Virgil Zeigler-Hill
and
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Encyclopedia of Personality and Individual Differences
10.1007/978-3-319-28099-8_578-1

Dependent Personality Disorder

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Without Abstract

Synonyms

Asthenic personality disorder; DPD

Definition

Dependent personality disorder (DPD) is characterized by an enduring pattern of pervasive and excessive psychological dependence on other people (in order to be taken care of and to meet one's own emotional and physical needs), fear of separation, and passive, clinging, and submissive behavior. It begins by early adulthood, and it is present in a variety of contexts and is associated with inadequate functioning.

Introduction

Dependency is a ubiquitous construct in developmental, personality, social, and clinical psychology and refers to an aspect of personality associated with both adaptive and maladaptive functioning. It shows significant variability in its behavioral expression. Thus, it is important to distinguish between pathological expressions of dependency (i.e., DPD), characterized by significant distress and impairments, and dependency with a developmental and/ora adaptive function, that is, ensuring child survival and development. Numerous theoretical approaches have explored pathological dependency, and the current perspective emphasizes perceiving oneself as weak and ineffectual. These representations of the self appear to play a key role in the intrapersonal and interpersonal dynamics of people with dependent personality disorder (Bornstein *2012a*). All the main classification systems of mental disorders, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), include dependent personality disorder (DPD) as a

diagnosis. Despite receiving less attention than other personality disorders (PDs), empirical studies have addressed the prevalence, antecedents, possible complications, and comorbidity of DPD. The negative implications of DPD point to the importance of assessment in clinical work and of specific therapeutic interventions.

Evolution of the Construct of Maladaptive Dependency

In classical psychoanalytic theory, dependency is strictly associated with Freud's (1905/ *1953*) oral psychosexual stage of development; specifically, frustration or over-gratification was said to result in an oral fixation and in an oral type of character, characterized by feeling dependent on others for nurturance and by behaviors representative of the oral stage. Later psychoanalytic theories, such as the object relations model, shifted the focus from a drive-based approach of dependency to the recognition of the importance of early relationships and establishing separation from these early caregivers, as well as the internalization of these people in representations of the self and the other (Bornstein *2012a*). More in details, according to object relations theory, the exchanges between the caregiving figure and child become internalized, and the nature of these interactions becomes part of the concepts of the self and of others. When the mother is excessively indulgent, the child tends to expect the same attitude from other people and to relate in a dependent way. On the contrary, if the mother is absent in her nurturance, the child will tend to demand excessively of others to meet his unfulfilled needs (Bornstein *1996*).

According to attachment theory, the internal working models of dependent individuals encompass representations of the self as needy and helpless, while others are perceived as competent; the best way to cope, then, is to rely on others as a source of care and protection (Sroufe et al. *1983*). Individuals with DPD tend to have an anxious-insecure attachment style (Crawford et al. *2007*; MacDonald et al. *2013*); adults who have an anxious attachment tend to be self-critical and insecure and seek approval and reassurance from others, in order to validate their self-worth, but deep-seated expectations of rejection make them constantly worried and not trusting. However, anxious-insecure attachment and dependency are theoretically and empirically distinct constructs. Ainsworth and Gewirtz (*1972*) and Livesley et al. (*1990*) distinguished that attachment is a specific bond formed with a preferred individual and dependency is more a generalized trait; moreover, empirical evidence suggests various individual and interpersonal differences and identifies only a moderate correlation between measures of insecure attachment styles and dependency (Bornstein *2012a*).

Behavioral and cognitive models describe dependency as behaviors learned in the context of the earliest interactions with caregivers and then generalized to subsequent relationships as a way to elicit care and other emotional rewards. Children gradually learn which behaviors are effective in eliciting the desired response, adjusting their care-seeking behaviors to maximize rewards. Thus, dependent behaviors are shaped by social influence strategies (Bhogle *1978*; Turkata *1990*). Contemporary cognitive approaches, such as Beck and Freeman's contribution (*1990*), identify feelings of incompetence as the core of maladaptive dependency.

