Addressing the Overprotected Past of Dependent Personality Disorder

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Abstract. Studies and research relevant to Dependent Personality Disorder (DPD) recently have shown controversy regarding whether genetic or external factors contributed more to the development of DPD. This review aims to investigate the relationship between parental overprotection and DPD from the perspectives of the specific effect of overprotective parenting styles on DPD, factors regarding overprotection in DPD, and relevant interventions for DPD. It was found that there was an association between overprotective parenting styles and the development of DPD symptoms. Factors related to overprotection, such as distress intolerance and sensitivity to falsehoods detected from facial expressions, have a relationship with DPD traits. Different psychotherapies have demonstrated their effectiveness. Cognitive behavioral therapy (CBT), clarification-oriented psychotherapy (COP), existential group therapy, and cognitive analytic therapy (CAT) are effective to treat clients' DPD, targeting different symptoms. It is concluded that CBT can aid decision-making, self-confidence, and proper self-cognition. Furthermore, COP and existential group therapy can facilitate emotional and social adjustment. Lastly, CAT can improve identity recognition and reassurance-seeking. Regardless of these effectual treatments, the small sample sizes of previous studies may lower the generalizability. More efforts should be devoted to this field of personality disorder and expand the number of empirical research. The present paper may offer some guidelines for the later development of family intervention studies and programs.

Keywords: Dependent Personality Disorder; overprotection; parenting styles; interventions

1. Introduction

Dependent Personality Disorder (DPD) is characterized as a long-time condition of pervasive and excessive dependency on others to meet one's physiological and psychological needs. This type of Cluster C personality disorder leads to submissive, clinging, and passive behaviors, and fears of separation [1]. This disorder usually starts prior to early adulthood and affects functioning in a variety of situations. Based on a survey in 2018, dependent personality disorder is the least prevalent (0.78%; 95% CI, 0.37 – 1.32%) among all personality disorders (12.16%; 95% CI, 8.01 – 17.02%) [2]. Parental overprotection is known for pampering their children with excessive nurturance and help. This type of overprotection is mainly shown in the area of fulfilling or regulating children's demands. Besides overprotection, there are other categorizations of parenting style. They can be classified as authoritarian, permissive, and authoritative parenting styles [3]. Authoritarian parents set strict rules for children yet with little responsiveness and sympathy for children's thoughts, whilst permissive parenting has little control over children. In contrast, the authoritative style allows for children's natural development with appropriate governance [3]. The early clinging behaviors mostly start in childhood [1]. Hence, it is essential to understand the impact of different parenting styles particularly authoritarian and overprotective types during childhood on the later development of DPD.

Recent research mainly focused on symptoms and the biological aspect of the etiology of this personality disorder. One primary theory is that DPD symptoms are most strongly associated with anxiousness, submissiveness, and separation insecurity among the 25 pathological personality traits in the alternative model for personality disorder (AMPD), despite that the previous studies investigating the connection between submissiveness and DPD symptoms produced inconsistent results [4]. Besides, similar to earlier papers (28-36% variability), it actively illustrated that 30% variability of DPD symptoms was linked with anxiousness, submissiveness, and separation insecurity [4, 5]. The DPD symptoms accompanied by these three key features in real life manifest in different

ways. Individuals with DPD feel extremely uncomfortable or helpless when being alone. They are afraid of losing the nurturance and recognition from others [1]. Additionally, it is striking that people with DPD have a great likelihood to allow others to take over and run their lives, as they generally have difficulties making decisions by themselves and getting things done without others' assistance or suggestions [1]. Individuals with DPD tend to lack self-confidence, and self-esteem, and sometimes intensively generate passivity and doubt about themselves [1]. Dependency could be demonstrated distinctively in different age groups. Adolescents with DPD might manifest their dependency as close connections with peers instead of parents, whereas adults with DPD may shift their reliance from valued peers to mentors or authority figures [6].

