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# Psychodynamic, cognitive behavioural and group approaches in managing dependent personality disorder (DPD) among secondary school students in Rivers State

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**Abstract**
This study investigated effect of psychodynamic, cognitive behavioural and group approaches in managing dependent personality disorder (DPD) among secondary school students in Rivers State. Two research questions and two hypotheses guided the study. The study adopted a quasi-experimental design involving pre-test and post-test. A sample size of 80 students was drawn from the population of 400 students using the simple random sampling as well as the non-proportionate sampling technique. The Dependent Personality Disorder Questionnaire (PDQ-IV-TR, DSM-IV) was used as instrument for data collection (Adapted from the work of Hyler 2002). Validity of the instrument was done by the supervisor and two experts in measurement and evaluation. Reliability was done via Cronbach Alpha and a reliability index of 0.94 was realized. Mean, standard deviation, t-test, analysis of Covariance (ANCOVA) and analysis of variance (ANOVA) were used for data analysis. Result showed that; psychodynamic therapy (PT), cognitive behaviour therapy (CBT) and group therapy (GT) had a significant effect on management of dependent personality disorder among subjects; there is a significant effect of psychodynamic therapy, CBT and group therapy on management of DPD among male and female participants as shown by their post test scores. Recommendations were made among which is that continuous assessment of the students should be done in order to ensure their continuous retention of the treatment in managing dependent personality disorder (DPD).

**Keywords:** psychodynamic, cognitive behavioural, group, dependent personality disorder, students

## Introduction

It is worthy of note that we have all been completely dependent on another during infancy stage, or even when we have grown-up. Dependency is seen in every sphere of life, ranging from infancy to marital dependency, (that is, one spouse depending heavily on the other) in the offices and even in business milieu. Generally, we show some degree of dependency on others or one another and have a need for support, guidance, and approval from others, especially during stressful times. Although for some of us, this only happened during our youthful years. This is because a few life experiences are so widely shared by people of different backgrounds that cuts-across the boundaries of culture and norms like; submissiveness, politeness, gender, age, ethnicity, educational attainment, social status, passivity etc. specially to elders and higher authority which are valuable virtues and are held at a very high esteem in most society. This could account for the reason why Dependent personality disorder (DPD) is one of the most common personality disorders seen but yet difficult to recognize because of the differences in cultural believes, and orientation.

Dependency becomes a form of psychopathology when there is abnormal dependency which causes personal distress and/or functional impairment (Sperry, 2003, American Psychiatric Association; 2000) [36]. The concept of DPD was first viewed primarily as personality trait other than a mental disorder in its own right, and was mentioned first as a type of disorder in DSM-III (American Psychiatric Association, 1980) which is considered to be a vulnerability factor that increases a person's risk for other types of mental disorder, particularly depression (Bornstein, 1998). But now, it is listed in the 3rd cluster of Axis II in DSM–IV -TR which is the anxious and the fearful personality disorder. These are those who lack self-reliance and are overly dependent on others (Seligman & Rickabaugh, 2007) [33].

The Cluster C personality disorders, including DPD, has shown a high base occurrence rates, yet they still have less studies compared to other personality disorders (Endler & Kocovski, 2002) [16]. DPD is said to be found in about 14% of people who have personality disorders and about 2.5% of the general population. In general, the prevalence rate of Dependent Personality Disorder (DPD) and it comorbidity have been estimated between 1.5% to 53%. The prevalence rate has also shown higher figure in women than men, especially in India and Japan.

The categorical approach of the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV-TR; American Psychiatric Association, 2000) towards the diagnosis of Dependent Personality Disorder has often been criticized for failing to completely capture the underlying traits that make up personality disorders. The DSM-IV-TR used operational criteria to define behavioral elements of disorders according to chosen categories in the classification. This approach was only successful in Axis I disorders. It is suggested that the most efficient way of diagnosing personality disorders is to use dimensional trait data. Such a

system expresses personality as a continuum, with normal degrees of traits at one end and personality disorder at the other end. Thus, Dependency may not be a categorical personality trait, but have varying degrees within its expression. Maddux and Winstead (2012) [24] have argued that dimensional system of diagnosis is far reaching and better than categorical system. Yet, Ollendick and March (2004) [25] has favoured both the categorical and dimensional approach of classifying Personality Disorders (PDs).