Since the 1970s, empirical research has aimed to identify the main components related to the construct of maladaptive dependency, such as emotional reliance on others, lack of self-confidence, assertion, and autonomy. The five-factor model (FFMB; Bornstein and Cecero *2000*) is an empirically based personality trait model that describes dependency as characterized by high levels of anxiety and insecurity and low levels of risk taking and perceived competence. An alternative trait model was proposed by Pincus and Gurtman (*1995*), who identified three subtypes of dependency marked by different intrapersonal and interpersonal functioning (submissive, exploitable, and love dependence);

according to authors, these subtypes could contribute to a reconceptualization of DPD. Submissive dependence is associated with insecure-anxious attachment, loneliness, and tendency to yield to high authority; exploitable dependency captures the strong evaluation apprehension of the highly dependent personality; love dependence is associated with attachment security, interpersonal sensitivity, and affiliative behaviors. More recently, Millon et al. (*2004*) elaborated on subtypes of dependency, suggesting five adult subtypes of DPD: disquieted, including avoidant features; selfless, including masochistic features; immature, a variant of the pure pattern (it describes a childish, inexperienced, and incapable of assuming adult responsibilities person); accommodating, including histrionic features; and ineffectual, including schizoid features.
Bornstein (*2012a*) has studied DPD in depth and proposed an empirically tested model of dependency combining cognitive, developmental, and object relations models. He highlights the frequency of overprotective and authoritarian parenting, the ubiquity of gender role socialization in influencing self-concepts as ineffectual and weak (especially for girls), which have important consequences in forming motivations (to seek guidance and support from other people) and affects (e.g., fear of abandonment or fear of negative evaluation); these motivations in turn produce passive behaviors.

Diagnostic Classifications

In the last decades, DPD diagnosis has evolved significantly since first Kraepelin's and Schneider's descriptions (Bornstein *2012a*), which can be considered the precursors of the current diagnosis and identified immaturity, naiveté, and the tendency to be exploited as characteristic of DPD.

Diagnostic and Statistical Manual of Mental Disorders

The Diagnostic and Statistical Manual of Mental Disorders (DSM) first acknowledged DPD as a subtype of the passive-aggressive personality in the DSM-I (American Psychiatric Association; APA *1952*) and then eliminating it in the DSM-II. The DSM-III (APA *1980*) was the first time that excessive interpersonal dependency was identified as a separate disorder, and it included a definition based on passivity, a tendency to subordinate one's needs, and lack of self-confidence. DSM-IV (APA *1994*) and DSM-IV-R (APA *2000*) represented an evolution of the diagnostic criteria. The current edition, DSM-5 (APA *2013*), maintains the same criteria as the DSM-IV and categorizes DPD among Cluster C personality disorders, together with avoidant personality disorder and obsessive-compulsive personality disorder, all of which are characterized by excessive fear and anxiety. According to the DSM-5, there is one criterion with eight features for DPD. It is listed as 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, as indicated by five (or more) of the following:

1.
Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others

2.
Needs others to assume responsibility for most major areas of his or her life

3.
Has difficulty expressing disagreement with others because of fear of loss of support or approval

4.
Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)

5.
Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant

6.
Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself

7.
Urgently seeks another relationship as a source of care and support when a close relationship ends

8.
Is unrealistically preoccupied with fears of being left to take care of himself or herself (APA *2013*)

The DSM-5 also proposes a new hybrid model for personality assessment and diagnosis (the alternative model for personality disorders in Section III); it is based on dimensional ratings of the severity of impairment and of five broad personality trait domains (negative affectivity, detachment, antagonism, disinhibition, and psychoticism). It enables the diagnosis of six personality disorder (antisocial, borderline, narcissistic, avoidant, schizotypal, obsessive-compulsive), but it does not include a specific disorder based on dependency.

