

Effectiveness of cognitive therapy in treatment of Dependent personality disorder (DPD)

Dr. Nimrat Singh [1]

Abstract:

Three middle aged and middle class women aged 34, 41 and 33 undergoing treatment for 5, 10, and 12 years respectively were referred by a renowned Psychiatrist for Psychotherapy. All the women were being treated for dependent personality disorder with predominant symptoms of anxiety by the Psychiatrist. This was further diagnosed clinically using the Rorschach Inkblot Test and Draw-A-Man test. Psychotherapy using Life Role Analysis and CBT were designed and patients were met twice a week for 3 months. The technique was evolved by the author during clinical practice in which, for the first 2 to 3 sessions, childhood experiences and critical incidents were explored. Further to that, the CBT technique was applied.

Two weeks after psychotherapy began, all patients showed progress measured by their symptoms and reduction of dosage of medication. They reported that they were more assertive, and were able to do things independently. They were less self-doubting and hence less anxious and helpless in their behavior. This change was observed and endorsed by their respective spouses. Therapy worked on the common schemata 'I am inadequate hence, I need others to complete me'. Homework assignment provided instant feedback and reinforced continuous and positive change.

The result of short term psychotherapy has been highly encouraging in helping individuals adapt healthy thinking patterns and hence reduce their dependency on medication.

Key Words: Dependent Personality Disorder (DPD), Life Role Analysis (LRA), Cognitive Behaviour Therapy (CBT).

Article History: Received: 15th May 2019, Revised: 29th May 2019, Accepted: 03rd June 2019, Published: 30th June 2019.

Introduction:

Psychopharmacological treatment has been partially effective in the treatment of 'Dependency personality disorders'. However, the biggest challenge is the pace of therapy as patient with DPD, fall out of therapy very quickly. Moreover, they tend to lean heavily on drugs to appease anxiety levels most often associated to DPD. Psychodynamic therapy was thought to be only effective approach around five decades back as it showed effective results in some controlled trial studies. Stone (1993)⁽¹⁾ suggested using a collaborative approach of supportive therapy, psychoanalytical intervention and cognitive behaviour therapy for effective results.

CBT focuses on self-defeating thought patterns. It fails to resolve characterological issues as CBT ignores deep down hidden schemas which are resistant to change with conscious effort. Hence, these inflexible patterns hinder challenging thoughts and adopt healthier behaviour. Even large number of session sometimes proves to be futile due to underlying rigidity. (Masroor & Seema, 2012)⁽²⁾

Schema is characterological component of personality. The other is the temperament defined as innate biological and constitutional influence on personality while dealing with PD in Psychotherapy, both dimension held to be considered for effective results. (Costello, 1996)⁽³⁾

The concept of schemas can be traced back to the early

writings of Beck and from the perspective of psychology /psychotherapy; a schema can be referred as some extensive organizing code for making sense of one's life experience. Adler used the term "schema of apperception" and for him it is central to person's life style and the psychopathology refers to a person's "neurotic schema". Millon established that personality disorders can be conceptualized in a broader perspective by including both temperament and character. Schema refers to a set of core beliefs that he has learned from his childhood experiences, and has been utilizing them to maintain a view of self, world and future. It also is believed to be central to CBT and psychoanalytic therapy, yet these both have their own traditional conceptual frameworks.

Individuals with DPD do not actively participate in therapy process usually. Yet another pattern of dependency as responsibility of taking care of their lives is assumed to be domain of others around them. They view the world as others will protect them and will care for them.

Young (1999)⁽⁴⁾, developed schema therapy as a systematic approach to treat patients with chronic characterological problems expanding traditional CBT by utilizing techniques from several other therapies for treating such cases. Schema focused CBT mainly places its emphasize on exploring childhood and adolescence experiences to reach to the dysfunctional and maladaptive attitudes and schemas. He also asserted that some of these schemas were the result of "toxic childhood experiences" a core of personality disorders.

