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Case Study

Overprotecting Parenting Style and Dependent Personality Disorder: A Case Study -

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ABSTRACT

Dependent Personality Disorder (DPD) is one of the most common personality disorders seen in mental health clinics. A girl of 24 years age came into counselling centre of Foundation University Rawalpindi Campus with the symptoms of Dependent Personality Disorder. Initial pre-testing and therapist observations of client verbcal and non-verbal attitude/behaviour confirmed diagnosis of Dependent Personality Disorder (DPD). Diagnosis was made according to DSM-5. After initial intake interview, psychological tests including House-Tree-Person (HTP), Thematic Apprehension Test (TAT), Rotter Incomplete Sentence Blank (RISB), Beck Depression Inventory (BDI) and Raven Standard Progressive Matrices (SPM) were administered on the client. Overprotection by her parent was the cause of her problems. After exploring the causal factors of her problem and diagnostic sessions, therapeutic sessions were conducted. Some techniques from cognitive behavioral therapy were selected for the client. After achieving satisfactory results of psychotherapeutic sessions, psychotherapy was terminated and client was recommended for follow up sessions.

Keywords: Dependent personality disorder; Overprotection; Psychotherapy

INTRODUCTION

Dependent Personality Disorder is classified as a Cluster C personality disorder (Fearful/anxious presentation). Throughout the developmental span, there are varying degrees of dependence on others which are normal and socially accepted and expected [1]. Infants are helpless and totally reliant on their caregivers for survival needs. Toddlers have a bit more autonomy, but are not able to care for themselves. Children and adolescents are expected to develop increasing degrees of autonomy and adults are expected to be self-reliant, unless they have a physical or psychological disability, or are in a short term impaired conditioned, e.g, an injury which impairs mobility. Elderly people may require varying degrees of care, depending on their health, and toward end of life, some will again be completely reliant on caregivers for survival. However, when an able-bodied adult or older adolescent does not have age appropriate ability to operate autonomously, the diagnostic criteria for Dependent Personality Disorder may be met.

According to the DSM-5, the prevalence of Dependent Personality Disorder was found to be 0.49% in the early 2000's, and is diagnosed much more frequently in females than males [2].

The DSM-5 does not specify risk factors for Dependent Personality Disorder. One risk factor that can be inferred is being female, as the disorder is more frequently seen in women than men. One possible risk factor for the development of Dependent Personality Disorder is very strict authoritarian parenting where decisions are made for children and teenagers inappropriately, fostering dependence and an inability to make decisions [2].

Individuals with dependent PD have extreme difficulty making decisions even with activities of daily living (such as choosing what clothes to wear). Any decisions require advice and reassurance from others, usually from one specific person. They have a fear of losing support and approval from others, particularly the individual they are dependent upon. Emotional reactions may not be appropriate, such as not expressing anger for fear of causing negative reactions [3].

These persons are submissive, helpless, have low self-esteem, and lack confidence. They have no initiative to take on projects without assistance, and are unable to act independently. The fear of being alone and unsupported can lead these individuals to enduring unpleasant actions or abuse to stay with the person they are dependent upon. Social relations tend to be limited to those few people for whom the individual is dependent. If a close relationship ends, there is an urgency to establish another one [4].

Individuals with dependent PD demonstrate self-doubt and pessimism, criticizing themselves and may consistently demean themselves. They take criticism and disapproval as proof they are worthless, and may seek overprotection and domination from others. Dependent PD is association with disorders including mood, adjustment, and anxiety disorders, and other personality disorders such as avoidant, borderline, and histrionic [2].

West found that participants with DPD had significantly higher scores on a compulsive care seeking attachment style and that participants with schizoid PD reported significantly higher scores on a compulsive self-reliance attachment style. They concluded that insecure attachment patterns offer a clinically useful system for characterizing the different interpersonal difficulties of DPD and schizoid PD.

Cognitive-Behavioral Therapy (CBT) is evidence based approach for DPD, with the goal of increasing a person's autonomy and self-efficacy. Allowing some dependence initially is important so the client becomes engaged. As this relationship is formed, the therapist may challenge dichotomous beliefs, such as the need to either be dependent or independent with no in-between. Therapists should note what triggers a client. For example, situations in which a client faces being alone may trigger the client's maladaptive patterns, which then causes anxiety [5]. Knowing these triggers will allow the client to learn more adaptive ways to deal with difficult situations. The behavioral techniques used involve techniques such as assertiveness training or dating skills, homework, relaxation training, and role playing [5].

