CHAPTER 22

Dependent Personality Disorder

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WHAT IS DEPENDENT PERSONALITY DISORDER?

Dependent personality disorder (DPD) is a personality disorder wherein the individual exhibits longstanding, inflexible, excessive dependency, which leads to difficulties in social, sexual, and occupational functioning. According to the DSM-IV-TR, the essential feature of DPD is a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts (American Psychiatric Association, 2000). In addition to the essential feature, individuals with DPD have difficulties making everyday decisions without an excessive amount of advice and reassurance from others. They exhibit passivity and rely on others to assume responsibility for most major areas of life, such as living arrangements, career choices, and social relationships. Similarly, they have difficulties initiating projects or doing things on their own because they lack confidence in their judgment or abilities. Individuals with DPD have difficulties expressing disagreement because of a fear of loss of support or approval. Because of their perceived inability to function alone they will go to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant. This includes submitting to demands that are unreasonable and tolerating various forms of abuse. In general, individuals with DPD have exaggerated fears about being unable to care for themselves and are unrealistically preoccupied with being alone. Therefore, they feel uncomfortable or helpless when alone and urgently seek another relationship as a source of care and support upon the dissolution of a close relationship (American Psychiatric Association, 2000).

Clinicians and clinical researchers conceptualize DPD in terms of four related components:

- *Cognitive.* A perception of oneself as powerless and ineffectual, coupled with the belief that other people are comparatively powerful and potent.
- *Motivational.* A desire to obtain and maintain relationships with protectors and caregivers.
- *Behavioral.* A pattern of relationship-facilitating behavior designed to strengthen interpersonal ties and minimize the possibility of abandonment and rejection.
- *Emotional.* Fear of abandonment, fear of rejection, and anxiety regarding evaluation by figures of authority.

These four core features lead to a pattern of self-defeating interpersonal functioning characterized by insecurity, low self-esteem, jealousy, clinginess, help-seeking, frequent requests for reassurance, and intolerance of separation (Pincus & Gurtman, 1995; Overholser, 1996). Although different patients express underlying dependency strivings in different ways, it is important to note that some expressions of dependency can involve behavior that is active and assertive—even quite aggressive (Bornstein, 1995). Thus, the clinician must take care not to equate dependency

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with passivity, and recognize that DPD can be characterized by a variety of active relationship-facilitating behaviors.

BASIC FACTS ABOUT DPD

Comorbidity. Comorbidity studies in inpatients, outpatients, and community samples suggest that DPD is in fact associated with a broader range of Axis I and Axis II syndromes than the DSM-IV-TR acknowledges. On Axis I, DPD is comorbid with mood disorders, anxiety disorders, eating disorders, adjustment disorder, and somatization disorder. On Axis II, DPD co-occurs with the majority of other PDs, including some (e.g., antisocial and schizoid) that bear little resemblance to DPD (Bornstein, 2005). These Axis II comorbidity patterns likely reflect the generalized, nonspecific nature of personality pathology, and the fact that patients who show PD symptoms in one category often show PD symptoms from an array of other categories as well.

Prevalence. According to a recent survey of 43,093 Americans, 0.49% of adults meet diagnostic criteria for DPD (National Epidemiologic Survey on Alcohol and Related Conditions (NESARC; Grant et al., 2004).

Age at onset. Like other personality disorders, DPD traits emerge in childhood or early adulthood, however individuals with DPD may not come to clinical attention until later in life (American Psychiatric Association, 2000). Results from the NESARC study suggest that 18- to 29-year-olds have a significantly higher risk of having DPD (Grant et al., 2004).

Gender. The prevalence of DPD in women is 0.6% and 0.4% in men (Grant et al., 2004). Thus, women are somewhat more likely than men to receive a DPD diagnosis.

Course. No studies have documented the pathways through which genetics alter DPD risk, but it is likely that inherited infantile temperament differences (e.g., high reactivity and low soothability) are involved. Overprotective and authoritarian parenting, alone or in combination, foster problematic dependency in offspring (Bornstein, 1992). In terms of gender role socialization, high levels of femininity and low levels of masculinity are associated with increased likelihood of a DPD diagnosis. These patterns hold for both men and women, although causal links between gender role and DPD risk have not been established (Bornstein, 1992). Children or adolescents who suffer from chronic physical illness or Separation Anxiety Disorder may be at greater risk to developing DPD (American Psychiatric Association, 2000).