⁽¹⁾Tangram-tracking the human mind Email: nimrat@tangramhr.com

A revised, comprehensive definition of an Early Maladaptive Schema was given by Young (1999)⁽¹¹⁾ is as follows “An extensive, persistent theme or pattern:

- comprised of memories, emotions, cognitions, and bodily sensations
- regarding oneself and one's relationships with others
- developed during childhood or adolescence
- elaborated throughout one's lifetime and
- dysfunctional to a significant degree”

Failure to achieve desired results through merely CBT in case of DPD refers to the core set of beliefs that one cannot perform as well as others, so no attempt is made out of fears of failure. As we proceed a little deeper, we can easily identify some schema functioning as determining factor. Their functional dependency/incompetence schema are supported by their beliefs like “I am helpless when am left alone” and “I must not do anything that offends my supporters and helpers”. Uncovering the deeper layers of behaviour patterns and reaching into the inner most layers of thoughts, core beliefs and schema while making sense in the present context poses the biggest challenge. The paper attempts to discover and unfold the steps using the life-role analysis along with the techniques of CBT.

The Life Role Analysis (LRA) is a counselling process that was largely adapted by Dr. Keith Magnussen of the University of Saskatchewan and Dr. David Redekopp for The Centre of Career Development Innovation in Alberta. It is a comprehensive view of Career Development that integrates elements of classic trait and factor techniques with person-centered cognitive behavioural and system theory approaches. In this view, 5 processes seem to be critical in the counselling practice, which include initiation, exploration, decision-making, preparation and implementation. (Magnussen 1992).⁽⁵⁾

The Life Role Analysis requires personal involvement from the client. It involves their direct contribution and it increases their participation as well as their self-awareness in vocational and a-vocational opportunities. A Life Role Analysis increases their level of responsibility for a positive well thought outcome. In essence, the client takes ownership of the outcome where they have fully participated and engaged in the Life Role Analysis process.

Aspects of the Life Role Analysis involve a Career Self Portrait which is a simple method that assists the clients to examine themselves from four aspects. The first aspect is meaning what are their values, beliefs, interests and barriers to any of their goals and meaningful relationships or interactions? Outcomes A component of a dream or future vision. What could happen if I do this? How would I choose my goals? Activities Includes what he / she have preferred to do given the choice for leisure, work, family, etc, and also examining their past what they need or what has not been fulfilled in their life from an activity level. Finally, Tools and Techniques include the vision of potential transferable skills

such as general skills, knowledge, personal characteristics and attitudes.

Life Role Analysis becomes “a living document”. It also encourages dreaming. “In the best of all worlds, what do you want to get out of life?” Where do you vision yourself? What do you think the future will hold for you from a personal, psycho-social and physical / cognitive level?”

The process assists the participant to identifying their current situation, environment, strength, abilities, barriers, needs, skills / knowledge (self management), technical (transferable), values (interests, beliefs), support networks, goals (education, employment, personal) and action plan. Each goal has an action plan and, as well, the Life Role Analysis, along with the individual, set time frames around pursuing these areas. (Redekopp, 1994)⁽⁶⁾

The Integration of LRA and CBT Process in the therapy is represented in the following description:

Table 1:

Initiative	Exploration	Decision Making	Preparation	Implication
Introduction and case study of client. Meeting with the spouse	5 significant incidents, + parental description, + parental message.	Understanding underlying pattern and common threads of behavior (action) choices and the implication on the 'here & now'.	Understanding AT, assumption in thinking and schemas. Readiness for change CBT worksheet and Homework assignments	Action plan, experiencing change and overcoming defenses, blocks and difficulties

Case 1:

A 34 year married woman, highly accomplished with M.Ed., C.A., and Fashion Designing degrees. She was the first born and presently she is a home maker by choice.

She described herself as lazy, uncommitted, irresponsible, and low on self-drive, and reactive. She reflected that she has been on and off on medication. Her immediate reason for coming for psychotherapy was her husband's insistence to meet a Psychiatrist to deal with anger and laziness. In the past, she had been put on drugs (Anti-Depressant and Anxiolytics)

She felt that her parents and husband have different ideas from her and end up pushing her into activities she disliked. To gain their approval and acceptance she had succumbed to their demands and done things to please them. So, she does not feel energized and enthused to do much. She cannot handle adversities. She was overly sentimental, yet responded by showing indifference to most people. She expressed that others can't understand her and left vain about it.

Father's message: 'I am there, whenever you want'.

Mother's message: 'You can do anything'.

She shared that her father was ever ready to help her but did not empower her. While the mother felt that she was resourceful enough to do anything she wished to do.