Total sessions 9, Agency/Setting-Case was taken from Foundation University Rawalpindi Campus (Table 1).

History of present illness

Client was not well from past 3 months. She was having symptoms of fear, irrational worries, can't decide for herself, irresponsible, high need for other approval, fear of loneliness and difficulty in expressing disagreement. According to her, she was reared in too much supportive and pampered environment which incorporated all these traits in her. As she was the only child of her parents so her parents were too much conscious about her.

Past psychiatric history

Client reported that she experience these symptoms around 3 years ago firstly. Initially her worries were not too much high but with time she became stuck in all these problems. Before the onset of these symptoms, she did not report any other mental distress in her childhood and adolescence time period.

Table 1: Background of Client and Demographic details.

Background of Client	Demographic details
Name	XYZ
Age	22
Gender	Female
Education	B.A
Marital Status	Single
siblings	cccOnly child
Birth order	Only child
Occupation	House wife
Residence	ABC
S.E.S	Middle
Reasons/Mode/Source of Referral	Client was brought by her mother
Total sessions	9
Agency	Setting-Case was taken from Foundation University Rawalpindi Campus

Past medical history

Not found

Family history

Client family orientation of the client was religious. Her father was business man and her mother was lecturer. She was the only child of her parents. Her parents were happily married. No relationship problem was reported in any member of her family. She reported her parents too much caring, attentive and conscious.

Personal history

Client was born with full time pregnancy. She was born through C section but she and her mother did not suffer from any medical complication at the time of her birth. Her weight at birth was 5 pounds. She passed all the significant milestones at appropriate age.

Client was very shy since her childhood. She has and had very few close friends. She was very irritated and annoyed child since her childhood. She never shared her feeling to anyone. She was average child in academics. Her relationship with her parents were very good.

Pre morbid personality

Before the onset of her sign and symptoms she was little bit friendly and use to trust people very easily. She had few friends and some were very close to her.

Mental Status Examination (MSE)

Client was well dressed. Her appearance was neat and clean. She was behaving cooperatively. Her mood was good. She was well award by time, place and setting. No illusion and hallucination was noticed. She was fully attentive and her short term as well as long term was intact. She was looking anxious and submissive. No suicidibity and homosuicidibity was noticed.

Assessment

- House-Tree-Person (HTP)
- Thematic Apperception test (TAT)
- Rotter Incomplete Sentence Blank (RISB)
- Raven Standard Progressive Matrices (SPM)

House-Tree-Person (HTP): Her HTP interpretation indicated that client is having introvert personality type and having intrapersonal issues. HTP revealed that client is using regression mechanism and was living in withdrawal. Some indicators on HTP revealed that was having confused thinking, distorted personality and low self-esteem. Immature thinking, instability, inability to take initiatives and poor self-image was revealed by her drawing.

Thematic Apperception Test (TAT): TAT was administered on the client. It took 90 minutes to complete test. 10 cards were administered on the client. Main hero of her most of the stories was male. Her responses on TAT cards revealed that she was having conflicting relationships. Main hero of her most of the stories was male. It was observed while interpreting her stories that she has strong need for power. Her stories revealed that she was having intrapersonal issues and low self-esteem. Conflicting relationships with her environment were also indicated by the cards. Her resistance during responding to some of the TAT cards indicated her inner conflicts. At the start of the session, her mood was normal but as the session proceeded, her mood became depressed while responding on the TAT cards. She also demonstrated strong need for power and achievement. Regression of the feelings was also identified in all of her stories. The ending of her stories on TAT cards was optimistic, which indicated that no matter what she was experiencing, she was having positive attitude towards her life.

Rotter Incomplete Sentence Blank (RISB): She scored 130 on RISB which indicated that she was socially adjusted. Her responses on familial and sexual dimensions were negative like 'Parents must give freedom to their children', 'Father must not interfere too much in children matters'. Whereas her responses on other dimensions of RISB including social and general were satisfactory.

Raven Standard Progressive Matrices (SPM): Client completed SPM in 30 minutes. Her total score on SPM is 44 and her age is 22 which falls within 50th percentile which indicate that she is average intellectual.