Similar to other personality disorders, DPD is pervasive and persistent. Symptoms are not limited to particular developmental stages or Axis I or III disorders, however, and can be exacerbated by important losses (American Psychiatric Association, 2000).

Impairment and other demographic characteristics. DPD is associated with impairment in occupational functioning if independent initiative is required (American Psychiatric Association, 2000). Interpersonal problems are common in individuals with DPD. These individuals tend to feel inferior to others and are introverted, shy, self-critical, and socially anxious, which interferes with effective social functioning (Overholser, 1996). They are at increased risk for depression if they lack the requisite social skills needed to develop and maintain interpersonal relationships (Bornstein, 1993). In general, individuals with DPD may be at increased risk for mood, anxiety, and adjustment disorders.

Results from the NESARC study found no differences in risk of DPD among the race–ethic groups of the population (Grant et al., 2004). However, studies of trait dependency suggest that dependency levels may be somewhat lower in African

American than Caucasian adults in the United States (Bornstein, 1997). It also appears that the risk of DPD is higher for lower income, less educated, widowed, divorced, separated, or never married individuals (Grant et al., 2004).

ASSESSMENT

What Should be Ruled Out?

The DSM-IV-TR alerts clinicians to the fact that DPD must be distinguished from several Axis I and Axis II syndromes that often create an overlapping symptom picture and similar surface presentation. Differential diagnoses on Axis I include mood disorders, panic disorder, agoraphobia, and dependency arising from one or more general medical conditions. Differential diagnoses on Axis II include borderline, histrionic, and avoidant personality disorders.

Loss of an important relationship can temporarily increase dependency as the individual adjusts to loss (Overholser, 1990, 1992). Clinicians should be careful to distinguish an adjustment reaction from true DPD, which is associated with persistent dependency needs in the absence of a particular trigger (Overholser, 1996). In assigning a DPD diagnosis, it is important that the clinician ascertain that the patient's dependency does in fact cause difficulties in social, sexual, or occupational functioning. Research shows that many persons with relatively intense dependency needs actually function quite well (Bornstein & Languirand, 2003). Thus, intensity alone is insufficient to assign a DPD diagnosis, but when dependency is both *intense* and *maladaptive*, diagnosis may be warranted. Additionally, DPD should only be diagnosed when dependent behaviors (e.g., deferential treatment, passivity, or politeness) are in excess of the individual's cultural norms (American Psychiatric Association, 2000). To diagnose DPD, or any personality disorder, in an individual under 18, the features must be present for at least one year (American Psychiatric Association, 2000).

What is Involved in Effective Assessment?

In diagnosing DPD clinicians should be guided by three principles: (1) dependency is not always characterized by passivity. Dependent patients use a variety of self-presentation strategies to curry favor with others and preclude abandonment; some of these strategies (e.g., intimidation and breakdown threats) are quite active. (2) Self-reports do not always give a true picture. Because dependency is typically seen as a sign of weakness and immaturity, many adults—especially men—are reluctant to acknowledge dependent thoughts and feelings even if they experience them. Obtaining concurrent information from knowledgeable informants can be helpful in this regard. (3) Dependency levels vary over time and across situations. Increases in depression are associated with temporary increases in self-reported dependency, and even modest mood changes may have some impact on dependency levels.

When formal assessment is warranted the clinician should evaluate DSM-IV-TR diagnostic criteria and administer a validated instrument for quantifying DPD symptoms. Construct validity data for widely used DPD assessment tools are provided by Birtchnell (1991) and Bornstein (1999). Most of these instruments fall into one of two categories: clinician-administered and self-report measures.