International Classification of Diseases

In the International Classification of Diseases – 9 (ICD-9) by the World Health Organization (*1978*), the DPD was formerly known as asthenic personality disorder, while the ICD-10 (World Health Organization *1992*) lists DPD as F60.7 and provides symptoms similar to those in DSM:

1.
Encouraging or allowing others to make most of one's important life decisions

2.
Subordination of one's own needs to those of others on whom one is dependent and undue compliance with their wishes

3.
Unwillingness to make even reasonable demands on the people one depends on

4.
Feeling uncomfortable or helpless when alone, because of exaggerated fears of inability to care for oneself

5.
Preoccupation with fears of being abandoned by a person with whom one has a close relationship and of being left to care for oneself

6.
Limited capacity to make everyday decisions without an excessive amount of advice and reassurance from others

According to ICD, it is also applicable to asthenic, inadequate, and passive personality disorders.

SWAP-200

With the aim of overcoming the limitations inherent to the DSM, including the limited external validity of the diagnostic criteria for DPD (Bornstein *1997*), *Westen and Shedler (1999a, b)* proposed the SWAP-200. The SWAP-200 is a diagnostic tool and possible alternative nosological system which emerged from the efforts to create an empirically based approach to personality disorders (Blagov et al. *2012*; Smith et al. *2009*), also preserving the richness and complexity of clinical reality (Westen and Shedler *1999a*, *b*). According to SWAP-200, DPD is conceptualized as a clinical prototype, and composite description characteristic criteria (personality tendencies, rather than discrete symptoms) are provided. The SWAP-200 found that patients who match this prototype tend to be overly needy and/or dependent, requiring excessive reassurance or approval since they fear being alone, rejected, and/or abandoned (Westen and Shedler *1999a*, *b*). For these reasons, they tend to become attached quickly and/or intensely, developing feelings and expectations that are not warranted by the history or context of the relationship. Since they tend to be ingratiating and submissive, people with DPD tend to be in relationships in which they are emotionally or physically abused. They tend to feel ashamed, inadequate, and depressed. They also feel powerless and tend to be suggestible. They are often anxious and tend to feel guilty. These people have difficulty acknowledging and expressing anger and struggle to get their own needs and goals met. Unable to soothe or comfort themselves when distressed, they require involvement of another person to help regulate their emotions.

Psychodynamic Diagnostic Manual

The Psychodynamic Diagnostic Manual (PDM; Alliance of Psychoanalytic Organizations *2006*) adopts a descriptive rather than prescriptive approach; notably, this classification has received empirical support (Bornstein *2012a*). The PDM includes two different types of DPD: passive-aggressive and counter-dependent. The forthcoming second version (PDM-2) adopts a prototypic approach, relying on empirical measures such as the SWAP-200, and was influenced by Blatt's developmental and empirically grounded perspective (Blatt and Blass *1996*). This model appears of particular interest when focusing on DPD, since it claims that psychopathology derives from distortions of two main coordinates of psychological development: anaclitic/introjective and relatedness/self-definition dimensions. Individuals with an anaclitic personality organization present difficulties in interpersonal relatedness (they are preoccupied with relationships, show fear of abandonment and of rejection, seek closeness and intimacy, have difficulty managing interpersonal boundaries, and tend to have anxious-preoccupied attachment style). Introjective personality style is

associated with problems in self-definition. In the PDM-2, the P Axis, which lists personality patterns and disorders, ascribes the anaclitic features to dependent personality, together with borderline and histrionic personality disorders.

Epidemiology

According to the DSM-5 (APA *2013*), the prevalence of DPD in the general adult population is 0.49%, but a higher estimation, of 1–2%, has also been reported (Trull et al. *2010*). Prevalence rates for DPD range from 10% to 25% among inpatient populations and up to 47% among outpatient populations (Alnaes and Torgersen *1988*; Bornstein *1997*; Jackson et al. *1991*; Klein *2003*; Wilberg et al. *1998*). Taken together, results indicate prevalence rates in clinical setting average in the range 5–10% (Bornstein *2012a*).