Regarding the causes of this disorder, in a study in 2012, the heritability of the personality disorders was 0.66 for DPD, suggesting evidence of genetic influence on the emergence of DPD symptoms [7]. Likewise, another research reported that around 30% of the variability in risk for DPD was linked to genetic factors [8]. However, in addition to the effect of genetics, people can suffer from DPD due to external factors. Apart from the impact of the 0.66 heritability in DPD, environmental factors, in particular parenting styles, could be the major contributor to DPD. Given that the trend of discussions on DPD has its main concern with the role of biological factors in DPD symptoms, these studies have ignored the effect of different parenting styles on children's DPD traits. Therefore, this review emphasized the influence of overprotective parenting styles on the development of DPD. It discussed the unique effect of overprotective parenting styles on DPD, factors related to overprotection in DPD, and pertinent interventions for DPD. Providing an insight into this disorder from the developmental perspective of overprotective parenting styles may offer some thoughts to the early interventions in the DPD treatment and give a guideline to later family intervention studies, aiming to enhance the condition of children or adolescents at risk.

2. The Relationship between Overprotection and DPD

2.1 The Unique Effect of Overprotective Parenting Styles on DPD

Overprotective parenting styles could have a huge impact on the development of DPD. Although authoritarian and permissive parenting styles partially overlap with overprotection, they also possess their independent aspects and contribution. When authoritarian parents tend to be strict with their children and keep any risky tasks away from the children with the intention of protection, there is an overlap with parental overprotection. Similarly, permissive parents show patterns of overprotection if they choose to indulge children instead of refusing their requests or desires. By contrast, from independent aspects, some authoritarian parents act in their way to prove parental authority which cannot be challenged by children. Some parents may become permissive towards their children resulting from the inability to control their children even though they have the willingness to protect their children. Authoritative parents govern their children properly for their growth without overindulging. In a study by Onukwufor and Anyanwu, the effect of parental styles on dependent personality disorder in adolescents was inquired into through questionnaires about the influences of 4 parenting styles (authoritarian, authoritative, overprotecting, and permissive) on DPD development respectively [9]. Results indicated that overprotective parenting styles obtained the highest score of DPD traits, followed by authoritarian parenting with a score similar to overprotection while both authoritative style and permissive style had a much smaller score of DPD traits. It revealed that overprotection produced a greater impact on DPD symptoms than authoritarian and permissive parenting styles in terms of independent factors. To conclude, parental overprotection has a large inclination to develop DPD in their children. It may be inferred that authoritarian parenting shows a larger overlap with overprotection than permissive style to some extent.

2.2 Factors Relevant to Overprotection in DPD

First of all, DPD can be associated with distress intolerance. Distress tolerance is described as the capability to endure psychological distress. Emotional adjustment difficulties incorporate

maladaptive reactions to moods, trouble with adjusting and managing emotions and behaviors, and dysfunction in utilizing emotions as information [10]. Overprotective parents spoil their children so much to the extent that children with high dependency on parents may perceive themselves as ineffectual and unable to look after themselves or finish tasks independently. These children tend to lack self-care skills and resilience. For instance, their resistance to stress or challenges might appear weaker, potentially arising more daily distress than peers. Zamani and Azarbayjan investigated the relationship between DPD and distress endurance of young couples aged 25-35 years old using questionnaires measuring distress tolerance [10]. It was found that there was a significantly negative correlation between dependent personality disorder and distress tolerance. There was also a positive correlation between emotional adaption difficulties and distress endurance. Hence, DPD is negatively correlated with distress tolerance. Meanwhile, it may be anticipated that individuals with DPD might have a deficit in tackling problems and daily emotional distress in their lives as well as trouble regulating extreme moods.

In addition to distress intolerance, DPD traits could be linked with the sensitivity of deceit detected from facial expressions. Children suffering from overprotective parenting styles, particularly authoritarian, often have limited capacity and right to make choices by themselves. Thus, they have a propensity to develop abilities and skills in watching parents' facial expressions carefully, taking cues, and making conjecture from those looks in an attempt to please their parents or achieve their desires. These parenting styles are likely to form a typical personality of a people-pleaser and observant character. According to one previous study, the relationship between the deception detection accuracy by undergraduate adults and the level of subclinical DPD traits was examined through questionnaires on the dependent personality sub-scale. Adult participants with different levels of subclinical DPD traits detected whether children subjects lied by observing their facial expressions presented in video recordings [11]. The findings exhibited that there was a significantly positive correlation between deceit detection accuracy and subclinical traits of DPD. As a consequence, dependent personality traits show an association with the sensitivity to deceit observed in individuals' facial expressions. Especially, adults with DPD are prone to foster good lie-detecting ability.