The issue of comorbidity is a concern in the diagnosis of dependent personality disorder and the classification of personality disorders (PDs) between researchers and psychologist/clinicians. According to Allport, cited in Schultz and Schultz (2005) [32] personality is defined as the dynamic organization within the individual of those psychological systems that determines characteristic behaviour and thought. Schultz and Schultz (2005) [32] on their own defined personality as the sum total of everything about one's self; his/her likes and dislikes, fears and virtues, strength and weakness. They posit that the word" I" defines one as individual, separate from all others. They assert that human personality is the dynamic organization of the psycho-biological system by which a person shapes and adapts in a unique way to changing internal and external environments. Personality is one's most essential asset which helps to shape one' life and so personality development is essential to the successful social interactions as well as the ability to fit-in in the society and react positively in a balanced way to the various internal and external stimuli from the social environment. Thus, strong and independent personality often leads to a stable society with less social vices as people with these personalities are capable of acting in a socially accepted pattern to various social stimuli. People with strong and independent personality are often determined, having high morals and ethics, also possessing good behaviour and attitudes. Thus, Dependent Personality Disorder (DPD) is a personality disorder(PD) which describes a person who relies heavily on a person or others for virtually all aspects of his life and possess little will power to live effectively in a social environment without the social system on which they rely totally on.

DPD affects both sexes and common in adolescence. According to a survey by the National Epidemiologic Survey on Alcohol and Related Conditions 0.49% of adults meet dependent personality diagnosis criteria, with 18-29-year-olds having the highest risk of the disorder. Slightly more women than men receive the diagnosis of DPD, with 0.6% compared to 0.4% of men (Grant, Hasin, & Stinson, 2004) [21]. One must take into consideration several factors for this difference because men may be less likely to report dependent behaviors. The survey by NESARC found no difference in the prevalence of DPD among different ethnic groups in the United States. However, lower income, less educated, widowed, divorced, separated, or never married individuals may be more at risk for developing DP. The causes/etiology of DPD are said to be; overprotective, authoritarian parenting style, insecure interpersonal attachment which may deprive or may be triggered by abnormal parent- child relationship, either by a clinging parent or by continued infantalization, when individualization and separation is supposed to occur (Gabbad, 2000). The abnormal type of parenting style tends to inhibit the development of feeling of self- efficacy.

The feelings of self-efficacy in other words, can be translated as a child having attachment problem. The idea is that at infant stage, these children become closely attached to an adult with whom they rely on for security in other to explore and pursue other goals in life, overprotection from parents or adult figure becomes a channel, or predisposing factor to making a child develop DPD. This is simply because the child is not given the opportunity to explore his/her potentials inherent in him/her. The parents for fear of not wanting the child to sustain injury or fear of losing the child (death) will want to refrain the child from exploring his/her environment, thereby keeping the child inactive and even depending on people for assistance. Even in most homes today, the practice of Nanny, house help, housekeeping, and employed staff to run domestic affairs or chores of the family (cooking, cleaning the house, laundry, winning errands) also throw these children in more jeopardy of over relying and depending on people for nurturance and assistance. Also exhibition of affluence/wealth, class and social status from parents predisposes some of these children in developing DPD. Even the over dependence reflects in their academic performance as most parents use their money to settle academic challenges faced by their children in other to see that these children graduate, this most times makes the children to come out, half-baked academically. These children fail to read or work hard because they know that they can always sorts themselves and that their parents/guardians are there to release the resources to make things happen. They are found to be agreeable always just to get what they desire (Stone cited in Davison & Neale (2003) [14].

