

Dependent Personality Disorder: Breaking Free from Submissiveness

Authored by
mohammad looti

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Dependent personality disorder (DPD), formerly known as asthenic personality disorder, is a personality disorder that is characterized by a pervasive psychological dependence on other people. This personality disorder is a long-term (chronic) condition in which people depend too much on others to meet their emotional and physical needs.

The difference between a 'dependent personality' and a 'dependent personality disorder' is somewhat subjective, which makes diagnosis sensitive to cultural influences such as gender role expectations.

Characteristics

View of others

Individuals with DPD see other people as much more capable to shoulder life's responsibilities, to navigate a complex world, and to deal with the competitions of life. Other people are powerful, competent, and capable of providing a sense of security and support to individuals with DPD. Dependent individuals avoid situations that require them to accept responsibility for themselves; they look to others to take the lead and provide continuous support. DPD judgment of others is distorted by their inclination to see others as they wish they were rather than as they are. These individuals are fixated in the past. They maintain youthful impressions; they retain unsophisticated ideas and childlike views of the people toward whom they remain totally submissive. Individuals with DPD view strong caretakers, in particular, in an idealized manner; they believe they will be all right as long as the strong figure upon whom they depend is accessible.

Self-image

Individuals with DPD see themselves as inadequate and helpless; they believe they are in a cold and dangerous world and are unable to cope on their own. They define themselves as inept and abdicate self-responsibility; they turn their fate over to others. These individuals will decline to be ambitious and believe that they lack abilities, virtues and attractiveness. The solution to being helpless in a frightening world is to find capable people who will be nurturing and supportive toward those with DPD. Within protective relationships, individuals with DPD will be self-effacing, obsequious, agreeable, docile, and ingratiating. They will deny their individuality and subordinate their desires to significant others. They internalize the beliefs and values of significant others. They imagine themselves to be one with or a part of something more powerful and they imagine themselves to be supporting others. By seeing themselves as protected by the power of others, they do not have to feel the anxiety attached to their own helplessness and impotence. However, to be comfortable with themselves and their inordinate helplessness, individuals with DPD must deny the feelings they experience and the deceptive strategies they employ. They limit their awareness of both themselves and others. Their limited perceptiveness allows them to be naive

and uncritical. Their limited tolerance for negative feelings, perceptions, or interaction results in the interpersonal and logistical ineptness that they already believe to be true about themselves. Their defensive structure reinforces and actually results in verification of the self-image they already hold.

Relationships

Individuals with DPD see relationships with significant others as necessary for survival. They do not define themselves as able to function independently; they have to be in supportive relationships to be able to manage their lives. In order to establish and maintain these life-sustaining relationships, people with DPD will avoid even covert expressions of anger. They will be more than meek and docile; they will be admiring, loving, and willing to give their all. They will be loyal, unquestioning, and affectionate. They will be tender and considerate toward those upon whom they depend.

Dependent individuals play the inferior role to the superior other very well; they communicate to the dominant people in their lives that they are useful, sympathetic, strong, and competent. With these methods, individuals with DPD are often able to get along with unpredictable or isolated people. To further make this possible, individuals with DPD will approach both their own and others' failures and shortcomings with a saccharine attitude and indulgent tolerance. They will engage in a mawkish minimization, denial, or distortion of both their own and others' negative, self-defeating, or destructive behaviors to sustain an idealized, and sometimes fictional, story of the relationships upon which they depend. They will deny their individuality, their differences, and ask for little other than acceptance and support.

Not only will individuals with DPD subordinate their needs to those of others, they will meet unreasonable demands and submit to abuse and intimidation to avoid isolation and abandonment. Dependent individuals so fear being unable to function alone that they will agree with things they believe are wrong rather than risk losing the help of people upon whom they depend. They will volunteer for unpleasant tasks if that will bring them the care and support they need. They will make extraordinary self-sacrifices to maintain important bonds.

