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Dependent Personality Disorder and Its Gender Differences

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Abstract: This article mainly focuses on the overview of dependent personality disorder as well as its gender differences, incorporating its definition, distribution, some reasons for gender difference in prevalence rate, impacts, treatments, and recommendations for future development. In the literature review section, the definition and features of DPD are firstly illustrated. According to DSM-5, dependency and submissiveness are summarized as two main traits of this disorder. Then, the distribution characteristics of age and sex of personality disorders are introduced and the findings of gender differences in DPD's prevalence rate are special and significant. To provide a more accurate diagnosis and treatment, the reasons for this gender difference have been discussed. In terms of previous studies, the causes can be summarized into two broad categories, namely factors related to measurement and factors for the real difference. Additionally, I clarify its impacts on individuals including physical abuse and occupational functioning and consider gender factors. Subsequently, some useful treatment methods are discussed. Recommendations at the end provided directions for future investigation. Overall, readers can have a more comprehensive understanding of this personality disorder and its gender differences after reading this paper.

Keywords: dependency, gender differences, personality disorders

1. Introduction

As social animals, human beings always have some dependent traits in their personality and the level of dependency could be varied at different ages. Therefore, dependency is relatively normal for everyone but when a dependent personality style becomes dysfunctional which has a negative influence on people's lives, this personality style would be conceptualized as a dependent personality disorder (DPD) [1].

Personality disorders are divided into three clusters, each reflecting overlapping traits: cluster A (sometimes referred to as "odd") disorders, cluster B ("dramatic") disorders, and cluster C ("anxious") disorders [2]. With some anxious and fearful features, like fear of separation and being abandoned, a dependent personality disorder is one of the clusters C. DPD is one of the most often diagnosed personality disorders, with roughly 14% of persons with personality disorders and 2.5 percent of the overall population having it [3]. Due to its relatively high prevalence rate, researchers need to attach more importance to DPD, which will be beneficial to the efficiency of treatment.

The debate concerning gender diagnosis rates still exists, prompting many professionals to investigate the disparities that genders display in DPD. Specifically, females have been diagnosed with DPD more commonly in clinical settings, while some research shows that males and females have equivalent prevalence rates [4]. There are also contradictions around whether this gender difference is real, which means whether the difference is caused by biological and environmental factors or by various errors in measurement. This article will concentrate on those controversies and

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some possible reasons to explain them.

Although plentiful literature has studied the etiology and treatment of DPD, this field still lacks enough research on its impacts or outcomes on individuals, especially the gender differences in the impact of DPD on either personal relationships or work. Besides, there are few studies discussing a comparison between real etiology and measurement error that might account for gender differences in the diagnosis rate.

In short, the focus of this paper is to offer an overall review of the etiology, impacts, and treatments of DPD. Besides, this article will consider gender and mainly discuss gender differences in prevalence rates as well as some possible reasons behind this phenomenon. Overall, this article is aimed to provide comprehensive knowledge about dependent personality disorder. The emphasis on gender differences is intended to provide possible direction for improving the accuracy of diagnosis and treatment of DPD in the future.

2. Literature review

2.1. Connotation

2.1.1. Definition

Dependent Personality Disorder, according to DSM-5, is characterized as a pervasive and excessive desire to be taken care of that leads to submissive and clingy behavior as well as separation anxiety [4]. Based on this definition, two major features of DPD could be summarized as dependency and submissiveness. Specifically, dependent behaviors include problems making day-to-day decisions and accomplishing tasks without the support or assistance of others. Submissiveness can manifest itself as fear of expressing opinions against others and involvement in undesirable activities because individuals with DPD are afraid of being disliked or abandoned by others.

2.1.2. Distribution

Dependent personality disorder doesn't require onset until early adulthood. Clinicians should note that the diagnosis should be used with extreme care in children and teenagers, whose dependent behavior may be developmentally appropriate.

In Loranger's empirical study, compared with people with most other personality disorders, people who are over 40 years of age and females were more likely to be diagnosed with a dependent personality disorder. In detail, 51.2% of people with DPD were over 40 years of age, and the dependent sample was 69.6% female compared with 30.4% male [5]. In clinical settings, the sex ratio for dependent PD is larger in females, according to the DSM-5 (prevalence in females according to NESARC 0.6 percent vs in male 0.4 percent) [4]. Therefore, it is necessary to explore the differences in the population of DPD.