There are several hypotheses regarding the origins of DPD. According to Ainsworth, cited in Gluszik (2006), dependent personality may form during infancy, having stemmed from maternal over-involvement and intrusiveness throughout all stages of development. Such parenting will reward the child for maintaining loyalty, and somewhat reject him or her when separation or independence is attempted. This would lead to crying or clingy behavior, while being immobilized by fear and dread of abandonment. The child may then internalize this working model of themselves and others, influencing the child's expectations concerning future interpersonal relationships (Bowlby, Main, Kaplan, & Cassidy, cited in Gluszik 2006).

Developmental Psychologists have thrown more light on the issue of attachment. The child becomes so attached to an adult for security reasons of which separation from the adult leads to anger and distress. Abnormal attachment could also result from failure in the usual developmental process as a disruption in the early parent-child relationship caused by death, neglect, rejection, or over protectiveness (Bornstein cited in Davison & Neale 2003) [14]. Bornstein (2005) noted that over-anxious, over protective and authoritative parenting style often leads to the viability of the child to provide security for him or herself. Thus, creating heavy reliance on a parental figure for consistence reassurance of their worth. Hence, these persons exhibit dependent personality disorder, with the main belief that their self-worth is defined by their importance to other persons (Beck, Freeman and Davies 2004).

Personality disorders are enduring patterns in our behaviors and with dependent personality disorder (DPD),this pattern involves submissive, clinging behavior in which a person has an extreme need to be taken care of (American Psychiatric Association [APA], 2000; Bornstein, 2005). Sperry (2003) [36] comments that there is generally a lack of self-confidence, great discomfort in being alone, self-doubting, and approval seeking found with DPD. People with DPD may easily be taken advantage of because they are so compliant, agreeable, and trusting of others (Ansell & Grilo, 2007) [5]. Bornstein (2005) posits that when a close relation ends, they urgently seek another relationship to replace old one. They also have this to say about them, that they lack both self-confidence and a sense of autonomy; they view themselves as weak and others powerful. They also have an intense need to be taken care of, which often leads them to feel uncomfortable when alone; they may be preoccupied with fears of being left alone to take care of themselves. They subordinate their own needs to ensure that they do not break up the protective relationships they've established.

Shahar, Joiner, Zuroff, and Blatt (2004) posit that essentially, they live their lives through others and for others, to whom they offer warmth, tenderness, and consideration. When people they cared for are happy, they are happy. Not surprisingly, they tend to assume the more passive role in their relationships, deferring to the opinions and desires of those they love, whose pleasure and fulfillment they then enjoy vicariously. They prefer harmony in their relationships and tend to be apologetic even when others should take the greater part of responsibility for a disagreement. They suffocate their partners with their clinginess and in turn leave themselves vulnerable to abandonment.

Blatt (2004) [10] and Bornstein (2005) posit that the self-esteem of the DPD has to be maintained through supportive and nurturing relationship. Meaning that their continuous need of reassurance has a paradoxical effect of driving their helpers away, exposing them to their worse fear of being left alone to come true. This will eventually down play their self-worth, meaning, or value, throwing them into more jeopardy. This will automatically throw the DPD into a readily available, unreliable and abusive relationship just not to be left alone and this may result to a more abusive, derogation and denigration. (That is the helper passing a kind of message to the DPD, that indeed entering a relationship with him or her is disgusting, undesirable, and unlovable). The DPD is then faced with depression as a result of combination of the environment and evocation, reaction, and proactive encounter (Shahar et.al., 2004). They (DPD) lack adequate self - reliance, self - responsibility, self-direction and sufficient independence of social influences. One can simply say that they lack autonomy. It is expected that one who is of age should not rely heavily on other for their personal desires, they should take responsibility of themselves and to any other group or persons they are legally and culturally supposed to protect. They lack what Carl Rogers cited in Schultz & Schultz (2005) call a reliance on their own experience and lack the attributes of a fully functioning person which are;