Clinician-administered measures. The major advantage of diagnosing DPD via interview is the opportunity to follow up and obtain additional detail; the main disadvantage is the modest interdiagnostician reliability frequently obtained when Axis II disorders (including DPD) are diagnosed via interview. In recent years three interviews have been used most often to quantify DPD symptoms and diagnoses:

(1) the Structured Clinical Interview for DSM Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997), (2) the International Personality Disorder Examination (IPDE; Loranger et al., 1994), and (3) the Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl, Blum, & Zimmerman).

Self-report measures. Although paper-and-pencil measures do not allow the diagnostician to probe and follow up, they are relatively inexpensive and efficient, and they circumvent interdiagnostician reliability problems that characterize structured interviews. Two self-report instruments that have been used most frequently to diagnose DPD in recent years are the Millon Clinical Muliaxial Inventory-III (MCMI-III; Millon, 1994) and the Personality Diagnostic Questionnaire-4+ (PDQ-4+; Hyler, 1994a,b).

The Dependent Personality Questionnaire (DPQ) has recently been developed as a brief screening measure for DPD (Tyrer, Morgan, & Cicchetti, 2004). A strength of the DPQ is that it consists of eight items and requires 5–10 minutes for patients to complete. An initial study demonstrated that the DPQ predicts the diagnosis of DPD with predicted positive and negative accuracies of 87% (Tyrer et al., 2004). Given the recent development of this measure, further psychometric evaluation using larger samples is needed.

Behavioral assessment. Although behavioral observation may provide information about the range of dependent behaviors manifest in various situations in vivo, there are several limitations to this method. Direct observation can be difficult to perform, is limited to certain settings, and only provides information about overt behavior (Bornstein, 1993). Although observation systems have been developed to assess dependent behaviors in children, there are no specific direct observation systems for DPD.

What Assessments are Not Helpful?

There are no biological tests for DPD. The Rorschach Oral Dependency scale (ROD; Masling, Rabie, & Blondheim, 1967) and the Interpersonal Dependency Inventory (IDI; Hirschfeld et al., 1977) are good measures of trait dependency, but are not as useful for assessing DPD (Bornstein, 1994; Bornstein, 1999; Loas, Verrier, Gayant, & Guelfi, 1998).

TREATMENT

Recommendations for treatment of problematic dependency have been offered by cognitive (Overholser & Fine, 1994), psychodynamic (Coen, 1992), behavioral (Turkat, 1990) and experiential (Schneider & May, 1995) clinicians. A detailed review of these treatment strategies is provided by Bornstein (2005).

What Treatments are Effective?

There is no specific treatment for DPD that has consistently shown to be effective in well-designed studies. DPD is often studied in the context of other Axis I disorders, such as mood and anxiety disorders. Investigations typically evaluate the efficacy of empirically supported treatments for an Axis I condition with co-occurring DPD.

What are Effective Self-Help Treatments?

Currently there are no empirically supported self-help treatments for DPD. However, there are a number of websites that provide information about DPD and related resources:

- http://mentalhelp.net/poc/ view_doc.php?type=doc&id=477&cn=8 (Mental Help Net)
- http://www.nmha.org/ infoctr/factsheets/91.cfm (National Mental Health Association)
- http://www.mental health.com/rx/p23-pe09.html (Internet Mental Health)

What are Effective Therapist-Based Treatments?

Given the extensive clinical literature surrounding treatment of dependent patients, it is surprising that no studies have examined the impact of psychotherapy on DPD symptoms in psychiatric inpatients. Two clinical trials have assessed the effectiveness of psychotherapy in ameliorating DPD symptoms in outpatients, but these investigations produced contrasting results. Rathus, Sanderson, Miller, & Wetzler (1995) used cognitive-behavioral techniques to treat 18 DPD-diagnosed agoraphobic outpatients, finding a significant decrease in dependency levels during the 12-week course of therapy. Black, Monahan, Wesner, Gabel, & Bowers (1996) used cognitive intervention techniques to treat 44 DPD-diagnosed outpatients with cooccurring panic disorder, finding no change in dependency levels over 8 weeks of therapy.

What is Effective Medical Treatment?

Like studies of psychotherapy, clinical trials assessing the impact of pharmacological treatments on DPD symptoms have not produced promising findings. A broad range of medication classes have been assessed in these investigations (e.g., antidepressants, anxiolytics, and antipsychotics), and none have consistently fared better than placebo in reducing DPD symptoms. A review of these investigations is provided by Bornstein (2005).