Diagnosis

301.6(F60.7) dependent personality disorder

Case Conceptualization/Theoretical Orientation: Early studies of dependent personality traits were looked at psychoanalytically [3]. These traits were associated with breastfeeding and weaning. Those who became fixated at the oral stage would remain dependent on others for support. It was thought that high levels of dependency came from either frustration or over gratification during the oral stage, although research in this area has shown inconclusive results [6]. Loranger [7] found that a group of researchers identified two dimensions labelled insecure attachment and dependency, underlying the salient characteristics of DPD. These underlying dimensions appear to be the same as the attachment dimensions identified by Brennan [3], anxiety and avoidance respectively.

Progression of Therapy (No. of sessions): Total no of session with the client XYZ is 10. During the 1st session, initial intake was done from the client and client shared her problem and therapist tried to explore causal factors behind her issues. Consent was taken from the client and client was ensured that all the information taken from her will be kept confidential but confidently can be break if situation arises and information will be shared with the supervisor for case consultation purpose. Therapist observed that source of her problematic thoughts and behavior was her family environment.

Too much interference of her parents into her personal matters was the source of her worries and anxieties. Client was brought by her mother. Her mother complained that she over thinks and talks to herself most of the time.

2nd session was conducted with the aim of exploring causes behind her issues. Client was encouraged to describe all of the issues in details and possible causes behind her problematic behaviors. During 2nd session, client revealed that she suffered from extreme loneliness since her childhood. She also reported that she use to talk with her imagery friend in her childhood. While taking about her childhood, client revealed that her parents were too much caring since her childhood and they never allow her to play with her friends due to probability of possible injury. Client reported an average herself in studies. She revealed that she did not take interest in studies and just wanted to talk with her imagery friends all the time.

During 3rd session, different psychological test were administered on the client based on identifying problems of the client. Non-verbal behavior of the client was also observed during test administration process. TAT was administered on the client during 4th session. Some common themes which therapist identified in all the stories on TAT cards were emotional instability, strong need for affiliation, power, nurturance and fear of rejection.

After initial and diagnostic sessions, focus of the 5th session was on applying psychotherapies to overcome client's problems. Focus of the 5th session was to give some therapeutic suggestions to the client. Goals of the psychotherapy were set with the consent of the client at the beginning of the session. As the client was having intrapersonal and dependency issues so it was mutually agreed by the client and the therapist that the focus of the therapy will be on overcoming client anxieties and worries. During session client was taught the importance of taking decision of her life by herself. Focus of the therapy was also on teaching assertive techniques to the client. Client was encouraged to take all the decision of her life by herself rather by depending on her parent's approval. E.g, she was encouraged to wear dresses of her own choice rather than by her parent's choice. It was noticed during session that client was showing resistance in taking new ideas and replacing older one.

After the gap of 1 week, client came for 6th session. After some time, therapist inquired the client about the techniques which were taught to her in last week. Client reported that she tried to practiced them but was unable to act upon them due to high level of anxiety and fear of being alone if she did not seek approval/ support of her parents. Therapist encouraged client to trust her abilities by thinking what worst will happen if other will disagree her. Client was encouraged to put herself in a self-dialogue and dispute her irrational thinking by providing evidence to herself. Client was make realized that only she is responsible for her life decisions so she must have the courage to live realistically. At the end of session, client was given homework assignment of writing 5 plus and 5 negative points of being too much dependent on others. Focus of the session was to create awareness in the client and make her ready for treatment. As her problems were deep rooted in her personality so progression of psychotherapy was slow.

7th session was started with the positive mode. Client was inquired about the home-work assignment given in last session. Client wrote only 1 point for being dependant on others while she wrote 7 negative points of being dependant on others. In this way she was realized about the risk of dependency on others. Client was having insight about her problems but was adopting new thinking patterns slowly. Client was encouraged to trust her talents and abilities. Some aspects of religious therapy were also incorporated into session and she given references from religious books about the worthiness of independent decision making and about the purpose of life.

Therapeutic suggestions were continued during 8th sessions. Progress of client was slow. Client was asked to rate her improvement on the scale of 1 to 10. She rated 5 out 10. Client was encouraged to have realistic approach. She was encouraged to use positive statements about her capabilities and verbalize them as much as possible. Attempts were made to realize client that she is solely responsible for all the major decision of her life and it is not the thumb role that every of her decision must be correct rather making mistakes is the part of human life.

Last session was of termination. When client and therapist both felt that psychotherapy has achieved most of it goals set by the client and the therapist mutually, psychotherapy was terminated. Fellow up sessions were recommended to the client.

Therapist/client orientation dynamics

No issue of transference and counter transference happened in the whole process of psychotherapy.

Prognosis

The prognosis was not much favourable. As she was having personality disorder and prognosis of personality disorders is not always good due to their stable and enduring traits.