- Exhibiting an awareness of experience that is, they are open to both positive negative and they accept a wider range of both positive and negative emotions and feel them more intensely.
- Have nothing to threaten them, unlike the DPD who sees every situation with tension.
- Trusting in their own organism other than being guided by other people's opinion.
- Living fully and richly in each moment of their lives.
- Freedom to make choices and decisions without constraints or inhibition of any sort.
- Being creative, live constructively, and adaptive as the environmental condition changes. That is to say, they are flexible, quick and ready to seek new experiences and challenges, not requiring predictability, security, or freedom from tension.
- Though may face difficulty, but this difficulty predisposes them to continuous testing, growing, striving and using one's potentials to make him or herself an actualizing person.

Rogers believe that the developing of the self should be progressive, striving, growing, spontaneous, flexible and open. (Rogers cited in Schultz & Schultz, 2005). It is obvious that all the above characteristics are complete and direct opposite of the DPD. In order to diagnose a person with DPD, they must exhibit five or more of the eight criteria that are listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR, APA, 2000). See Appendix4.

The DPD are ineffective in adjusting to the demands placed on them by other individuals and their social environments, they cannot engage in a positive interpersonal relation with other people without heavily depending on them. They are seen not able to be the hero to some of their personal responsibilities; they cannot adapt to their society, but constitute problems to those around them. The DPD is maladjusted. For them to keep a positive interpersonal relationship, they have to recognize and respect the dignity and worth of all and sundry. Independence is an anathema to them hence the study of some psychotherapeutic approaches in managing DPD such as psychodynamic therapy, cognitive behavioral therapy (CBT) and group therapy are essential in this study. These therapeutic strategies are said to be plans that determine the best treatment options for a person's conditions and specific needs. They are joint efforts designed by a client or person's entire team, and each plan is unique to the person, as every person has different needs and responds to treatment differently (Davison & Neale, 2003) [14].

Therefore, using some psychotherapeutic approaches (psychodynamic, cognitive behavioral therapy (CBT), and group Therapy) in managing these DPD can help a great deal. Many Clients have little, if any, exposure to psychotherapy. Providing clients with an understanding of the therapeutic process allows clients to be more active and aware of their role in the progression of therapy. Knowledge of the processes of therapies enhances the collaborative nature of therapy for both the client and therapist.

Psychodynamic therapy is similar to psychoanalytic therapy in that it is an in-depth form of talk therapy based on the theories and principles of Sigmund Freud's psychoanalysis. Psychodynamic therapy is not only focused on the client-therapist relationship, but it is equally focused on the client's

relationship with his or her external world. Often, psychodynamic therapy is shorter than psychoanalytic therapy with respect to the frequency and number of sessions. Since the 1950s a shorter, more intense type of psychodynamic therapy has emerged. Following its introduction in a series of workshops, the method of short-term psychodynamic therapy (also known as intensive short-term dynamic psychotherapy - ISTDP) was eventually developed in the 1960s and 1970s by psychiatrist Habib Davanloo whose aim was to enhance the efficacy of psychoanalysis and minimize the length of treatment. Short-term therapy specific goals are preferred because long-term therapy can lead to dependence on the therapist.

The theories and techniques that distinguish psychodynamic therapy from other types of therapy include a focus on recognizing, acknowledging, understanding, expressing, and overcoming negative and contradictory feelings and repressed emotions in order to improve the client's interpersonal experiences and relationships. This includes helping the client understand how repressed earlier emotions affect current decision-making, behavior, and relationships. Psychodynamic therapy also aims to help those who are aware and understand the origins of their social difficulties, but are not able to overcome their problems on their own. Clients learn to analyze and resolve their current issues and change their behavior in current relationships through this deep exploration and analysis of earlier experiences and emotions.

The psychodynamic approach is guided by the core principle that the unconscious mind harbors' deep-rooted feelings and memories that can affect our behaviour. The technique implores the maintenance of equal relationship with clients, adopting an attitude of unconditional acceptance, aiming at developing a trusting relationship which encourages the client to open up and explore unresolved issues and conflict hidden in their unconscious that are affecting their mood and behaviour.