Although she had a love marriage, she constantly, suspected

her husband is having affairs. She undermined herself as not being good enough. She held her husband in great respect till the time she suspected him having an affair. Her husband was overly critical about her behaviour. He shared that he was grossly disappointed with her infantile attitude towards household duties. She lacked energy and enthusiasm and could not manage servants too. He has been and has caused medically. He showed apathy towards the relations and constantly reminded her of how useless she has been. She has been occupied by, his cold war and ends up whiling away time. She fantasized her feelings as she had fears of confrontations and rejection from her spouse. She believed that 'things are never under control and I can't manage'. She felt utterly helpless.

Case 2:

She is 41 year first born child. She is an MD Doctor and working in Government Service teaching in a Medical College, She had been suffering from Psychotic Depression as diagnosed by a Psychiatrist 10 years back and has been on medication for the last 6 years.

She described herself as very confident, extroverted and affiliative, loved being with family and friends. She tended to go out of the way to be helpful to family. She is married to a civil servant for last 24 years. She is suspicious about her husband and fear that he is having an affair. Since he is an IAS officer his work demands travel, but she is always gripped with fear of losing him and questions his fidelity. Her immediate reason for coming for psychotherapy was her that she is suffering from anxiety and sleeping difficulty.

In her case history, she shared that her parents were very strict and their primary focus was only to get the children to do well academically. They were rarely taken for outings. When she was 5 years old, she was physically abused by her servant, while the parents were away. Then again at the age of 13 years, she was abused by her maternal uncle. Her parents never understood her fears. Father frequently hit her and mother expressed passive aggression towards her. She would stop talking to her when upset.

Father's message: 'Always study and be ambitious'.

Mother's message: 'Don't trust people easily.'

Her father had struggled in life so he believed that all can be accomplished if one has a good degree. The mother was a reserved and aloof woman and found it difficult to express physical affection on her children.

She continued to remain focused, serious and determined in perusing her career. It was difficult for her to enjoy humor and fun. She felt socially anxious during get together. Husband described her as infantile, touchy, sulking, doubting him with female colleagues, suspicious and detached to her primary as well as her secondary family.

She come through as utterly helpless, had a very high need to belong, despite her accomplishments. Yet her behaviour is incongruent to her feelings she is unable to communicate her feelings. She ended up with outbursts of anger especially with husband and children. She had suffered from panic attacks in the past. She expressed her duality 'outside I show I am jolly and happy, but within I am insecure and dependent'.

She felt like a misfit in her in-laws family. She expressed that others extract from her as she cannot assert herself. She believed that she had no control on things and her husband was more influenced by his family and friends rather by her.

Case 3:

She is 33 years old, and a home maker. She is a commerce graduate. She has been on medication for the last 6 years and wanted to give it up. She was paranoid about getting drug dependent, had developed an aversion towards medication. She was of the belief that her in-laws are purposely forcing her to take medication. So that she was sick, and her sister-in-law could take over the house hold control. She was suspicious and doubted people around her.

She was the middle child, came from a humble background. Her father ran a grocery store and she would help him at times. Her parents caught her dating her father's employee in the 9th grade, ever since she was kept under their scrutiny and she felt deprived and 'went crazy' on seeing boys.

She grew up feeling confused and throttled. Her sexual urges remained unfulfilled, and feared losing he parents acceptance. Her need to belong was predominant and she felt guilty about her behaviour. She has been highly anxious about failing, social acceptance, and being ridiculed. She grew up confused about being herself versus fulfilling others expectation.

Father's message: 'Be a good, obedient person'.

Mother's message: 'Don't make friends'. 'You are gullible, so don't trust others'.

He father was a simple god fearing man and lived by the rules of his culture. No imperfections were tolerated and he wanted her to be obedient and lady like. Her mother stopped trusting her coping skills and encouraged her to keep a safe distance from friends. She was married in a joint family. Her elder sister was hands in and very resourceful. Her husband respected and listened to his Bhabhi and the client felt inadequate and inconsistent as compared to her sister-in-law. She had put on tremendous weight because of the psychiatric medicines and started feeling self-conscious. She got into a shell and the husband was worried about her. She expressed jealousy towards her sister-in-law and yet loved her.