3. Relevant Interventions for DPD

Among effective therapies, cognitive behavioral therapy (CBT) has shown its effectiveness in treating DPD symptoms concerned with overprotection in the past few decades. The main objective of CBT is to identify the distorted cognition of clients and change thinking patterns to influence their behaviors. A case study using CBT was effective to alleviate the DPD symptoms of a 24-year-old girl targeting her problems of dependency and coping ability brought by the overprotective parenting style [12]. During therapeutic sessions, therapists taught the client how to reduce her anxiety and fear and how to make decisions alone. The client was also encouraged to build new positive beliefs and trust about her abilities and self-worth by putting forward optimistic statements regarding her abilities and replacing previously negative thoughts. These skills imparted to clients turned out effective, which could reduce the negative impacts of overprotective parenting styles in childhood and possibly lower the risk of the development of DPD. Hence, CBT has been proven to be resultful in DPD treatment targeting dependency issues and making decisions without others' assistance or intervention. Midway through the therapy, the therapists could teach some useful skills to boost the self-confidence of the client and recreate a cognitive conceptualization to perceive them as confident and able to handle their lives.

Apart from CBT, clarification-oriented psychotherapy (COP) becomes an effectual therapy empirically. COP is a psychological therapy targeting the clarification of true therapist-client relationship concerns from clients' perspective, dysfunctional schemes (false beliefs) of clients, and reduction in clients' estrangement [13]. The clarification refers to the transformation from unobtrusive schema information into oral messages. Each schema consists of specific content and psychological

functions enabling information processing. 4 typical schemes are self-schema, relationship schema, and 2 compensatory schemes, which are norm schemata and rule schemata. Self-schema means people with DPD assume they lack self-confidence in building relationships. Relationship schema refers to clients feeling insecure and unreliable towards a relationship. Compensatory schemes make self- and relationship schema controllable. Norm schemata describe DPD clients following a routine of responsibilities and restrictions while rule schemata indicate one's expectations of others (weak among DPD clients). It is believed that clients would lack consciousness of the actual existence of schema assumptions. Under overprotective parenting styles, children are inclined to have a dysfunctional schema in managing interpersonal relationships and affective issues such as friends-making resulting from parents' excessive intervention in building social connections. Sachse and Kramer's study gave an account of COP targeting interpersonal relationships and unique ego-syntonic features in individuals with DPD [13]. In treatment sessions, several double approaches were put into practice because of the probable little motivation for therapy in DPD clients. Since it is mainly the person they cling to who could be greatly affected and bothered by DPD clients, clients themselves cannot perceive the severity or extensive impacts brought by this disorder (highly ego-syntonic) and may have little willingness to change. Complementarity was used to provide support for clients in taking their own decisions and confronting assumptions (schemes) by therapists who yet are not dutiful in problem-fixing. The "game" concept was also utilized in COP where therapists guided clients every time they had difficulties in solving problems to share some responsibility and also improve autonomy. COP used the "one person role play" technique that a client was required to play the role of his or her therapist to dispute, refute the dysfunctional schemata (internal determinants) and recreate new assumptions (schemata). Thereby, COP is especially helpful in targeting individuals with ego-syntonic character and problems with social relationships in DPD psychotherapy. A double strategy certifies its usefulness by aiming at these relationship and responsibility issues arising from dependent personality.

Similarly, in order to address the affective and relational adjustment problems among people with DPD, existential group therapy can also be effective. During existential group therapy, individuals were directed to find their meaning of existence by integrating into a group and enhancing the perception of themselves and the world in faced with existential anxiety (i.e., death, freedom, options, and loneliness) [14]. A quasi-experiment involving a control group and a treatment group examined the viability of existential group therapy on the social and emotional adaption of females with DPD measured via the Adjustment Inventory [14]. As mentioned above, such high levels of dependency on parents among DPD clients in their childhood might bring relational and emotional maladaptation for the rest of their lives. In group therapy sessions, the treatment group was asked to strengthen communication and share stories relevant to existential anxiety with others so that individuals may build self-consciousness regarding their capabilities. This group of DPD clients was also encouraged to generate a deeper understanding of death, isolation, freedom, choice, responsibility, and life purposes to acquire the courage to overcome these anxiety sources. Results suggested that there was a significant difference between the mean of social and emotional adjustment at the end of treatment. The existential group therapy significantly improved emotional and social adjustment during the final stage of therapy compared with the control group. Based on the empirical evidence, it can be surmised that existential group therapy is feasible to solve affective and relational issues of DPD.

