every modern diagnostic system. The most influential early conception of problematic dependency was Freud's (1905) psychosexual stage model, which contended that infants who are frustrated or overgratified during the oral phase of development (the first 6–12 months of life) will become orally fixated, develop an oral dependent character, and continue to show excessive dependency as well as a preoccupation with food, eating, and other oral activities during adulthood.

Although research did not support most aspects of Freud's oral fixation framework, his writings had a strong influence on the DSM-I conceptualization of dependency (Millon, 1996). In the DSM-I DPD was labeled *passive-dependent personality disorder*, and passive-dependent patients were described as being helpless, indecisive, and clinging to others in a childlike way. There was no mention of DPD in the DSM-II, but when the disorder reemerged in the DSM-III it was shorn of its psychoanalytic roots and described in terms of three broad symptoms: (1) pervasive passivity; (2) a tendency to subordinate personal needs to those of others; and (3) lack of self-confidence. The DSM-III-R DPD criteria, though more detailed, continued to emphasize the dependent patient's passivity, external focus, and difficulties with self-esteem and self-confidence.

DPD in the DSM-IV

The essential feature of DPD in the DSM-IV and DSM-IV-TR is "a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation" (American Psychiatric Assoction [APA], 2000, p. 725), which must be present by early adulthood and manifest in a variety of areas. In addition, to receive a diagnosis of DPD the person must show at least five of the following eight symptoms: (1) difficulty making everyday decisions without excessive reassurance; (2) needing others to assume responsibility for most areas of life; (3) difficulty expressing disagreement; (4) difficulty initiating projects or doing things on one's own; (5) going to excessive lengths to obtain nurturance and support from others; (6) feeling uncomfortable when alone due to fears of being unable to care for oneself; (7) urgently seeking another source of care and support when a close relationship ends; and (8) being preoccupied with fears of having to take care of oneself.

In addition to the essential criterion and eight DPD symptoms, the DSM-IV-TR lists several differential diagnoses—psychological disorders whose symptoms resemble DPD closely enough that the clinician is alerted to possible confusion and misdiagnosis. Differential diagnoses for DPD on Axis I include mood disorders, panic disorder, and agoraphobia; differential diagnoses on Axis II are borderline personality disorder (PD), histrionic PD, and avoidant PD.

The DSM-IV-TR is a bit vague regarding the prevalence rate of DPD, noting only that it is "among the most frequently reported Personality Disorders encountered in mental health settings" (APA, 2000, p. 723). Epidemiological studies suggest that the overall base rate of DPD in the adult population in America is between 1% and 2%, with the prevalence rates of DPD in psychiatric inpatient and outpatient populations averaging 3%–5% and 5%–10%, respectively. These latter prevalence rate estimates vary considerably from sample to sample, however, ranging from a low of 0% in some clinical samples to 20% or more in others (see Bornstein, 2005, for a review of these studies).

Findings regarding gender and cultural differences in DPD are more consistent. Overall the base rate of DPD in women exceeds that in men by about 50% (in other words, for every two men diagnosed with DPD three women receive the diagnosis). Studies further indicate that the base rate of DPD symptoms in people from traditionally sociocentric cultures (e.g., Japan, India) are far higher than that in people raised in more individualistic societies (e.g., America, Great Britain).

Limitations of DSM-IV DPD Diagnoses

Studies indicate that high levels of interpersonal dependency are associated with a broad array of traits and behavior patterns including help-seeking, cooperativeness, compliance with medical and psychiatric treatment, a strong desire to strengthen ties with others (especially figures of authority), fear of abandonment, and acute sensitivity to interpersonal conflict and disruption (see Bornstein, 1993, 2005, for reviews). As Bornstein (1997) noted, the diagnostic criteria for DPD in the DSM-IV, although more consistent with research on dependency than were the DPD criteria in earlier versions of the manual, are limited in at least three respects.

The Passivity Problem

The DSM-IV DPD criteria focus almost exclusively on the passive, helpless features of dependency, but research

The Corsini Encyclopedia of Psychology, edited by Irving B. Weiner and W. Edward Craighead.

shows that dependent people—including people with DPD—can be quite assertive (even downright aggressive) in strengthening ties to others when important relationships are threatened (Pincus & Wilson, 2001). Among the active features of dependency not captured by these criteria are assertive help-seeking in academic and medical settings, frequent pseudo-emergencies (e.g., requests for after-hours therapy sessions), and increased likelihood of perpetrating child abuse (in women) and domestic violence (in men).