2.2. Reasons for Gender Difference in Prevalence Rate

2.2.1. Factors Related to Measurement

First, a sort of examiner prejudice in which diagnosticians' gender preconceptions impact their assessments of psychopathology (and normalcy) in men and women [6]. For example, many people view dependency as a central feature of the concept of femininity.

Secondly, the diagnostic criteria may be biased because it was pointed out that the sex ratio in the DSM PD working groups is significantly unbalanced (for example, 82 percent of contributors were male) and that the diagnostic criterion may be formed by a masculine perspective as a result [7]. Besides, Bornstein illustrated that a symptom mentioned in the criteria may exist in one gender but

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the criteria don't provide comparable symptoms for the other gender [6].

Thirdly, some research found that when using self-report or interviews, females would have a higher prevalence rate of DPD than males but this difference could disappear by using projective measures of dependency. As Bornstein pointed out, the vast majority of the questionnaire and interview-based measures of DPD symptoms have high face validity, whereas all projective measures of DPD have low face validity [6]. In this instance, when individuals could be aware of what objects like dependent traits that examiners aim to test, males are less likely to acknowledge their experiences and symptoms of dependency than females in those self-report measures and interviews because of social norms and expectations.

Lastly, an inclination in sampling is probably responsible for this gender difference, which means more women than men are willing to seek help from professionals. The reasons for the difference in willingness to look for help might be that society expects males to behave more independently and assertively while females are looked forward to being emotional and agreeable [8]. This tendency leads to more female participants recruited in the clinical settings so that the proportion of each gender is uneven.

2.2.2. Factors for Real Difference

Genetic factors could account for the gender difference in the diagnosis rate of DPD. When extreme scores perform in the dimension of personality traits, individuals could be diagnosed with personality disorders. Women have been measured to have more dependent traits than men in several studies. Almost 50% of personality traits are heritable, according to a significant body of behavioral genetic evidence. Jang et al. conducted gender-by-genotype studies of the Dimensional Assessment of Personality Pathology in a large twin sample to investigate the association between gender, heritability, and characteristics [9]. The findings revealed that sex variations in dimensional measures of personality disorder and personality disorder diagnoses might be due to sex-specific genetic variables, but the effect of the environment was consistent across all dimensions in both genders.

2.3. Impact

2.3.1. Physical Abuse

According to DSM-5, people with DPD are usually equipped with submissive behaviors, such as volunteering to do unpleasant activities because of their low self-esteem and fear of separation. Therefore, it is extremely difficult for some of them to end a relationship that they can rely on by themselves even though this relationship is toxic. Loas and Perez found that DPD patients are more likely to suffer from domestic violence and the level of dependency is significantly correlated to the severity of physical abuse. Although the link between victim dependency and the risk of abuse is not exclusive to women, researchers discovered that the possibility of abusers being spouses increased from 1- to 11-fold in women. [10].

Another research by Dutton has studied abandonment homicide. Males are more likely to experience rage when they are aware that their spouses might leave or abandon them. Besides, researchers found most uxoricide (wife murder) perpetrators have suffered from childhood trauma and some personality disorders including DPD and their insecure attachment might become risk factors for abandonment homicide [11].

2.3.2. Occupational Functioning

Moscoso and Salgado illustrated that work performance is classified as task performance and contextual performance. They found the degree of dependent personality is negatively correlated with

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work performance and contextual performance and it also has a significantly negative correlation with task performance (r = -.24, p < .05) [1]. Therefore, dependent personality disorder might impair an individual's occupational functioning to some extent. The reasons for this impairment could be that people with DPD who lack confidence have difficulties in initiating projects or dealing with tasks independently and believe only other people rule or support them can they finish the work tasks [4].

People with DPD also have special features in labor market outcomes, including some gender differences. Maladaptive coping techniques are very common in personality disorders, and they can affect all interpersonal connections, including people's working relationships. For example, it is hard for individuals who are diagnosed with DPD to accomplish their work assignments only by themselves. However, completing one's work tasks or projects independently is a basic requirement in the workplace so people who couldn't meet this demand will be more likely to have negative labor outcomes. Specifically, data among males, diagnosis of any personality disorder was linked to a 0.020 increase in the chance of long-term unemployment (baseline probability = .090), and the reported problems of having had conflicts with a supervisor or coworker in the previous year were statistically significant [12]. Females had similar data reported but there still were some differences from males. For instance, the scores that women have trouble with bosses or colleagues are higher than males', and women who have any personality disorder in the past year have a higher risk of not having a job than men. Although there is still no specific data on occupational sex differences in DPD, we can infer from the available data as well as the description of the work characteristics of DPD patients in the DSM-5 that people with DPD may perform occupational dysfunction because of their excessive dependency on others.

