Current PSYCHIATRY

Dependent personality disorder
Effective time-limited therapy
Help turn neediness into flexible, adaptive behavior

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Some dependent patients are needy, clingy, and insecure—unable to make the smallest decisions without inordinate advice and reassurance—whereas others are less easy to recognize. Dependency can be expressed in many different ways: obvious or subtle, maladaptive or adaptive.

Dependent psychotherapy patients are compliant and eager to please but can have difficulty terminating treatment. This article offers recommendations for clinical work with dependent adults to help you:

- assess and diagnose dependent personality disorder (DPD)
- distinguish unhealthy from healthy dependency
- provide effective psychotherapy for DPD in inpatient and outpatient settings.

WHAT IS A DEPENDENT PERSONALITY?

DPD is diagnosed when an individual exhibits long-standing, inflexible dependency that creates

Table 1

Symptoms of dependent personality disorder (DPD)*

Difficulty making everyday decisions without excessive advice and reassurance
Needing others to assume responsibility for most major areas of life
Difficulty expressing disagreement because of a fear of disapproval
Difficulty initiating projects or doing things on one's own
Going to excessive lengths to obtain nurturance and support from others
Feeling uncomfortable or helpless when alone
Urgently seeking another relationship as a source of care and support when a close relationship ends
Being unrealistically preoccupied with fears of being left to care for oneself

* 5 of 8 symptoms required for DPD
Source: Adapted from DSM-IV-TR

difficulties in social, sexual, and occupational functioning, according to DSM-IV-TR.[1] DPD's essential feature 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. To receive a DPD diagnosis, a patient must show 5 of 8 possible symptoms (*Table 1*).

To diagnose DPD, ascertain that the patient's dependency causes difficulties in his or her life. Persons with intense dependency needs can function well if they have a supportive environment, good social skills, and can control their impulses and express dependency in a flexible, situation-appropriate manner.[2] Thus a DPD diagnosis may be warranted when dependency is both intense and maladaptive.

Who has DPD? One of the more common Axis II disorders, DPD is not distributed equally across the population. No studies have assessed the impact of age on DPD risk, but variables that affect DPD prevalence include:

- gender (women are far more likely than men to receive a DPD diagnosis)
- practice setting (DPD is more prevalent in rehabilitation and psychiatric inpatient settings than in outpatient practices)
- race and ethnicity (dependency may be less prevalent in African-American than in Caucasian adults).[3,4]

INTERPERSONAL, INTRAPSYCHIC DYNAMICS

DPD is viewed as having 4 related components:[4,5]

- Cognitive: A perception of oneself as powerless and ineffectual plus the belief that other people are comparatively confident and competent.
- Motivational: A strong desire to maintain close ties with protectors and caregivers.
- Emotional: Fear of abandonment or rejection; anxiety about evaluation by authority figures.
- Behavioral: A pattern of relationship-facilitating behavior designed to minimize the possibility of abandonment and rejection.

When extreme, these core features produce 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.[6,7]

Interpersonal strategies. Dependent persons use interpersonal strategies to strengthen social ties and minimize the possibility of being rejected or abandoned (*Table 2*). Some strategies involve behavior that is active and assertive—even quite aggressive.[8] Therefore, dependency does not necessarily equate with passivity.

WHAT CAUSES DPD?

Three theoretical frameworks have been used to explain the development and dynamics of DPD.

Each suggests intervention techniques for dealing with dependency-related problems.

Psychodynamic. Psychodynamic theorists conceptualize problematic dependency in terms of dependency conflicts (such as conflicts between a desire to be cared for and an urge to dominate and compete). Ego defenses used to manage the affect associated with these conflicts (such as denial or projection) help determine the manner in which underlying dependency needs are expressed.[9]

Cognitive. Cognitive theorists regard problematic dependency as stemming from self-defeating thought patterns,[10] including:

- helplessness-inducing automatic thoughts (reflexive thoughts that reflect the person's lack of self-confidence)
- negative self-statements (self-deprecating internal monologues in which dependent persons reaffirm their perceived lack of competence and skill).