The External Validity Problem

The DSM-IV DPD criteria are problematic from a validity standpoint as well. Of these eight diagnostic criteria, four (Symptoms 1, 5, 6, and 8) are supported by the results of published empirical studies, two (Symptoms 2 and 7) have never been tested empirically, and two (Symptoms 3 and 4) have been contradicted repeatedly. Research on the external validity of the DSM-IV DPD symptoms is reviewed by Bornstein (1997, 2005).

The Gender Bias Problem

The third limitation in the DSM-IV DPD criteria concerns the differential base rates of DPD in women and men. Numerous studies have shown that on measures wherein dependency is assessed primarily by self-report (e.g., interviews, questionnaires), women score higher than men do. However, when dependency is assessed via subtler measures that do not rely on self-reports (e.g., free-response tests like the Rorschach), women and men obtain comparable dependency scores (Bornstein, 1995). The degree to which observed gender differences in DPD prevalence rates may be due to overreporting of dependency in women, or underreporting in men, warrants continued investigation.

Relationship of DPD to Other Clinical Syndromes

Research in this area has focused on two issues: (1) the comorbidity (or co-occurrence) of DPD with other Axis I and Axis II diagnoses, and (2) the pathways underlying these observed relationships.

DPD-Axis I Comorbidity

The DSM-IV notes that DPD may be comorbid with three Axis I syndromes: mood disorders, anxiety disorders, and adjustment disorders. For the most part research supports these assertions, although evidence indicates that DPD is actually comorbid with some anxiety disorders (e.g., agoraphobia) but not others (e.g., generalized anxiety disorder; see Ng & Bornstein, 2005). Studies also suggest that the DPD Axis I comorbidity information in the DSM-IV may be underinclusive; in addition to the aforementioned syndromes DPD shows higher-than-expected co-occurrence with substance use disorders, eating disorders, and somatization disorder.

Documenting the comorbidity of DPD with other clinical syndromes is comparatively straightforward; delineating causal links—the underlying psychological and biological pathways that account for observed comorbidity patterns—is more complex. Three pathways appear to account for most (perhaps all) of these links. In some cases DPD represents a diathesis, or risk factor, that when coupled with one or more stressors, leads to the onset of an Axis I syndrome. Evidence suggests that this dynamic underlies the DPD–mood disorders link: When excessive dependency (diathesis) is coupled with relationship conflict or disruption (stressor), depression is likely to ensue (Bornstein, 2005). In other cases DPD and a co-occurring pathology reflect a common underlying factor, or hidden variable. For example, DPD and agoraphobia both stem in part from a view of oneself as helpless, vulnerable, and weak (Ng & Bornstein, 2005). Other DPD-pathology associations reflect a more indirect link. For example, observed associations between DPD and tobacco addiction appear to result from the dependent person's desire to please others and strengthen social ties, which renders them vulnerable to peer pressure during childhood and adolescence (Bornstein, 1993).

DPD-Axis II Comorbidity

Although the DSM-IV indicates that DPD is comorbid with only three Axis II PDs—borderline, histrionic, and avoidant—evidence confirms that DPD actually shows higher-than-expected associations with the majority of Axis II syndromes, including several that bear little resemblance to DPD, either dynamically or behaviorally (e.g., paranoid PD, obsessive-compulsive PD). Because these sorts of nonspecific comorbidity patterns have been found for other Axis II diagnoses as well, they may reflect a more generalized discriminant validity problem on Axis II (Ekselius, Lindstrom, Knorring, Bodlund, & Kullgren, 1994).

DPD across the Life Span

As questions regarding the epidemiology and comorbidity of DPD become resolved, researchers are increasingly examining the precursors of DPD, and the changing manifestations of DPD across the life span. Numerous studies have shown that two parenting styles (overprotective and authoritarian) play a role in the etiology of DPD, in part because these two parenting styles communicate to children that they are fragile and weak, and must look outward for guidance and support. In some instances overprotective and/or authoritarian parenting may be evoked by certain temperament-linked behaviors (e.g., easy startling, difficulty soothing) exhibited by infants and young children; twin and adoption studies indicate that about 30% of the variance in DPD symptom onset can be accounted for by genetic factors (Torgerson et al., 2000).