2.4. Prognosis and Treatment

2.4.1. Prognosis

Treatment of DPD has a relatively good prognosis as well as a shorter and more efficient course of therapies since patients with DPD like to please therapies and seek help from others actively. Also, they can form relationships and make commitments [3].

2.4.2. Treatment

Many effective treatments could be used for DPD. First of all, because cognitive therapy (CT) can focus on patients' views about themselves as well as their fear of being evaluated, it is particularly useful for DPD [13]. CT could help patients with DPD reconstruct cognitions and then have a rational and appropriate understanding of their self-image and competence. Cognitive-behavioral therapy (CBT) and schema therapy (a developed form of CBT), are also used for DPD, to increase a person's autonomy and self-efficacy [14]. CBT generally includes relaxation and desensitization that could assist patients in dealing with their social problems and reducing their anxiety or fear of being abandoned.

Psychodynamic therapy is another efficient method to relieve DPD symptoms. These interventions can improve clients' self-esteem, autonomy, and individuation, educate them on how to manage their own lives, and seek help without being manipulative [3]. Based on the duration of treatment, psychodynamic therapy could be divided into two types: long-term and short-term psychodynamic therapy. Long-term therapy could promote emotional growth effectively, but time costs are high and it might be very hard to carry out in reality.

For people diagnosed with DPD, group and family therapy are frequently recommended. With many benefits for the validity of treatment, group therapy has been found to reduce the number of crisis visits and the amount of medication used by these clients [15], and family therapy could both facilitate progress and improve familial relationships [3].

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Sometimes, medication is required by people with DPD. Although there is no specific medication only aimed at DPD, a lot of medications could help people relieve their depression and anxiety. However, Sperry notes that a similar effect can be achieved through social skills training [12].

For the time being, there is no guarantee that gender-specific stereotypes will not influence the diagnoses and treatments of DPD and there is no study about gender differences in treatments of DPD.

3. Future Implication

Even though the existing literature has already provided sufficient knowledge about dependent personality disorder, there are still some areas for improvement in the future.

Firstly, more empirical studies should be carried out to provide solid evidence on whether genetic factors could explain the causes of gender differences in DPD. Although there has already been little research about the relation between personality traits and heredity, there is still a lack of research on pathologically dependent traits and genes.

Also, areas of study for DPD require more research about gender differences in the impact of DPD on individuals. The impacts of the high level of dependency as well as dependent personality disorders have been widely discussed in this field, but no researcher has done a specific survey on gender differences in each impact of DPD. For example, some researchers have explored gender differences in personality disorders on individual work performance or labor market outcomes but still haven't specifically addressed each personality disorder. Therefore, this is where future research could make some improvements. After understanding the different effects of personality disorders on different genders, experts can help patients overcome these difficulties in a targeted manner to reduce the harm of DPD to the patient's life.

Besides, in terms of treatments for DPD, no study on different treatment options between men and women. However, it is essential to consider gender factors because the severity of DPD in each sex seems to be varied. If clinicians provide different therapies to patients based on their gender traits, the efficiency and course of treatment could be improved to some degree.

Lastly, professionals in this field are recommended to make progress together to improve the diagnostic criteria of DPD since some sex biases may exist in standard settings. The DSM PD Work Groups are recommended to recruit more female experts so that the gender ratio within the groups could be balanced which may reduce the level of sex bias from the masculine perspective.

4. Conclusions

In conclusion, the gender difference in the prevalence rate of DPD has attracted many researchers' attention. The gender difference in DPD is attributed to both factors related to the measurement process and genetic factors. First of all, many studies have found females are diagnosed with DPD more frequently than males, and the reasons behind this might be diagnostic, criterion, self-report and sampling sex bias. Additionally, some professionals hold the opinion that there are some sex differences in personality traits, such as dependency and these traits are heritable through genetics.

Two impacts of DPD which are physical abuse and impaired occupational functioning as well as their gender differences are mentioned in this article. Individuals with DPD may have a higher possibility to suffer from physical abuse from their spouse than other personality disorders because of their fear of ending relationships and the female gender tends to increase the possibility that perpetrators are a spouse. Besides, males with DPD might commit abandonment homicide. Concerning work, people with DPD have trouble accomplishing projects without help from others so they tend to have worse work performance, especially task performance than others.

To prevent those terrible consequences, several treatments including cognitive-behavioral therapy, psychodynamic approaches, group, and family therapy as well as medication could be applied to

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practice.

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