Regarding gender differences, women are 40% more likely than men to be diagnosed with DPD, both in questionnaire- and interview-based studies (Bornstein *2012a*). However, gender differences in DPD remain open to debate. It has been hypothesized that men and women have comparable underlying dependency needs; in fact, no sex differences are present in childhood, and they tend to increase with increasing age (Bornstein *2012a*). But these needs appear to be expressed differently, as men are more reluctant to acknowledge dependency and tend to present themselves as more autonomous than they actually are, likely due to self-presentation effect due to sex role socialization (Bornstein *1992*, *2012a*).

Varied Implications of Dependency

Throughout the life span, there are varying degrees of dependence on others: in infants that are completely reliant on their caregivers, during childhood and adolescence, an increase in autonomy and independence is expected, in order to become sufficiently competent and self-reliant adults, before requiring again varying degrees of care in the old age. Dependent behavior is expressed differently at different ages; thus, the same behaviors can be appropriate or not according to the developmental stage and specific condition in which it occurs (Bornstein *1997*). These manifestations of dependency should be differentiated from maladaptive or pathological dependency. Blatt et al. (*1995*), in the context of a maturational perspective, differentiated an immature (labeled “neediness” and characterized by a generalized and undifferentiated dependence on others, feelings of helplessness and depression, fear of abandonment) and a mature form of dependency (labeled “connectedness” or “relatedness,” based on valuing relationships and sensitivity to interpersonal cues; it is associated with well-being).

Dependency must be evaluated with sensitivity to cultural contexts. While Western cultures emphasize independence and individual accomplishment, and dependence is considered problematic, collectivistic societies value cohesion and dependency. In such cultures, people are socialized to encourage dependant and submissive behavior. This different perspective could explain the higher rates of overt dependent behavior in some eastern cultures (Bornstein *1997*).

In distinguishing between dysfunctional and adaptive dependency, recent contributions have suggested that there might be individual differences in how underlying dependency needs are expressed. Intense, unmodulated, and indiscriminant expressions of dependency represent the maladaptive type, while selective and flexible expressions are adaptive and healthy, fostering better outcomes in terms of psychological well-being and interpersonal relationships (Bornstein et al. *2009*).

Antecedents and Risk Factors of DPD

Studies indicate that approximately 30% of the variability in risk for DPD is attributable to genetic factors, but it is less clear which specific physiological factors underline observed DPD cognitions and behaviors and are inherited (Bornstein *2012a*). Little has been determined regarding the relationship between temperament and dependency. Temperamental trait of negativity, low adaptability, and tendency to withdrawal may contribute to later dependency both directly (e.g., insecure attachment) and indirectly, fostering parenting attitudes of overprotection (Bornstein *2012a*). Bornstein in his recent review (*2012a*) attested that no empirical studies investigating the biological markers (e.g., fMRI patterns) of DPD were available.

Sociocultural factors have been shown to be incredibly important to the development of DPD (Bornstein *2012a*). Parenting behaviors and attitudes characterized by overprotectiveness and authoritarianism were more likely to increase dependent traits in children and later DPD as it prevents them from developing a sense of autonomy and self-efficacy, instead learning that others are powerful and competent (Bornstein 1991). Early adverse or traumatic experiences, such as neglect and abuse or serious illness, can increase the likelihood of developing PDS later on in life, especially for individuals who also experience high interpersonal stress and poor social support (Bornstein *2012b*; Tyrka et al. *2009*). Also gender role expectations may contribute to the understanding of why the disorder is more frequently seen in women than men (APA *2013*).