II.METHODOLOGY:

Hence the focus of the therapy was around the following objectives:-

All the three had almost common goals and expectations from the therapy sessions:

1. Don't want to depend on medication any more.
2. Want to work towards being more respectful towards myself and reduce my dependency on my husband.
3. Want to stop bothering about the past and what others say to me and think about me.

In keeping with their goals the therapist aimed to:

Reduce dependency on repetitive schematic thinking by providing insights and empathy into behaviour.

- Proactively plan and carry out tasks and activities in the 'here and now'. So they get hands on understanding of how change can happen just by trying new behaviour.
- Empower them to manage their thoughts even though they are disturbing.
- Find ways to confront thoughts and anxiety provoking situations rather than avoiding them.

Assessment Findings: The key and common areas for all three clients as the Draw- A- man and Rorschach Inkblot test are summarized below:-

Draw – A – Man	Rorschach
• Childish ways of thinking • Indecisiveness • Low self-image • Aggressive • Insecurity regarding relationships • Helplessness	• Feeling of Inferiority • Fixed ways of thinking • Adjustment difficulty with environment • Difficulty taking decisions • Disturbed inter-personal relationship (especially with mothers) • Over sensitive disposition • Low self-confident • Difficulty accepting reality (Kindly refer to Appendix 1 for detailed summary and findings.)

They fulfilled the DSM-IV criteria of dependent personality with features of generalized anxiety. (Refer to Appendix 2)

Therapeutic intervention:

1. After establishing a comfortable working relationship with the client, the first structured exercise was designed to give the client an idea of 'patterns in thinking'. The exercise is called life-role analysis in which she was asked to recall and narrate incidents around different phases of life. Namely, story of birth, from birth to 5 years, from 6 to 12 years, from 12 to 18 years and one or two recent incidents. The client was free to choose any incident she wished. It could be sad or happy.
2. In the second part, of LRA, the client had to describe both her parents giving adjectives / attributes.
3. Lastly, she was asked to recall one significant statement or a message that she received specifically from her mother and father respectively.

These incidents, adjectives and messages were all expressed, discussed and interpreted. The common threads were picked up by the author and the client was helped to discover her own meanings to the incidents narrated by her.

The clients were encouraged to use the technique of 'free

association'. The essential part of the sharing was the feelings and sentiments associated to the incidents. The client was given unlimited time to reflect on the significant experiences. Once the client was over with all the three exercises she was asked to share them in her own verbatim. Journaling formed an integral part of the therapy. She came back with many more thoughts and insights from her past. Hence, this created a strong sense of ownership and commitment towards her being and it opened up doors to the unconscious material hidden from childhood. Two of them remarked that they had never shared such truth with anybody. They were certain more relaxed as the therapy continued.

Once the cause(s) and symptoms were recognized and established for each client, the way forward was to identify the 'difficulties and conflicts' in the here and now. And to establish the connection between their own automatic thoughts (AT), core beliefs and schema and its implication of present behaviour. For example: one of the women had difficulty in trusting on her husband on many occasions. In reality, he had not shown such patterns of infidelity. However, the belief about 'men' behaving in particular ways was stemming from her past. She had been molested on two occasions. So her automatic thoughts was 'Men are trust worthy'. Her core belief was 'Men don't respect women' they treat women as sex objects.

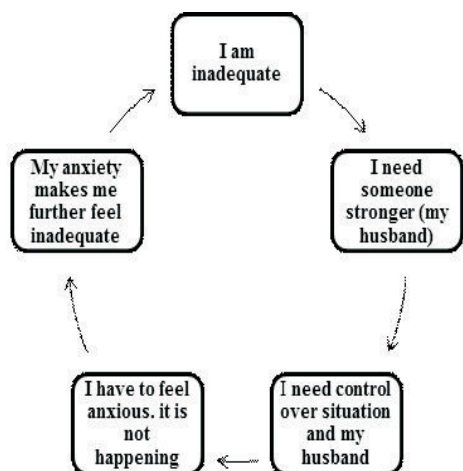
Schema 'I need strong protection from my husband. I am incapable of protecting myself.'⁽⁷⁾

Hence, these thoughts used to manifest themselves in a way that even if the husband went to play badminton with his friends, she would keep visualizing, that he is getting physical with the friends' wife and he will leave her. She aborted her husbands' foreign study trip on account of her fears. Hence, this deep rooted anxiety stemming from her past traumatic experiences with men kept manifesting in paranoid ways, whenever the husband left home.