Cognitive Behavioural therapy (CBT) combines cognitive and behavioral therapies aimed at ameliorating the types of problems that commonly characterize dependent individuals (e.g., behavioral activation, social skills training, problem-solving, goal setting, cognitive restructuring etc.), and has strong empirical support for treating mood and anxiety disorders (Chambless & Ollendick, 2001) [13]. For instance, CBT has received the most empirical support among the psychosocial therapies including the successful use in children between ages 5-9 years (Curry, 2001).

Introduction to Cognitive Behavioural Therapy (CBT), involves case conceptualization and treatment planning, as the hallmark. Case conceptualization aids in establishing rapport and a sense of hope for clients, and is vital for effective treatment and represents a defining characteristic of expert psychologists/ therapist. It is a framework used to: Understand the client and his/her current problems, inform therapy and intervention techniques and a foundation to assess client change/progress. The behavioral techniques used involve techniques such as assertiveness training or dating skills, homework, relaxation training, and role playing (Perry, 2005) [29]. Behavioral therapy teaches the skills in assertive communication of both negative and positive feelings and accurate desires that will enhance the client's notion to develop interpersonal skills that will allow for becoming more independence and self-reliance (Goldfried & Davison, cited in Oltmanns & Emery 2007) [27]. The therapy helps to reconstruct the client's attitude towards an idea, especially when he or she is always being criticized. The behaviorist uses systematic desensitization and rationale-emotive behavioral therapy in helping and managing the Dependent Personality until he becomes more independent (Renneberg *et al.* cited in Davison & Neale, 2003) [14].

Group therapy is a kind of psychological therapy that takes place with a group of people together rather than with an individual during a one-on-one session. In some respect group therapy and individual therapy are alike and the aims are usually similar. While the term can technically be applied to any kind of psychotherapy that is delivered to a group, it is most commonly associated with a specific therapy type that makes use of the group dynamic to achieve the aims in different ways.

Group sessions like individual ones are time-limited, semi-structured, and focused on interpersonal dynamics, providing more opportunities for clients to practice interpersonal skills in a safe, supportive environment. Group therapy often includes pre-treatment, mid-treatment, and post-treatment individual meetings to review goals, strategies, and progress. Group therapy has a higher attrition than individual therapy, and may be less problematic for clients with DPD (Perry & Bond, 2000). Group psychotherapy has also been demonstrated to be successful in treating DPD (Sperry, 2003) [36]. Seeking support from others can be invaluable when one is having emotional difficulties and it's important to find an approach that works. Speaking to a professional such as one's therapist or psychologists can help someone to benefit from either group therapy or support/self-help groups as the case may be.

Ferrero, Pierò, Fassina, Massola, Lanteri, Daga (2007) [17], carried out a study on "A 12-month comparison of brief psychodynamic psychotherapy and pharmacotherapy treatment in subjects with Generalised Anxiety Disorders in a community setting with duration of10 weekly sessions, plus sessions at 3months and 1year, 45min each on 87 (76 at follow up) participants with Patient with GAD in Australia. HAM-A, HAM-D, CGI, SOFAS were used for data analyzes. The effect of the therapy revealed Anxiety: ↓ ($d$ = 1.58). Depression: ↓ ($d$ = 1.26). Global impression: ↓ ($d$ = 1.73). Social and occupational functioning: ↑ ($d$ = 0.99). 12 months' follow-up change between post treatment and follow up indicated 6-12mths - Anxiety: ↑ ($d$ = 0.02). Depression: ↓ ($d$ =.02). Global impression: ↓ ($d$ = 0.05). Social and occupational functioning: ↑ ($d$ = 0.03).