It is important to note that individuals with DPD, in spite of the intensity of their need for others, do not necessarily attach strongly to specific individuals, i.e., they will become quickly and indiscriminately attached to others when they have lost a significant relationship. It is the strength of the dependency needs that is being addressed; attachment figures are basically interchangeable. Attachment to others is a self-referenced and, at times, haphazard process of securing the protection of the most readily available powerful other willing to provide nurturance and care. Both DPD and HPD are distinguished from other personality disorders by their need for social approval and affection and by their willingness to live in accord with the desires of others.

They both feel paralyzed when they are alone and need constant assurance that they will not be abandoned. Individuals with DPD are passive individuals who lean on others to guide their lives. People with HPD are active individuals who take the initiative to arrange and modify the circumstances of their lives. They have the will and ability to take charge of their lives and to make active demands on others.

Causes

No studies of genetics or of biological traits for dependents have been conducted. Central to their psychodynamic constellation is an insecure form of attachment to others, which may be the result of clinging parental behavior.

DSM-IV

The Diagnostic and Statistical Manual of Mental Disorders fourth edition, DSM IV-TR, a widely used manual for diagnosing mental disorders, defines dependent personality disorder as at least five of the following (in Axis II Cluster C) as:

has difficulty making everyday decisions without an excessive amount of advice and reassurance from others

needs others to assume responsibility for most major areas of his or her life

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

Note: do not include realistic fears of retribution.

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

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

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

urgently seeks another relationship as a source of care and support when a close relationship ends

is unrealistically preoccupied with fears of being left to take care of himself or herself

It is a requirement of DSM-IV that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Diagnosis

The following questions when assessing individuals for DPD:

Some people enjoy making decisions. Others prefer to have someone they trust guide them.

Which do you prefer?

Do you seek advice for everyday decisions? (Are the decisions you make understood by the practitioner?)

Do you find yourself in situations where other people have made decisions about important areas in your life, e.g. what job to take?, Symptoms you have they do not understand?

Is it hard for you to express a different opinion with someone you are close to? What do you think might happen if you did?

Do you often pretend to agree with others even if you do not? Why? Could it get you into trouble if you disagree?

Do you often need help to get started on a project?

Do you ever volunteer to do unpleasant things for others so they will take care of you when you need it?

Are you uncomfortable when you are alone? Are you afraid you will not be able to take care of yourself?

Have you found that you are desperate to get into another relationship right away when a close relationship ends? Even if the new relationship might not be the best person for you?

Do you worry about important people in your life leaving you?

World Health Organization

The World Health Organization's ICD-10 lists dependent personality disorder as F60.7 Dependent personality disorder:

It is characterized by at least 3 of the following:

encouraging or allowing others to make most of one's important life decisions;

subordination of one's own needs to those of others on whom one is dependent, and undue compliance with their wishes;

unwillingness to make even reasonable demands on the people one depends on;

feeling uncomfortable or helpless when alone, because of exaggerated fears of inability to care for oneself;

preoccupation with fears of being abandoned by a person with whom one has a close relationship, and of being left to care for oneself;

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

Associated features may include perceiving oneself as helpless, incompetent, and lacking stamina.

Includes:

asthenic, inadequate, passive, and self-defeating personality (disorder)

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Millon's subtypes

Psychologist Theodore Millon identified five adult subtypes of dependent personality disorder. Any individual dependent may exhibit none or one of the following:

disquieted dependant
including avoidant features
accommodating dependant
including histrionic features
immature dependant
variant of pure pattern
ineffectual dependant
including schizoid features
selfless dependant
including masochistic features

Differential diagnosis

The following conditions commonly coexist (comorbid) with dependent personality disorder:

mood disorders
anxiety disorders
adjustment disorder
borderline personality disorder
avoidant personality disorder
histrionic personality disorder

Treatment

Adler suggests that treatment goals for all personality disorders include: preventing further deterioration, regaining an adaptive equilibrium, alleviating symptoms, restoring lost skills, and fostering improved adaptive capacity. Goals may not necessarily include characterological restructuring. The focus of treatment is adaptation, i.e., how individuals respond to the environment. Treatment interventions teach more adaptive methods of managing distress, improving interpersonal effectiveness, and building skills for affective regulation.