The CBT worksheets where she was able to identify the physical symptoms, her manifest behaviour, the feelings associated to the thoughts were slowly introduced in the fourth session. She identified her own unhelpful thought (cognitive distortion) and made her own connection. The seed (cause) and tree (symptom) diagram was continuously examined in each session. She slowly started making her own connections, questioning her own propensity of recreating her past despite not wanting to do so. Her anxieties and her defenses were identified. How they were protecting her from dealing with her childhood traumas.

Her husband was asked to share his difficulties and he echoed the same sentiments that she had described. She was sorry for being such a difficult wife. The discussion helped the husband empathize without pitying or irking her. It was important to bring in the spouse to understand her past and how it's unfolding in the present were important for rehabilitation her and healing her. This was significant for their understanding the difficulties that both had gone through on account of her assumptions and schemas.

The vicious loop of thinking that was reinforced from childhood put her behavioral patterns into a new perspective.



This had a strong impact on her understanding and she felt easier, slept well and remarked 'I am not as strong as I thought I was. Now, I know I can help myself and can begin again'. She was ready to put down her defenses and face the realities in the present context.

The above cited therapeutic intervention is one way of how the client was helped to see through her thoughts, assumptions and schemas. Similarly other clients too were guided through their experiences. There were few common findings although the incidents narrated by each client were very different. The common thread running between the experiences were as below:

Common aspects of personality derived from their sharing's:

1. All had difficulties with the mother. The mother figure was seen as impersonal, detached and tough poised.
2. All were bitter with their parents and yet tried very hard to make them happy. (Reaction formation)
3. They carried undischarged anger (passive-aggressive) within. Masked their feelings and appeared socially appropriate.
4. They had poor coping skills and lived with the inner v/s outer conflict throughout life. They grew up with a strong 'poor me' feeling and brought it to the counseling sessions.

All the above aspects were substantiated independently by the Rorschach findings as well.

III. DISCUSSION:

Treatment of Personality Disorders remained questionable on account of diversity and overlap of diagnostic criteria. Hence, every case has to be examined individually and modulated vis-à-vis the frequency of sessions, medication, alongside therapy, termination of medication, termination of

therapy, and the use of other therapeutic techniques. This in a way forms the hallmark of a successful treatment. The three clients also showed different inclinations, orientations and insights into their life experiences. Psychological mindedness, readiness to change and the ego strength along with the family support play a significant role in the client's recovery.

The present cases demonstrate certain key features of DPD and the psychological management of the core symptom i.e. intense insecurity sphere(s) of life, avoidance, aggression or passive aggression. In all the clients - a strong rigidity in thinking and difficulty with interpersonal relationships with significant others was noticed. Through the LRA the clients were helped to examine themselves from four aspects of the significant incidents that they got in touch with meaning, outcome, activities and tools and techniques.

They are able to constantly provide themselves with valuable insights given the same situation and environmental context. The challenge is to make changes on their schema by being aware of their automatic thoughts about themselves significant others and the world at large.

The process assessed the participants to identify their current situation, environment, strength, abilities, barriers, and needs, skills, learning mechanisms, support system (family and work) and action plan. Defined times lines with focused goals formed working framework of the therapy. The LRA and CBT were interwoven into the design of the therapy.

This resulted in client's feelings the need to explore the power and energy within themselves. One client reported that she is already feeling lighter and has been consistently going for a walk without worrying about what others would think of her. Another client started going to the gym, on her own. Her husband had forced her to go earlier on many occasions but in vain. The third client called her in-laws for the first time in 23 years just to bond with them. She was far at ease, when her husband left home for his morning sports. The next challenge was to reduce the intake of medicines and give them up if possible. Two of the clients tapered and slowly gave up medication. One client is still preparing herself to do so. However, her dosage has come down and she showed marked improvement in her relationship with her husband.

During the course of treatment, the respective spouses were involved too and they were informed about the nature of disorder and encouraged to provide strategic support to their wives. Interestingly, the suggestion was well received as they too were tired of the difficulties. The family had faced on account of the DPD symptoms.

They were provided with graded challenges as per their reality and were provided self-help worksheets. So, that they carried the changed behaviour into their day-to-day lives.