Because dependency and help-seeking are normative early in life, identifying the childhood precursors of DPD is difficult. Among the earliest behavioral manifestations of DPD are a pattern of insecure attachment, excessive clinginess around teachers, and increased incidence of school refusal. The transition to adulthood is characterized by a change in the objects (or targets) of dependency-related behavior; typically this entails a shift from dependency on parents and other authority figures (e.g., teachers) to exaggerated peer-group dependency, followed by a shift during early and middle adulthood from reliance on peers to dependency on romantic partners, colleagues, and supervisors at work (see Bornstein, 1993, 2005, for a review of relevant research).

There have been no well-controlled studies of DPD in later adulthood, in part because of the difficulty distinguishing excessive dependency from the expectable losses of normal aging. Studies consistently show an increase in functional (but not emotional) dependency during later adulthood, and some investigations suggest that as individuals with DPD age they may express dependency strivings in age-normative, indirect ways. Increases in somatic complaints, and cognitive impairment with no identifiable neurological cause (sometimes called *pseudodementia*) are common manifestations of DPD in later life.

DPD in the DSM-V

As the DPD diagnostic criteria are revised for the DSM-V, two issues warrant attention. First, greater attention must be paid to the active components of DPD, and to situational variability in dependency-related behavior. By doing this clinicians and researchers will capture more completely the range of maladaptive and adaptive behaviors associated with DPD, and can tailor intervention programs to minimizing dependency's problematic aspects (e.g., relationship stress, depression risk) while strengthening its more adaptive features (e.g., conscientiousness during medical and psychological treatment).

Increased focus on the psychological processes that underlie DPD is also needed. Research indicates that a perception of oneself as weak and ineffectual (sometimes called a "helpless self-concept") is central to the etiology and dynamics of DPD (Bornstein, 1996, 1997). This cognitive element of dependency is not present in the DSM-IV DPD essential feature or symptom criteria, however. Inclusion of the cognitive features of DPD would not only lead to more accurate diagnosis and less problematic comorbidity patterns, but would also provide a conceptual and empirical foundation for examining context-driven variations in dependency-related behavior.

REFERENCES

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Bornstein, R. F. (1993). *The dependent personality*. New York: Guilford Press.

Bornstein, R. F. (1995). Sex differences in objective and projective dependency tests: A meta-analytic review. *Assessment*, *2*, 319–331.

Bornstein, R. F. (1996). Beyond orality: Toward an object relations/interactionist reconceptualization of the etiology and dynamics of dependency. *Psychoanalytic Psychology*, *13*, 177–203.

Bornstein, R. F. (1997). Dependent personality disorder in the DSM-IV and beyond. *Clinical Psychology: Science and Practice*, *4*, 175–187.

Bornstein, R. F. (2005). *The dependent patient: A practitioner's guide*. Washington, DC: American Psychological Association.

Ekselius, L., Lindstrom, E., Knorring, L., Bodlund, O., & Kullgren, G. (1994). Comorbidity among personality disorders in DSM-III-R. *Personality and Individual Differences*, *17*, 155–160.

Freud, S. (1905). Three essays on the theory of sexuality. *SE 7*, (pp. 125–248). London: Hogarth.

Millon, T. (1996). *Disorders of personality: DSM-IV and beyond*. New York: John Wiley & Sons.

Ng, H. M., & Bornstein, R. F. (2005). Comorbidity of dependent personality disorder and anxiety disorders: A meta-analytic review. *Clinical Psychology: Science and Practice*, *12*, 395–406.

Pincus, A. L., & Wilson, K. R. (2001). Interpersonal variability in dependent behavior. *Journal of Personality*, *69*, 744–758.

Torgerson, S., Lygren, S., Oien, P. A., Skre, I., Onstad, S., Evdardsen, J., et al. (2000). A twin study of personality disorders. *Comprehensive Psychiatry*, *41*, 416–425.

SUGGESTED READINGS

Coen, S. J. (1982). *The misuse of persons: Analyzing pathological dependency*. Hillsdale, NJ: Analytic Press.

Huprich, S. K. (Ed.). (2006). *Rorschach assessment of the personality disorders*. Mahwah, NJ: Lawrence Erlbaum.

Pincus, A. L., & Gurtman, M. B. (1995). The three faces of interpersonal dependency: Structure analysis of self-report dependency measures. *Journal of Personality and Social Psychology*, *69*, 744–758.

Robert F. Bornstein
Adelphi University

See also: **Dependency; Personality Disorders**