Finally, cognitive analytic therapy (CAT) manifests its effectiveness in DPD symptoms. CAT is an integrative therapeutic approach targeting identity recognition in a relationship and reduction in reassurance-seeking amongst individuals with DPD based upon 2 theories (object relations theory and personal construct) and 3 therapeutic backgrounds. Firstly, the theory of reciprocal roles incorporates the perspectives of self-to-self, self-to-other, and other-to-self. Self-to-self usually reflects little self-esteem in relationships. Self-to-other is linked with connections with others and reassurance-seeking. Other-to-self is an individual's perception of others. Secondly, targeting problem procedures means identifying DPD clients' perception problems. Thirdly, the multiple self-states model (MSSM) explains identity disruption, fast changes in moods, and corresponding results

regarding dependency. A quasi-experimental case study, conducted by Kellett and Lees, targeted identity recognition of a DPD female client using CAT [15]. Considering the formulation of a person's identity, he or she has to take all the decisions and risks independently. Thus, when parental overprotection blocks individuals' ability in choice-making and consistently offers reassurance, children might need to rid of their parents' control. This process requires the reshaping of identity. CAT is therapeutically comprised of 3 stages. The first stage is reformulation, including discovering the client's dependency-related issue, identifying its development, and providing willingness of support. The second stage is recognition, defined as utilizing techniques like self-monitoring and sequential diagrammatic reformulation according to MSSM to facilitate self-consciousness on the client's issues. The third stage is revision, involving concentrating on change approaches composed of assessing reciprocal roles, completing tasks to achieve independent decision-making and escape from parents, training in decisiveness and other-to-self, and goodbye-letters ending. Results illustrated that there was a significant decrease in reassurance-seeking, affective dependency, and a reliable enhancement in relational confidence and decision-making. Therefore, CAT could act as effective integrative psychotherapy in mitigating reassurance and dysfunctional identity perception in groups of DPD clients.

4. Conclusion

In summary, the present review indicates that overprotective parenting style has shown an evident association with the development of DPD from the aspects of the unique impact of parental overprotection on DPD symptoms, two factors related to overprotection, and pertinent psychotherapies for DPD. Authoritarian parenting style overlapping with overprotection has a larger tendency to raise children who are likely to suffer from DPD symptoms, in contrast to permissive and authoritative parenting styles. Distress tolerance and deceit detection accuracy of facial expressions could be related to overprotection and are correlated with DPD traits. Despite little empirical evidence relevant to DPD, recent empirical research revealed that certain cognitive and integrative psychotherapies have proven their effectiveness in treating different DPD symptoms. CBT can target difficulties in decision-making and excessive reliance on others through training useful skills to adjust the clients' perception regarding their abilities and increase self-confidence. It is suggested that COT and existential group therapy highlight their effectiveness directed at maladaptive responses in emotions and social relationships. Furthermore, CAT as an integrative therapeutic approach, emphasizing dysfunction in identity recognition and alleviation in reassurance-seeking, is also resultful empirically. Conclusively, these psychotherapies could be considered to provide some guidelines in subsequent interventions for individuals with corresponding DPD symptoms. Nevertheless, there are several limitations in the field of DPD, mainly concerning sample size and number of empirical studies. One part of previous studies relevant to overprotection limited their sample selection to a fixed age range, a small number of participants, one side of gender, and restricted regions, cultures, and societies. As a result, low representativeness could bias the generalizability of the results to other groups with DPD. Noticeably, many empirical therapies related to DPD are subjected to western countries and are rather insufficient regarding the other parts of the world, potentially because DPD is regarded as westernized. Sociocultural factors might influence the actual effectiveness of different therapies. Consequently, researchers should include large sample size, with both gender and different cultures across the globe. Plus, partially due to the sparse cases of this disorder, there has been much less evidence of empirical studies on DPD in comparison with more popular axle I and axle II disorders. Hopefully, more attention can be paid to rare disorders like DPD in psychotherapy and research. This review can provide some suggestions for the design of intervention studies and practices for at-risk children and adolescents.

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