Buchheim, Viviani, Kessler, Kächele, Cierpka and Roth (2012) carried out a study on "Changes in prefrontal-limbic function in major depression after 15 months of long-term psychotherapy with 2-4hrs of weekly therapy for 15 months' participants were (1) 16 (2) 17 (1) Outpatients with recurrent depression (2) Non-depressed controls. There was no comparison condition BDI, SCL-90-R (GSI) were used for data analysis**.** The following were the Post Treatment results**:** Depression: larger difference between conditions at pre-treatment ($d$ = 3.35) than post- treatment ($d$ = 1.90). Global severity of symptoms: larger difference between conditions at

pre-treatment (*d* = 2.96) than post- treatment (*d* = 2.20).

Slonim, Shefler, Gvirsman and Tishby (2011) [34] carried out a study on Changes in rigidity and symptoms among adolescents in psychodynamic psychotherapy (based on object relations, self-psychology, and relational theories) to carry out a duration of Weekly 45-50min sessions for 12 months Participants were(1) 30 (2) 42 (1) Adolescents (aged 15-18) in treatment, mostly (88%) with Symptoms of emotional distress (2) Adolescents (aged 15-18) in the community, there was no comparison condition. Youth-Outcome Questionnaire **(**Y-OQ) and Target Complaints Scale, (TCS) are used for data analysis. Comparison effect of size post treatment revealed**:** Psychosocial distress: larger difference between conditions at pre-treatment (*d* = 1.54) than post- treatment (*d* = 1.14). Target complaints: minimal difference between conditions at pre-treatment (*d* = 0.63) than post-treatment (*d* = 0.67). The findings of meta-analyses and systematic reviews with meta analyses on the effectiveness of psychodynamic psychotherapy.

Abbass, Kisely and Kroenke (2009) [1], carried out a Short-term psychodynamic psychotherapy for somatic disorders: Systematic review of meta-analysis of clinical trials in Australia with 13 Randomized Control Trials (RCTs), 10 case serious with pre-post data of 1,870 (intervention) and 535 (control) in systematic review of People with somatic disorders. The following are their findings: Pre-post – effective for general psychiatric symptoms (short-term outcomes [up to 3 months]: ES = -0.69, 95% CI: –0.86, –0.52]; long-term outcomes [over 9 months]: ES = –0.70, [95% CI – 0.91, –0.48]), depression (short-term: ES = -0.97 [95% CI –1.19, –0.74]; long-term: ES = –2.26, [95% CI: –2.75, –1.77), anxiety (short-term: ES = -0.74, 95% CI: –0.96, –0.52; long-term: ES = –2.28, 95% CI: –2.76, –1.80), and somatic symptoms (short term: ES = -0.59, 95% CI: –0.78, –0.40; long-term: ES = –0.49, 95% CI: –0.77, –0.21).

Abbass, Town and Driessen (2011), carried out a study in Australia titled": The efficacy of short-term psychodynamic psychotherapy for depressive disorders with comorbid personality disorder, with a Short-Term Psychodynamic Psychotherapy (STPP) with8 Randomized Control Trials(RCTs), of 166 People with comorbid depressive and personality disorders. Their studies revealed the following: Pre-post – effective for depression (ES = -1.13, 95% CI: -0.87, -1.39), general psychopathology (ES = 1.00, 95% CI: -0.67, 1.33), and interpersonal functioning (ES = 1.27, 95% CI: 0.76, 1.79). Post-follow up - no change for depression (ES = 0.1, 95% CI: -0.15, 0.35), general psychopathology (ES = 0.00, 95% CI: -0.17, 0.34), and interpersonal functioning (ES = 0.24, 95% CI: -0.23, 0.72). STPP equivalent to other psychotherapies (ES = -0.04, 95% CI: -0.44, 0.36).