Behavioral. The behavioral perspective on DPD is that people exhibit dependent behaviors—even those that are self-defeating—because these behaviors are rewarded, were rewarded, or are perceived by the individual as likely to elicit rewards.[11] Intermittent reinforcement helps propagate dependent behavior in social settings.

Table 2

Self-presentation strategies dependent persons use to facilitate relationships

Strategy	Goal	Typical behaviors
Supplication	Appear helpless and vulnerable	Submissiveness, self-deprecation
Ingratiation	Create indebtedness	Ego-bolstering, performing favors
Exemplification	Exploit others' guilt	Providing help, emphasizing effort and sacrifices
Self-promotion	Emphasize personal worth	Performance claims, exaggeration of accomplishments
Intimidation	Frighten and control others	Anger displays, breakdown threats

DIAGNOSIS AND ASSESSMENT

Three principles guide the diagnosis of DPD.

- Dependency, as noted, is not always characterized by passivity. Dependent patients may use active, dramatic self-presentation strategies—such as breakdown threats or parasuicide attempts—to protect themselves from being abandoned.[4,8]
- Self-reports do not always give a true picture. Because dependency may be viewed as a sign of weakness and immaturity, many adults—especially men—are reluctant to acknowledge dependent thoughts and feelings.[12] Interviewing knowledgeable informants can be enlightening.
- Dependency's severity varies over time and across situations. Depressive episodes are associated with temporary increases in self-reported dependency. Even modest mood changes can amplify dependency.[13,14]

Assessment tools. When formal assessment is warranted to confirm a tentative diagnosis or distinguish DPD from a similar Axis II disorder, administer a validated instrument for quantifying DPD symptoms. The 3 interviews used most often to quantify DPD symptoms are the

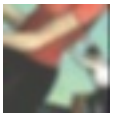

Table 3

5 useful psychotherapeutic methods for dependent patients

Explore key relationships from the patient's past that reinforced dependent behavior; determine if similar patterns occur in present relationships
Examine his or her 'helpless self-concept,' dependency's key cognitive component (Tip: Asking the patient to write a self-description can be useful)
Make explicit any self-denigrating statements that propagate the patient's feelings of helplessness and vulnerability; challenge these statements when appropriate
Help the patient gain insight into the ways he or she expresses dependency needs in different situations (and more-flexible, adaptive ways he or she could express these needs)
Use in-session role play and between-sessions homework to help the patient build coping skills that will enable him or her to function more autonomously

Structured Clinical Interview for DSM Personality Disorders, International Personality Disorder Examination, and Structured Interview for Diagnosis of Personality-Revised. Diagnostic interviews enable you to follow-up on patients' responses and obtain additional information.

Questionnaires do not allow you to probe and follow-up, but paper-and-pencil tools are relatively inexpensive and efficient. They also avoid reliability problems that can occur with structured interviews. The 2 self-report instruments used most often to diagnose DPD are:

- Millon Clinical Multiaxial Inventory-III
- Personality Diagnostic Questionnaire-IV.

DIFFERENTIAL DIAGNOSIS

DPD must be distinguished from Axis I and II syndromes with often-overlapping symptoms and similar presentations. These include:

- mood disorders, panic disorder, agoraphobia, and dependency arising from one or more general medical conditions
- borderline personality disorder, histrionic personality disorder, and avoidant personality disorder.[1]

Comorbidity studies suggest that DPD can be associated with a broad range of Axis I and II syndromes. 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 most other personality disorders, including some—such as antisocial or schizoid personality disorder—that bear little resemblance to DPD.[4,15]

Axis II comorbidity patterns likely reflect the generalized, nonspecific nature of personality pathology and the fact that patients may show personality disorder symptoms in one or more diagnostic categories.