For individuals with DPD, the goal of treatment is not independence but autonomy. Autonomy has been defined as the capacity for independence and the ability to develop intimate relationships.

Sperry suggests that the basic goal for DPD treatment is self-efficacy. Individuals with DPD must recognize their dependent patterns and the high price they pay to maintain those patterns. This allows them to explore alternatives. The long-range goal is to increase DPD individuals' sense of independence and ability to function. Clients with DPD must build strength rather than foster neediness.

As with other personality disorders, treatment goals should not be in contradiction to the basic personality and temperament of these individuals. They can work toward a more functional version of those characteristics that are intrinsic to their style. Oldham suggests seven traits and behaviors of the "devoted personality style," i.e., the non-personality-disordered version of DPD:

ability to make commitments;
enjoyment of intimacy;
skills as a team player--without need to compete with the leader;
willingness to seek the opinions and advice of others;
ability to promote interpersonal harmony;
thoughtfulness and consideration for others; and,
willingness to self-correct in response to criticism.

Group psychotherapy

Several reports suggest that group psychotherapy can be successful for the treatment of dependent personality disorder. Montgomery used group therapy for dependent patients who used medications for chronic complaints such as insomnia and nervousness. All but 3 of 30 patients eventually discontinued medications and began to confront their anger at being dependent on the therapist.

Sadoff and Collins administered weekly group psychotherapy to 22 patients who stuttered, most of whom had passive-dependent traits. Although the dropout rate was high, the authors found that the interpretation of passive-dependent behavior and attitudes (e.g., asking for help, believing that others are responsible for helping them) as a defense against recognizing and expressing anger proved helpful. Both stuttering and passive dependency improved in 2 patients who became angry and were able to confront their anger.

Torgersen studied college students who attended a weekend-long encounter group. On follow-up several weeks later, individuals who initially scored high on dependent traits had mixed responses. Although the group experience left them feeling disturbed and anxious, they also reported becoming more accepting of their own feelings and opinions. No other changes were found.

Attrition tends to be higher in group than in individual therapy for personality disorders but may be less of a problem for individuals with dependent personality disorder. Budman et al. reported

moderate improvements after an 18-month group for personality disorders (10% with dependent personality disorder), with some changes not beginning until after 6 months.

These reports suggest the usefulness of group psychotherapy for dependent personality disorder. Most clinicians use weekly sessions of an hour to an hour and a half. Treatment generally lasts several years.

Biological therapies

Four studies have explored the use of medications in the treatment of dependent personality disorder, and two studies have investigated their use in the treatment of dependent traits. Diagnostic and other limitations of the studies prevent firm conclusions about the efficacy of medications.

Klein and colleagues compared placebo with either imipramine or chlorpromazine in hospitalized patients with passive-aggressive and passive-dependent personality disorders that had been diagnosed according to DSM criteria. None of the patients showed a positive drug response.

Patients with major depressive disorder and an anxious-cluster personality disorder, many with dependent personality disorder, showed significant improvement in depression with imipramine or psychotherapeutic treatment. Fewer patients with Cluster C disorders fully recovered, however, and social adjustment problems remained.

Tyrer et al. drew a similar conclusion after studying patients with "general neurotic syndrome," which includes mixed anxiety-depression and dependent or obsessive personality. Although such patients initially appeared to be as responsive as others to 10-week treatments, including dothiepin (an antidepressant), diazepam, placebo, cognitive-behavioral therapy, or self-help, at 2-year follow-up, they had greater symptom levels and did significantly worse than other outpatients.