Complications and Comorbidity of DPD

DPD can lead to an array of negative outcomes in daily adjustment and can pose significant challenges for treatment. DPD's traits and emotional patterns of clinginess, insecurity, and suggestibility (Bornstein *1992*, *2012a*) often make independence, decisiveness, and confidence difficult. In fact, DPD impacts most areas of functioning; for example, one study found a strong positive relationship between dependency and academic underachievement (see Bornstein *1992*). Furthermore, individuals with DPD experience increased stress and interpersonal conflicts and have less social support than most (Trull et al. *2010*). Specifically, dependent patients have difficulties establishing and maintaining close interpersonal relationship, because of negative and disruptive social behaviors (such as harm to self or others, reluctance to act assertively, the use of helpless style to elicit guidance from others, scarce social skills, and low frustration tolerance), which lead to subjective feelings of loneliness and depression (Overholser *1996*). This chronic stress increases the risk of physical illnesses, reducing immunocompetence, and of somatization (Bornstein *1998*).

One troubling finding is the increased likelihood of victimization by others, in terms of physical, emotional, and/or sexual abuse (Bornstein *2012a*, *b*). Since dependent patients tend to be naïve and have poor boundaries, they may be prone to enter new relationships regardless of potential risks; women with DPD were found to be particularly at risk for spousal abuse (Loas et al. *2011*). On the one hand, as noted in the DSM-5 (APA *2013*), DPD individual will tolerate situations from which others would promptly withdraw, including verbal, physical, and sexual abuse, due to their fear of abandonment and their belief that they are unable to function without support. On the other hand, their clinging behavior may test individuals who are emotionally dyscontrolled and prone to violence (Bornstein *2012b*): high levels of pathological dependency are also associated with an increased risk for maltreatment of others. Despite their tendency to be submissive, DPD patients often engage in

active-aggressive behaviors that harm others when important relationships are threatened (Bornstein *2012b*). Dependent men who tend to be jealous, possessive, and insecure are at high risk for committing domestic violence when they feel their romantic relationship is jeopardized. Furthermore, mothers and fathers with DPD are at a greater risk for perpetrating child abuse than nondependent parents. Two possible trajectories linking dependency and child abuse have been hypothesized: child abuse occurs as an exacerbation of authoritarian parenting practices, and/or parents become abusive when they are overwhelmed by demands and emotions related to the parental role, because of the emotional neediness and low frustration tolerance characteristic of DPD (Bornstein *2012a*, *b*).

Though patients with DPD are usually described as compliant and "low risk," research indicates that they are likely to engage in behaviors that harm themselves. Studies show an increased risk for self-harm and demonstrate that DPD diagnosis is associated with both suicidal ideation and suicide attempts in clinical and nonclinical individuals. These behaviors have been interpreted as indirect attempts to preclude abandonment by others or as result of impulsivity and low frustration tolerance (Bornstein *2012b*).

High levels of dependency and DPD are linked with an increased risk for other mental illnesses. DPD is often comorbid with eating disorders, anxiety disorders, and somatization disorders (Bornstein *1992*, *2012a*). The link between DPD and mood disorders has shown mixed results and requires further research (Bornstein *1992*, *2012a*). Patients with depressive symptoms are more likely to be diagnosed as having a DPD. This association can be interpreted according to three hypotheses (Bornstein 1991): dependency might predispose individuals to depression, depression precedes the onset of dependency, and dependency and depression are both results of the same underlying trait. Other research has found the association between dependency and depression to be modest and that other factors should be considered, such as negative and stressful life events, especially related to dependency needs. Recently, the connection between DPD and alcohol and substance dependence has been found, with rates of 27–33%, (Bornstein 1991; Parolin et al. *2016*; Trull et al. *2010*). This comorbidity may be due to the fact that dependency might predict the risk for substance abuse or drug addiction may cause an increase in dependent feelings, behaviors, and cognitions, as reported by empirical studies (Bornstein *1992*).

The DSM-5 (APA *2013*) lists three disorders for Axis I (mood disorder, panic disorder, and agoraphobia) and three for Axis II (borderline, histrionic, and avoidant) as differential diagnosis. As regards Axis II disorders, borderline and dependent are both characterized by fear of abandonment, but individuals with DPD do not tend to react to abandonment with rage, emotional emptiness, and demand while are likely to seek conciliation or a replacement. Histrionic and dependent individuals have in common the strong need for approval and reassurance and a clinging attitude, but DPD is distinguished by a humble and docile attitude. Like avoidant individuals, people with DPD have a feeling of inadequacy and show hypersensitivity to criticism, but they seek to maintain connections (because they need the approval of others) rather than withdrawing if uncertain of acceptance, as avoidant individuals do, because of their intense fear of rejection that they will instinctively withdraw until they are certain of acceptance. Eventually, the DSM-5 recognizes that DPD should also be distinguished from symptoms associated with substance use.