III. CONCLUSION:

Challenging negative thoughts and breaking vicious cycles of marinating the problem are effective strategies of psychological treatment of personality disorders. Understanding, the seed (cause) and tree (symptoms) through CBT to address underlying maladaptive patterns of DPD needs to be constantly reinforced through follow up treatment and patient to be reassessed through the Rorschach Inkblot Test after 9-12 months.

Appendix 1

SUMMARY OF PATIENT HISTORY OF DISORDER

Pre morbid Personality	Significant incidents in growing up	Parental messages in growing up	Nature of clinical diagnosis and treatment	Precipitating cause for Psychotherapy	Schema and Cognitive Distortion
B.P. – 34 years • Mild, passive, contented, obedient, conforming, caring, socialized, secretive	- Born after death of elder sibling. - Made monitor of class due to good behaviour. - Forced to take commerce by parents. - Walked for 35 minutes to propose for marriage.	Father's message: 'I am there, whenever you want'. Mother's message: 'You can do anything'.	She has been on and off on medication. 1. DPD 2. Anxiety. 3. Poor Adjustment Medicines: Veniz, Cipralax, Tetrabe	- Getting too laid back and lazy. - Reactive, anger without provocation.	- If I want love and total acceptance of significant others, I have to comply and conform to them. (I am inadequate and incomplete). - Men are strong and in control of women. (I am helpless yet passively aggressive)
A.S. – 41 years Serious, hardworking, obedient, fearful, conforming and unexpressed	- Sexually abused by servant at an age 5. - Sexually abused by mama at an age 13. - Illustrious academic records	Father's message: 'Always study and be ambitious'. Mother's message: 'Don't trust people easily'.	1. DPD 2. Depression and poor impulse control Medicines: Venlift-OD, Lancovp,	- Uncontrollable anger outbursts. - Impulsive and regressive behaviour. - High level of anxiety.	I am inadequate so I have to work very hard to prove myself. - No degree is enough to complete me. - I have to rely on others relations. - I need to control the situation and need full check on my husband and his movement.
S.A - 33 years Responsible, touchy, guilt ridden, strong superego, fearful, risk averse	- Caught read handed with servant boy by parents. - Could not establish intimate relationships due to trust issues.	Father's message: 'never give into temptation's'. Mother's message: 'Don't make friends'. 'You are gullible, so don't trust others'.	Medication for 6 years. 1. DPD 2. Anxiety and poor adjustment. Medicines: Venlift-OD, Lancovp,	Insecurity and highly anxiety related to – Performance, Physical appearance and towards people.	- I am unworthy of love and I am inadequate. - People do not love me so, I have to hold on to them and do everything to belong to them.

Appendix 2

SYMPTOMS OF DEPENDENT PERSONALITY DISORDER

In the Diagnostic and Statistical Manual of Mental Disorders, ^{(8),(9)} 4th Edition Text Revision (DSM-IV-TR), the American Psychiatric Association states that five of the following criteria should be present for a diagnosis of dependent personality disorder:

- difficulty making decisions, even minor ones, without guidance and reassurance from others
- requiring others to take responsibility for major decisions and responsibilities beyond what would be age-appropriate (e.g., letting a parent choose a college without offering any input on the decision)
- difficulty disagreeing with others due to an unreasonable fear of alienation

- unable to initiate or complete projects or tasks due to a belief that he or she is either inept or that the appearance of success would lead a support person(s) to abandon him or her
- takes on unreasonably unpleasant tasks or sacrifices things in order to win the approval of others
- unable to spend time alone due to a lack of self-reliance and an unreasonable fear of being unable to care for oneself
- inability to remain independent of a close relationship as manifested by seeking a substitute support relationship immediately after one ends (e.g., a teenager who feels she must have a boyfriend constantly to validate her self-worth)
- Unrealistic preoccupation with the thought of being left to care for oneself.

Dependent personality disorder is more common in those who have suffered from chronic illness in childhood. A child may also exhibit dependent behavior in response to a specific stressful life event (such as the death of a caregiver or a divorce). However, it should not be considered a potential symptom of dependent personality disorder unless the behavior becomes chronic and significantly interferes with day-to-day functioning and/or causes the child significant distress.