Ekselius and von Knorring studied 145 depressed patients, 61% of whom scored in the personality disorder range by self-report questionnaire, who received sertraline or citalopram for 24 weeks. From baseline to termination, the percentage above the cutoff score for dependent personality disorder improved significantly (21% versus 8%) as did the mean number of dependent personality disorder criteria met by the whole sample (3.3 versus 2.3). The self-reported change in dependent personality disorder criteria was significant, even after controlling for change in observer-rated depressive symptoms. Although the comparison across two different measurement perspectives complicates these findings, self-reported dependent symptoms seem to improve with 24 weeks of selective serotonin reuptake inhibitor treatment. Whether this generalizes to observer-rated improvement in life functioning is unknown.

Residential and day treatment therapies

Although hospitalization is sometimes necessary for the treatment of an Axis I disorder in individuals with dependent personality disorder, residential treatments are generally not indicated. However, residential and day treatment may provide support necessary to allow definitive psychotherapy to continue, when dependent personality disorder is complicated by recurrent depression, severe anxiety disorders, repetitive suicide attempts, other more severe personality disorders (such as borderline personality) or overwhelming life stress.

Several day treatment and residential programs for severe personality disorders have included individuals with dependent personality disorder. Active treatment days varied from 4 to 5 days per week over a range of 17-30 weeks and usually involved both group and individual sessions, most within a dynamic framework. All had moderate to large effect sizes. Piper et al. (1993) conducted a randomized controlled trial and found significantly greater changes in the day treatment than in the control groups. These data suggest a valuable role for these modalities when dependent personality disorder is not responsive to other outpatient therapies.

Medication

There is little evidence to suggest that the use of medication will result in long-term benefits in the personality functioning of individuals with DPD. DPD is not amenable to pharmacological measures; treatment relies upon verbal therapies. It is recommended that target symptoms rather than specific personality disorders be medicated. One of these target symptoms of particular importance is dysphoria -- marked by low energy, leaden fatigue, and depression. Dysphoria can also be associated with a craving for chocolate and for stimulants, e.g. cocaine. DPD is one of the most vulnerable personality disorders to dysphoria and some individuals with DPD respond well to antidepressant medications.

People with DPD are prone to both depressive and anxiety disorders. Stone suggests that these individuals may respond well to benzodiazepines in a crisis. However, clients with DPD are likely to abuse anxiolytics and their use should be limited and monitored with caution.

Unfortunately, individuals with DPD tend to be appealing clients. They are not inclined to be demanding and provocative. This can be precisely why they are given benzodiazepines by psychiatrists who may feel both benevolent and protective. Their inclination to use denial and escape to manage their lives makes the use of sedative-hypnotics familiar and pleasant. Iatrogenic addiction is a serious concern.

Epidemiology

Dependent personality disorder occurs in about 0.5% of the general population. It is more frequent in females.

History

Clinical interest in dependent personality disorder has existed since Karl Abraham first described it. As a disorder, the personality type first appeared in a United States Department of War technical bulletin in 1945 and later in the first edition of the Diagnostic and Statistical Manual in 1952 (American Psychiatric Association, 1952) as a subtype of passive-aggressive personality disorder. Since then, a surprising number of studies have upheld the descriptive validity of dependent personality traits, viewed as submissiveness, oral character traits, oral dependence, or passive dependence, or as a constellation of both pathological and adaptive traits under the rubric

Dependent Personality Disorder: Summarized

Dependent Personality Disorder

Dependent personality disorder is characterized by a long-standing need for the person to be taken care of and a fear of being abandoned or separated from important individuals in his or her life. This leads the person to engage in dependent and submissive behaviors that are designed to elicit care-giving behaviors in others. The dependent behavior may be seen as being "clingy" or "clinging on" to others, because the person fears they can't live their lives without the help of others.

Individuals with Dependent Personality Disorder are often characterized by pessimism and self-doubt, tend to belittle their abilities and assets, and may constantly refer to themselves as "stupid." They take criticism and disapproval as proof of their worthlessness and lose faith in themselves. They may seek overprotection and dominance from others. Occupational functioning may be impaired if independent initiative is required. They may avoid positions of responsibility and become anxious when faced with decisions. Social relations tend to be limited to those few people on whom the individual is dependent.