In addition to negative consequences for the individual, DPD and trait dependency can lead to elevated societal costs; studies have attested that dependent individuals tend to excessively use health service, more than nondependent individuals with similar demographic and diagnostic profiles, in terms of number of medical consultations and medications prescribed (Bornstein *2012a*).

Assessment of DPD

More than 40 measures for the assessment of dependency and DPD are currently available; it is worth noting that scores on measures of trait dependency and scores on DPD symptoms and diagnoses show moderate to strong correlations, and so some use them interchangeably (Bornstein *2012b*). Bornstein (*2007*) and Cogswell (*2008*) suggest using both implicit and self-report measures, since self-report measures tend to assess self-attributed facets while free-response test assesses unaware aspects. The Interpersonal Dependency Inventory (IDI; Hirschfeld et al. *1977*) is a self-report measure consisting of 48 items, designed to measure three components: emotional reliance on others, lack of social self-confidence, and difficulties in asserting autonomy. The Dependent Personality Style Scale (DPSS; Overholser *1992*) is a self-report measure that includes 20 multiple-choice items; each one begins with a different situational anchor, such as "With close friends..." and "When I am alone...," in order to avoid overgeneralizations of behavior in various settings), and its total score reflects the overall frequency of dependency behaviors. The Five-Factor Dependency Inventory (FFFDI; Gore et al. *2012*) is a self-report measure of dependent personality traits based on the five-factor model; it consists of 191 items grouped in 12 scales. Two other measures are the Depressive Experiences Questionnaire (DEQ; Blatt et al. *1976*), which taps the two psychoanalytical dimensions of anaclitic dependency and introjective self-criticism, and the Sociotropy Autonomy Scale (SAS; Beck et al. *1983*), an assessment tool for social dependency and satisfying independency.

The Dependent Personality Questionnaire (DPQ; Tyrer et al. *2004*), the Personality Diagnostic Questionnarire-4 (PDQ-4+; Hyler *1994*), the Wisconsin Personality Disorder Inventory (WISPI; Klein et al. *1993*), and the Dependent Personality Inventory (DPI; Huber *2007*) are based on DSM-IV symptoms. The Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon et al. *2009*) is a self-report inventory consisting of 175 true-false statements, which assess 14 PDs, including the DPD, whose scale consists of 16 items., Eventually, also the Minnesota Multiphasic Personality Inventory-2 (MMPI-2 Si1, 2, 3; Ben-Porath et al. *1989*) social introversion subscales are a valid option: it is an instrument based on three subscales of the MMPI-2, designed to collectively measure DPD (shyness/self-consciousness, social avoidance, and self/other alienation).

The diagnosis of dependent personality disorder can be based on clinical interviews, such as the Structured Clinical Interviews for DSM-5 Personality Disorders (SCID-5-PD; First et al. *2016*). Another assessment tool helpful in confirming the diagnosis of dependent personality disorder is the SWAP-200 (Westen and Shedler *1999a*, *b*), a personality assessment procedure relying on an external observer's judgment and based on the Q-Sort method and prototype matching. It provides (a) a personality diagnosis expressed as the matching with ten prototypical descriptions of DSM-IV personality disorders, (b) a personality diagnosis based on the matching of the patient with 11 Q-factors of personality derived empirically, and (c) a dimensional profile of healthy and adaptive functioning.