Termination

After achieving psychotherapeutic goals set by the client and therapist during 1st psychotherapeutic session, psychotherapy was decided to terminate. During 9th session therapist checked the progress of the therapy. Client told the therapist that she is relieving from problematic thoughts and behaviors. Client told the therapist that her sign and symptoms are getting low in frequency and intensity and therapist observation also supported this.

Before termination client was asked to rate her problem on the scale of 1-10. She rated her symptoms 6 out of 10. Post testing was done during last session. After achieving target goals of psychotherapy (As described by the client, post test result and therapist observation) sessions was terminated and client was recommended for follow up sessions and to monitor her own progress.

DISCUSSION

Dependent Personality Disorder (DPD) is one of the most common personality disorders seen in mental health clinics. Those with DPD tend to cling to others and have an extreme need to be taken care of. Many of the diagnostic issues involve the comorbidity of DPD, especially with avoidant personality disorder. There are a wide range of theories that attempt to explain the etiology and treatment of DPD including: biological, environmental, social learning, and cognitive perspectives.

DPD is part of the Cluster C personality disorders, along with avoidant and obsessive-compulsive personality disorders, which are all considered the anxious and fearful type [2]. Being among the most commonly diagnosed personality disorder, DPD is found in about 14% of people who have personality disorders and about 2.5% of the general population [5]. Although Cluster C personality disorders,

including DPD, show high base rates they still have been studied less than other personality disorders [8].

The girl in this case study developed symptoms of DPD. She was unable to make choices by her own. She always looked forward for other approval. Research has also proved that individuals with a Dependent Personality Disorder often tend to put their needs second to others, and yet at the same time are often able to get others to take care of them and to take responsibility for many areas in their life. They often tend to lack self-confidence and have difficulty in being alone for any length of time [5].

In the past, this personality style has been termed passive-dependent personality because of these characteristics. As far back as Freud, according to one psychiatric text, he described what he termed an "oral-dependent" personality characterized by dependence, pessimism, and frequent fear of sexuality in a number of areas, lack of confidence, passivity, easily being influenced, and difficulty in persevering with tasks through difficult times. His description is actually quite similar to many of the characteristics described in the current DSM-IV-TR diagnostic manual. It is generally accepted that Dependent Personality Disorder tends to be more common in women than in men, and one study that examined personality disorders overall found that approximately 25% of all personality disorders fall into this category.

It has also been found in some studies that individuals with chronic physical illness during her childhood may be more prone to the disorder. Although all of the factors for this are not clear, in my experience it often seems related to the fact that because of that childhood illness parents frequently tended to be overprotective with much of that dependence being learned. In their daily lives, individuals with dependent personalities are often characterized by frequent and rather consistent behavior characterized by dependence upon others and frequently being submissive, particularly if conflict occurs. These individuals struggle in making decisions and often seek a great deal of advice and reassurance from others to the point that frequently they seem to want others to make the decisions for them. Because of this timidity, they frequently avoid positions of leadership, even if they might have the ability to handle the position. The dependent individual also has difficulty in initiating tasks on their own and sticking with them, even though they may be able to do this for other people when the tasks are assigned. Because individuals with dependent personalities do not like to be alone, they frequently may seek out individuals in relationships with stronger personalities on whom they feel they can depend and lean on for strength. Unfortunately, this may also set the individual up for being involved in an abusive relationship, whether it is emotional, verbal, physical, or sexual. Not infrequently one finds that these individuals have rarely been without a boyfriend or girlfriend from their teenage years on into adulthood. Negative thinking, generally seen as rather global pessimism, along with self-doubt and fears of expressing either sexual or aggressive feelings are quite characteristic as well.

Our client who developed symptom of DPD also reported her parents over protected. She was the only child of her parents, this fact made her parents more conscious towards her. Overprotection was the main cause of her dependency in our case study. Many researchers have also suggested the possible link between parents over protection and development of DPD among children [8].

LIMITATIONS OF THE STUDY

Our study has following limitation as well.

- As it is single case study, so this fact makes it generazibility limited. More researches with large sample size can be done to make results more genarazable.
- This paper only highlighted the association between over protecting parenting styles and Dependent Personality Disorder while ignoring the contribution of other parenting styles towards the development of Dependent Personality Disorder.
- As client parents were the cause of her problem, so psychotherapy must involve them in therapeutic process but here too some constrains made it difficult to invite client's parents in psychotherapeutic process.

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