Read more: <http://www.healthofchildren.com/D/Dependent-Personality-Disorder.html#ixzz2rCYt4E16>

Appendix 3

RORSCHACH REPORT

Total Responses: 23

Cards Rejected: 1

Total Time: 23 minutes

Average Reaction Time: 24.66 sec

Location	Determinants	Content	Reality Testing
W - 8	F%	Popular - 13	F+ - 10
D - 14	M - 1 C - 2 Fc	Original - 10	F- - 13
d	FM -1 CF -1 cF	A -7 H -1	F4% - 48%
Dd - 2	Fm -1 FC FK	Ad + Hd 2 + 0	Bt -0
(dd, dc, di, dr)	F -16 kF	At - 4	Sex -0
S - 1	C' - 1 KF	Blood -2	Art -2
	Cn - 1		
	VF - 1 Fk,	Arch-2	Cg-2
	V -1 FC' Hh - 2	(H)- 1	
	C'F N -1	(Hd)-1	
		Sc- 1 X-Ray-1	

SUMMARY: Dependent Personality Disorder

Appendix 4**Rorschach Test Findings:-**

A projective tool was used to gain insights into 3 client's thoughts, feelings, complexes and conflicts. The key findings are as below.

1. In Rorschach protocol, their reaction time varied on different plates on some plates they were fast in their response and on others they were slow.
2. In this protocol observed responses are detail oriented and rotated each card which shows high anxiety to deal with reality.
3. Depth responses, texture responses along with black as predominant color response indicated that they tend to regress and require emotional support from their environment. They are low on energy.
4. In plate number 7th the highest reaction time indicates difficulty with mother.
5. High response time recorded on 10th protocol indicates - difficulty in organizing thoughts and low stress tolerance.
6. Low reaction time recorded on 5th card indicates reactivity towards reality and fixed way of thinking.
7. Their high percentage of animal responses indicates immaturity and maladjustment with their environment. This protocol suggested poor ego strength and low group conformity- showing poor coping ability.
8. Human responses were low - that indicated withdrawn and disconnect with their environment. Their emotional bonding and connectivity with significant people was affected.
9. Color responses indicate heightened emotions and poor emotional control. They are likely to be experiencing many emotions, but are unable to channelize them constructively.
10. They had given four anatomical responses indicating inferiority complex and low self-confidence.
11. Prominent Colour red indicates increase in need of sexual desires.
12. Colour responses were higher than the movement response. That indicates that their impulse control is not well developed and is high on emotional excitability.

DIAGNOSIS:

Dependent Personality Disorder with Anxiety

RECOMMENDATION:

Psychotherapy along with medication is recommended.

References:

1. Stone, M. (1993). *Abnormalities of Personality: within and beyond the realm of treatment*. New York: Norton.
2. Uzma Masroor and Seema Gul: Schema focused CBT Intervention of Dependent Personality Disorder: A Case Study. *International Islamic University, Islamabad. Pakistan Journal of Clinical Psychology*, 2012, 11, 1, 43-57 Institute of Clinical Psychology, University of Karachi.
3. Costello, C. (Ed.). (1996). *Personality characteristics of the personal disordered*. New York: Wiley.
4. Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach*. Sarasota, FL: Professional Resource Press.
5. Stein, D., & Young, J. (1993). Schema approach to personality disorder. In D. Stein & J. Young (Eds), *Cognitive science and clinical disorders*, 272-288. San Diego: Academic Press.
6. Mary Hansen, with Susan Hrovat, and Gail Fraser, CDP. *Life Role Analysis- A Clients Personal Journey to Vocational Change on 20th Nov 2009 of "Moving Towards Wellness" Ltd.*
7. Redekoopp, (1994) LRA and CBT Process - Ontario doctor reprimanded for role in OxyContin overdose deaths.
8. Fawcett, J. (2002). Schemas or traits and states: Top down or bottom up? *Psychiatric Annuals*, 32 (10), 567.
9. Perry, J. (2004). Review: Psychodynamic therapy and cognitive behavioral therapy are effective in treatments of personality disorder. *EvidenceBased Mental Health*, 7, 16-17.
10. American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed, TR.)*. Washington, DC.
11. Sperry, L. (1995). *Handbook of the diagnosis and treatment of DSM-TR Personality disorder (2nd ed.)*. New York: Brunner-Routledge.