Chronic physical illness or Separation Anxiety Disorder in childhood or adolescence may predispose an individual to the development of dependent personality disorder.

Symptoms of Dependent Personality Disorder

Dependent personality disorder is characterized by a pervasive fear that leads to "clinging behavior" and usually manifests itself by early adulthood. It includes a majority of the following symptoms:

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

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

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

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

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

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

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

Is unrealistically preoccupied with fears of being left to take care of himself or herself

As with all personality disorders, the person must be at least 18 years old before they can be diagnosed with it.

Dependent personality disorder is the most commonly diagnosed personality disorder in mental health clinics.

Like most personality disorders, dependent personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

How is Dependent Personality Disorder Diagnosed?

Personality disorders such as dependent personality disorder are typically diagnosed by a trained mental health professional, such as a psychologist or psychiatrist. Family physicians and general practitioners are generally not trained or well-equipped to make this type of psychological diagnosis. So while you can initially consult a family physician about this problem, they should refer you to a mental health professional for diagnosis and treatment. There are no laboratory, blood or genetic tests that are used to diagnose dependent personality disorder.

Many people with dependent personality disorder don't seek out treatment. People with personality disorders, in general, do not often seek out treatment until the disorder starts to significantly interfere or otherwise impact a person's life. This most often happens when a person's coping resources are stretched too thin to deal with stress or other life events.

A diagnosis for dependent personality disorder is made by a mental health professional comparing your symptoms and life history with those listed here. They will make a determination whether your symptoms meet the criteria necessary for a personality disorder diagnosis.

Causes of Dependent Personality Disorder

Researchers today don't know what causes dependent personality disorder. There are many theories, however, about the possible causes of dependent personality disorder. Most professionals subscribe to a biopsychosocial model of causation -- that is, the causes of are likely due to biological and genetic factors, social factors (such as how a person interacts in their early development with their family and friends and other children), and psychological factors (the individual's personality and temperament, shaped by their environment and learned coping skills to deal with stress). This suggests that no single factor is responsible -- rather, it is the complex and likely intertwined nature of all three factors that are important. If a person has this personality disorder, research suggests that there is a slightly increased risk for this disorder to be "passed down" to their children.

Dependent Personality Disorder Treatment

Introduction

Individuals with dependent personality disorder are usually quite needy, for attention, valuation, and social contact. Clients with disorder usually don't present in a dramatic fashion, but will often make repeated requests for attention to their complaints, whether these complaints are about their lifestyle, social relationships, lack of meaning in life, medical, or education. People who suffer from this disorder are often outwardly compliant with clinicians' suggestion for treatment, and will usually be passive in their overall treatment, no matter what form it takes. However, real gains in therapy may not be made easily, because the client's compliance (due to the disorder) is often only surface-deep. While the individual may be one of the easiest to see week after week or month after month in therapy, they may also be one of the most difficult because of their strong need for constant reassurance and support. Dependency upon the clinician specifically and therapy in general should be carefully monitored and avoided.

Psychiatrists and physicians should be aware that individuals with dependent personality disorder will often present with a number of physical or somatic complaints. While appropriate medications need to be prescribed for these as necessary, the clinician should carefully monitor medication intake and maintenance to ensure the patient is not abusing it. Physical complaints should not be minimized or dismissed, as is often the case with someone who suffers from this disorder, but they must not also be encouraged. A simple, matter-of-fact approach works best in this case.

Clinicians in general should be wary of the therapeutic relationship with a person suffering from dependent personality disorder. The needs of the individual can be great and overwhelming at times, and the patient will often try to test the limits of the frame set for therapy. Burnout among therapists treating this disorder is common, because of the client's demands for constant

reassurance and attention, especially between therapy sessions. A clear explanation at the onset of therapy about how treatment is to be conducted, including a discussion of appropriate times and needs for contacting the clinician in-between sessions, is vitally important. While rapport and a close, therapeutic relationship must be established, the boundaries in therapy must also be constantly and clearly delineated.