DPD TREATMENT

Dependency is associated with patient cooperativeness and conscientiousness.[3,4,16,17] Compared with nondependent patients, those with dependent personalities:

- delay less time before seeking treatment for psychological or medical symptoms
- adhere more conscientiously to psychotherapeutic and psychotropic regimens
- miss fewer therapy sessions
- show higher rates of treatment completion in outpatient individual and group therapy.

Medication. No class of medications—including antidepressants, anxiolytics, and antipsychotics—is consistently more effective than placebo in reducing DPD symptoms.[18]

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Psychotherapy. Traditional psychotherapies—psychodynamic, cognitive, behavioral—modestly improve DPD symptoms.[19] Most effective has been psychotherapy that combines various modalities.[2,4,20] Five interventions (*Table 3, page 40*) have been shown to:

- help the patient and therapist identify aspects of the patient's environment that propagate dependent behavior
- provide the patient with coping skills needed to more effectively control dependency-related impulses.

These methods—which integrate aspects of psychodynamic, cognitive, and behavior therapies—can help patients gain insight into problematic dependency and the behaviors by which it is expressed.

LIMITATIONS AND CAVEATS

Clinical work with DPD patients traditionally has focused on diminishing problematic dependency. Recent research suggests, however, that expressing dependency strivings in a flexible, situation-appropriate manner can strengthen interpersonal ties and facilitate adaptation and healthy psychological functioning.[2,5] Thus, the most effective interventions emphasize replacing unhealthy, maladaptive dependency with flexible, adaptive dependency.

Beyond the strategies summarized in *Table 3*, several other considerations—such as setting limits—are important in managing DPD and in minimizing therapeutic obstacles and impasses.

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

In inpatient settings, patients with DPD receive more consultations and psychotropic medications than do non-DPD patients with similar

Table 4

5 warning signs of self-destructive behavior in dependent patients

Recent relationship conflict or interpersonal loss
Excessive or unrealistic jealousy
Poor impulse control
Difficulty modulating negative emotions
Previous suicide attempts or suicidal gestures

demographic and diagnostic profiles, and their treatment costs can become excessive.[21]

Shift responsibility. When you provide adequate structure early in treatment, the dependent patient will feel secure enough to open up and disclose troubling thoughts and feelings. Then, as therapy progresses, help the patient experience autonomy and competence within the therapeutic milieu by gradually requiring him or her to take on increasing responsibility for structuring treatment.[10]

Beware of countertransference. Many therapists infantilize dependent patients, and exploitation or abuse—financial or sexual—may follow. You must acknowledge and confront these problematic feelings when they occur, either in formal clinical supervision or in informal consultation with other mental health professionals.[4,21]

Bottom Line

Patients with dependent personality disorder tend to be conscientious and cooperative. Take advantage of these traits in guiding them toward more autonomous function. Be alert for strong abandonment fears, jealously, and self-destructive behavior.

Two countertransference reactions are particularly common (and problematic) in therapeutic work with dependent patients:

- the fantasy of insatiability (believing that no matter how much support and reassurance the patient receives, it will never be enough)
- the fantasy of permanence (believing the patient will become so comfortable in therapy's protective cocoon that he or she will never leave treatment).

Be alert for signs of patient deterioration or self-destructive behavior. Dependent men who experience jealousy and strong abandonment fears may perpetrate spousal abuse. Dependent women may perpetrate child abuse if they have difficulty tolerating the child's misbehavior and seek to be a "perfect parent."

Because some studies suggest that dependent patients may be at increased risk for suicide, monitor them continuously for negative indicators.[8,9] Five danger signs (*Table 4*) suggest an increased risk of self-destructive behavior in dependent patients.

Work with the system. Only by examining the patient and his or her surrounding system can you effectively treat problematic dependency.