Treatment Issues

Like other personality disorders, DPD is typically treatment resistant, but unlike many personality disorders, DPD presents some characteristics which can somehow facilitate treatment, such as being sensitive to interpersonal cues and being eager to please. They are also more likely to ask for guidance and assistance than nondependent people (Bornstein *1992*). Moreover, they tend to have greater insight and self-awareness than patients with other PDs; they also tend to make internal rather than external attributions, and they are capable of forming a strong working alliance early in treatment (Bornstein *2012b*). Research confirms that DPD individuals are compliant therapy patients and show a high adherence to medical treatment in general (Bornstein *2012a*). However, studies indicate that

there are some common issues that arise with DPD patients in psychotherapy (Bornstein *2012a*). Their relationship with the therapist is characterized by patterns of idealization, possessiveness, and projective identification (Bornstein *2012a*); thus, they often evoke negative feelings on the part of the therapist and tend to try the therapist's patience. Common therapist reactions to dependent patients are feeling burdened by the patient's submissiveness and excessive needs to be taken care of. Therapists are at risk for colluding with patient's desire to be nurtured and cared for, or, alternatively, they start thinking that there is nothing that they can do and fantasizing about ending treatment. Meanwhile, DPD patients tend to have difficulty terminating treatment, given their fear of abandonment (Bornstein *2012a*).

Though the DSM-5 (APA *2013*) does not specify treatment options for DPD, some considerations on effective treatment of problematic dependency and dependent DP are available (see Bornstein *2012a*). Psychodynamic approaches assume that individuals may experience ambivalence regarding autonomy and dependency; this conflict may cause disturbing inner states and evoke defense mechanisms (behaviors and thoughts that protect from unpleasant feelings and needs) in order to manage these unacceptable urges; these dependency-related conflicts may be conscious or unconscious. Thus, the primary therapeutic aim and prerequisite to therapeutic change is to make unconscious conflicts accessible and foster insight. When a secure working alliance is established, the patient should be confronted with his own contributions to recurring difficulties, and the therapist should be prepared for the patient's resulting anxiety or anger. Blatt's model can contribute to identify the most appropriate treatment approach for patients with DPD: a growing body of research indicates that anaclitic patients, such as individuals with DPD, and introjective patients may respond differently to divergent therapeutic approaches. Anaclitic patients seem more responsive to a supportive approach (aimed to improve the patient's immediate adaptation to his or her environment and characterized by praise, guidance, structured problem-solving) than to interpretative therapies (emphasizing insight and the exploration of unconscious and past themes) (Blatt and Shahar *2004*).

The behavioral approach to DPD combines operant techniques with classical conditioning strategies (Bellack and Hersen *2013*); the first aim of treatment is identifying and extinguishing specific problematic behaviors and then it aims to replace dependency responses with adaptive and autonomous behaviors. Systematic desensitization (to situations that elicit concerns regarding abandonment, rejection, or embarrassment) and posttreatment maintaining techniques can facilitate behavior change. Cognitive treatments (e.g., Overholser and Fine *1994*) focus on patients' maladaptive schemas and cognitive distortions, especially about themselves, since this negatively impacts self-esteem and increases anxiety. Cognitive restructuring focuses on strengthening self-efficacy beliefs and provides alternative ways to manage negative feedback.

It is important to bear in mind that DPD is associated with deficits as well strengths and has both dysfunctional and adaptive values. Thus, treatments should not focus only on symptom reduction but should include interventions designed to help the patients express his underlying dependency needs and traits in less problematic ways (Bornstein *2012a*).

Conclusion

DPD and the maladaptive manifestations of dependency represent a serious issue; a vast range of negative implications are linked to DPD, and some of them constitute serious clinical conditions (such as harm to self and others, comorbidity with depression, and substance use disorders). Thus, continued research on the etiology and dynamics of DPD is important as well as on treatment (Bornstein *2012a*).

Cross-References

Antisocial Personality Disorder
Avoidant Personality Disorder
Borderline Personality Disorder
Developmental Epochs
Fixation
Histrionic Personality Disorder
Narcissistic Personality Disorder
Neglect/Overburdening Childhood Situations
Obsessive-Compulsive Personality Disorder
Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder

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