Psychotherapy

As with all personality disorders, psychotherapy is the treatment of choice. Treatment is likely to be sought by individuals suffering from this disorder when stress or other complications within their life have led to decreased efficiency in life functioning. As with all other personality disorders as well, they may present with a clear Axis I diagnosis and the personality disorder may only become apparent after a few sessions of therapy.

The most effective psychotherapeutic approach is one which focuses on solutions to specific life problems the patient is presently experiencing. Long-term therapy, while ideal for many personality disorders, is contra-indicated in this instance since it reinforces a dependent relationship upon the therapist. While some form of dependency will exist no matter the length of therapy, the shorter the better in this case. Termination issues will likely be of extreme importance and will virtually be a litmus test of how effective the therapy has been. If the individual cannot end therapy successfully and move on to become more self-reliant, it should not be seen as a therapeutic failure. Rather, the individual was not likely seeking life-changing therapy in the first instance but instead solution-focused therapy.

Examining the client's faulty cognitions and related emotions (of lack of self-confidence, autonomy versus dependency, etc.) can be an important component of therapy. Assertiveness training and other behavioral approaches have been shown to be most effective in helping treat individuals with this disorder. Group therapy can also be helpful, although care should be utilized to ensure that the patient doesn't use groups to enhance existing or new dependent relationships. Challenging dependent relationships the client has with others that may be unhealthy for the client should generally be avoided at the onset of therapy. As therapy progresses, these challenges can occur but must be done carefully; restraint must be used if the individual is not ready to give up these unhealthy relationships.

Termination of therapy with a person who has this disorder is an extremely important issue to consider. While termination should always be a joint decision between the clinician and the client, people with this disorder often don't know "how much is enough" therapy. The therapist, therefore, may need to prod the patient toward ending therapy. As the end of therapy approaches, the patient is likely to re-experience feelings of insecurity, lack of self-confidence, increased anxiety and perhaps even depression. This can be typical of individuals with this disorder terminating therapy

and should be treated appropriately. The clinician should not allow the patient to use these new symptoms, though, as a way of prolonging the current therapy. The goal is to end a relationship at an agreed-upon time and way. The client should be reinforced for the positive gains made in therapy and encouraged to explore their new-found autonomy or improved management of their anxious feelings.

Medications

As with all personality disorders, medications should only be prescribed for specific problems suffered by the individual. Sedative drug abuse and overdose is common in this population and should be prescribed with additional caution. Anti-anxiety agents and antidepressants should be prescribed only when there is a clear Axis I diagnosis in conjunction with the personality disorder. Physicians should resist the temptation to overprescribe to someone with this disorder, because they often present with multiple physical complaints or anxiety. The anxiety in this instance is clearly situationally-related and medication may actually interfere with effective psychotherapeutic treatment.

Giving any individual with a personality or mental disorder a placebo drug for its perceived value by the patient is ethically questionable. Doctors rarely have need to prescribe a vitamin or other non-psychoactive substance unless a patient's medical condition clearly indicates it. When such a prescription is made, it should be made with the clear understanding what it is being prescribed for. Any indirect suggestion that such a medication will help an individual overcome their feelings of insecurity, inadequacy, need for dependence, etc. should be avoided. A medication should not be prescribed because of its "magical" effects, and more expensive medications should not be prescribed over less-expensive medications just because they are "newer." Prescriptions should always be written for a specific medication because of the research suggesting its effectiveness with the patient's specific medical complaint or diagnosed mental disorder and avoidance of intolerable side-effects.

Self-Help

Self-help methods for the treatment of this disorder are often overlooked by the medical profession because very few professionals are involved in them. Suggesting such a support group later in treatment, to help put some of their new skill sets to use in a group setting, may be helpful. Many support groups exist within communities throughout the world which are devoted to helping individuals with this disorder share their common experiences and feelings.

Individuals should likely avoid using a support group as the only means of treatment for this disorder, since it is likely to encourage additional dependent relationships.