Combination Treatments

Given the modest impact of traditional psychotherapeutic and pharmacological treatment regimens and the complex, multifaceted nature of dependency, the future of clinical work with DPD patients may lie in multimodal treatment. Intervention strategies aimed at altering multiple components of DPD—cognitive, motivational, behavioral, and emotional—will likely have stronger and more durable effects than intervention strategies aimed at altering a single dimension of functioning.

Other Issues in Management

In contrast to psychotherapy and pharmacotherapy outcome studies, studies examining the effect of DPD on treatment process and outcome have yielded consistent results, suggesting that in general, high levels of trait dependency and DPD are associated with a more positive treatment outcome when other disorders are the focus of treatment (e.g., depression and anxiety). Once engaged in treatment, DPD patients adhere more conscientiously than nondependent patients to psychotherapeutic and pharmacological treatment regimens, miss fewer therapy sessions than nondependent patients, and show higher rates of treatment completion in outpatient individual and group therapy (Bornstein, 1993).

Given the dynamics of DPD and the impact of dependency on psychotherapeutic process, several considerations are important in clinical management of DPD. Key guidelines include:

- *Set firm limits on after-hours contact early in treatment.* Unless firm limits are set at the outset of therapy, dependent patients tend to have a higher-than-average number of "pseudo-emergencies," and make frequent requests for between-session contact.

- *Gradually give the patient more responsibility for structuring treatment as therapy progresses.* By providing considerable structure early on and gradually requiring the patient to take increasing responsibility for structuring treatment, the therapist can help the patient experience autonomy within the therapeutic milieu.
- *Be aware of the potential for exploitation.* Many therapists infantilize dependent patients, and exploitation or abuse—usually financial or sexual—may follow. It is critical that the clinician acknowledges and confronts these problematic feelings, either in formal clinical supervision or in informal consultation with other mental health professionals.
- *Be alert for signs of patient deterioration or self-destructive behavior.* Dependent patients are at increased risk for perpetration of child and spouse abuse (Bornstein, 1993), and may be at increased risk for suicide as well (Bornstein & O'Neill, 2000); thus, the therapist must monitor continuously for negative indicators.
- *Work with the system, not just the person.* Because dependent people often construct interpersonal milieus that foster and propagate their dependency, concurrent marital and/or family therapy may be warranted to alter entrenched dysfunctional system patterns.

Although clinical work with dependent patients has traditionally focused on diminishing problematic dependency, recent research suggests that when dependency strivings are expressed in a flexible, modulated manner they can actually strengthen interpersonal ties and facilitate adaptation and healthy psychological functioning. Treatment of DPD should emphasize replacing unhealthy, maladaptive dependency with flexible, adaptive dependency.

How Does One Select Among Treatments

Given the lack of empirically supported treatments for DPD alone, the clinician should assess and provide empirically supported interventions for comorbid Axis I and II disorders when appropriate. Clinicians can follow our recommendations and recommendations made by other clinicians for treating DPD symptoms (e.g., Coen, 1992; Overholser & Fine, 1994; Schneider & May, 1995; Turkat, 1990). However, prior to beginning treatment the clinician should inform the patient about the empirical support, or lack thereof, for the intervention(s) they will be providing. If pharmacotherapy for a comorbid psychiatric disorder is indicated, side effects and possible contraindications should be considered and discussed with the patient. Given the nature of DPD, clinicians should evaluate their own strengths and liabilities and their willingness to treat this population. Because patients with DPD may be at increased risk for self-destructive behavior, ongoing risk assessment and management of that risk is necessary. By virtue of the diagnostic symptom presentation of DPD, these patients may at times be more taxing than other types of patients. Therefore, some clinicians may feel overwhelmed and easily burned out. Clinicians who do not feel able to effectively treat DPD should refer these patients elsewhere. Finally, it is important for clinicians to consider compliance issues when selecting among interventions. DPD patients may be hesitant to disagree with treatment recommendations, even if they are averse to engaging treatment or an aspect of treatment.

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