Because dependent persons often construct interpersonal milieus that foster and propagate their dependency, concurrent marital and/or family therapy may be warranted to disrupt entrenched dysfunctional patterns.[16,17] Examine the rewards dependent patients obtain for behaving helpless and vulnerable and ways in which their dependency may reward friends, family members, and coworkers.

References

1. *Diagnostic and statistical manual of mental disorders.* 4th ed, text revision. Washington, DC: American Psychiatric Association; 2000.
2. Bornstein RF, Languirand MA. *Healthy dependency: leaning on others without losing yourself.* New York, NY: Newmarket Press; 2003.
3. Bornstein RF. *The dependent personality.* New York, NY: Guilford Press; 1993.
4. Bornstein RF. *The dependent patient: a practitioner's guide.* Washington, DC: American Psychological Association; 2005.

Related resources

- Baltes MM. *The many faces of dependency in old age.* Cambridge, UK: Cambridge University Press; 1996.
- Bornstein RF. The dependent personality: developmental, social, and clinical perspectives. *Psychol Bull* 1992;112(1):3-23.
- Millon T. *Disorders of personality: DSM-IV and beyond.* New York, NY: Wiley; 1996.

DISCLOSURE

The author reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

5. Pincus AL, Wilson KR. Interpersonal variability in dependent personality. *J Pers* 2001;69(2):223-51.
6. Pincus AL, Gurtman MB. The three faces of interpersonal dependency: structural analysis of self-report dependency measures. *J Pers Soc Psychol* 1995;69(4):744-58.
7. Overholser JC. The dependent personality and interpersonal problems. *J Nerv Ment Dis* 1996;184(1)1:8-16.
8. Bornstein RF. The complex relationship between dependency and domestic violence: converging psychological factors and social forces. *Am Psychol* 2006;61(6):595-606.
9. Coen SJ. *The misuse of persons: analyzing pathological dependency.* Hillsdale, NJ: Analytic Press; 1992.
10. Overholser JC, Fine MA. Cognitive-behavioral treatment of excessive interpersonal dependency: a four-stage psychotherapy model. *Journal of Cognitive Psychotherapy* 1994;8(1):55-70.
11. Turkat ID. *The personality disorders: a psychological approach to clinical management.* New York, NY: Pergamon Press; 1990.
12. Bornstein RF. Criterion validity of objective and projective dependency tests: a meta-analytic assessment of behavioral prediction. *Psychological Assessment* 1999;11(1):48-57.
13. Birtchnell J. The measurement of dependence by questionnaire. *Journal of Personality Disorders* 1991;5(3):281-95.
14. Nietzel MT, Harris MJ. Relationship of dependency and achievement/autonomy to depression. *Clinical Psychology Review* 1990; 10:279-97.
15. Bornstein RF. Dependent personality disorder in the DSM-IV and beyond. *Clinical Psychology: Science and Practice* 1997;4(2):175-87.
16. Ryder RD, Parry-Jones WL. Fears of dependence and its value in working with adolescents. *J Adolesc* 1982;5(1):71-8.
17. Tait M. Dependence: a means or an impediment to growth? *British Journal of Guidance and Counselling* 1997;25(1):17-26.
18. Black DW, Monahan P, Wesner R, et al. The effects of fluvoxamine, cognitive therapy, and placebo on abnormal personality traits in 44 patients with panic disorder. *Journal of Personality Disorders* 1996;10(2):185-94.
19. Rathus JH, Sanderson WC, Miller AL, Wetzler S. Impact of personality functioning on cognitive behavioral treatment of panic disorder: a preliminary report. *Journal of Personality Disorders* 1995; 9(2):160-8.
20. Bornstein RF. Integrating cognitive and existential treatment strategies in psychotherapy with dependent patients. *Journal of Contemporary Psychotherapy* 2004;34(4):293-309.
21. Abramson PR, Cloud MY, Keese N, Keese R. How much is too much? Dependency in a psychotherapeutic relationship. *Am J Psychother* 1994;48(2):294-301.