Abbass, Town and Driessen, (2012), carried out an Intensive short-term dynamic psychotherapy: A systematic review and meta-analysis of outcome research with 6 RCTs, 4 nonrandomized, controlled trials, and 11 studies with no control groups in Australia.664 participants met the analysis of People with mood, anxiety, personality, and somatic disorders. Pre-post – effective for general psychopathology (d = -1.16, 95% CI: -0.82, -1.50), interpersonal functioning (d = 0.84, 95% CI: 0.50, 1.18), depression (d = -1.51, 95% CI: -1.16, -1.87), anxiety (d = -0.98, 95% CI: 0.47, 1.49). Post-follow up –no change for general psychopathology (d = 0.01, 95% CI: -0.51, 0.53), interpersonal functioning (d = 0.12, 95% CI = -0.27, 0.51). ISTDP is found to be superior to control conditions (active controls, n = 3; waiting list controls, n = 2) post-treatment - general psychopathology (d = 1.18, 95% CI: 0.61, 1.75).

Saini (2009) [31] in a meta-analysis of the psychological treatment of anger: Developing guidelines for evidence-based practice, carried out a study using Various psychological treatments on 73 RCTs, 19 nonrandom comparative design, 4 designs without comparison conditions on 7440 adults with anger issues Pre-post – effective in reducing anger (2 studies - d = -1.40, 95% CI: -1.14, -1.72). PP may be superior to other psychotherapies (only based on 2 studies with PP, however).

A study carried out by Gerull, Meares, Stevenson, Korner, & Newman (2008) [19] on "The beneficial effect on family life in treating borderline personality and Meares, Gerull, Stevenson & Korner (2011) on Is self-disturbance the core of borderline personality disorder? An outcome study of borderline personality factors. They used group/conversational model for12months on 60 Participants with BPD Compared with Treatment as usual (TAU; waiting list control) SAS, WSS was used to analyze. The following findings were made.

Time × group - Partner: CM > TAU (η2 =.26, p =.001). Children: CM > TAU (η2 =.18, p =.004). Family-unit: CM ≈ TAU (η2 =.07, p =.06). Self: CM > TAU (η2 =.14, p =.004). Affect deregulation: CM > TAU (η2 =.10, p =.02). Impulse: CM ≈ TAU (η2 =.05, p =.11).

In a work carried out by Gjerde, Czajkowski, Røysamb, Ørstavik, Knudsen, Østby, Torgersen, Myers, Kendler, and Reichborn-Kjennerud (2012) titled: The heritability of avoidant and dependent personality disorder assessed by personal interview and questionnaire. Data were obtained from a population-based cohort of young adult Norwegian twins, of whom 8045 had completed a self-report questionnaire assessing PD traits. 2794 of these twins subsequently underwent a structured diagnostic interview for DSM-IV PDs. Questionnaire items predicting interview results were selected by multiple regression, and measurement models of the PDs were fitted in Mx. The heritability's of the personality disorder (PD) factors were 0.64 for avoidant PD and 0.66 for dependent Personality disorder. No evidence of environmental factors shared between twins was found. Genetic and environmental contributions to avoidant and dependent Personality disorder seemed to be the same across sexes.

Reich (1990) carried out a study to determine whether DSM-111 dependent personality disorder differed in males and females. A sample of 30 females and 11 males were drawn using structured clinical interview for DSM-111, personality diagnostic questionnaire was the instrument employed to determine patients with DPD from the population of study. Standardized measures of axis I, II and the family history were used. The study revealed that there was no significant difference in age or in score axis 1 or axis II disorders in males and females with dependent PD. Also, relatives of males had an increased incidence of major depression and DSM-III anxious personality disorder cluster, while relatives of females have an increased incidence of panic disorder. This

study concluded that there may be different predisposing factors to dependent Personality disorder in males and females.

Baker, Capon, and Azorlosa (1996) [8], examined the family environment of non-clinical samples of subjects with histrionic and dependent personality disorder and control subjects. The subjects in the study were undergraduates' females of a university. A total of 683 subjects were screened before 15 subjects were obtained for each group. The study used the Million Clinical Multiaxial Inventory (MCMI) to identify subjects with histrionic personality disorder and employed the structured clinical interviews for DSM-IV-R to identify subjects with dependent personality disorder. The family environment scale was used to compare the three groups on 10 characteristics of their families of origin. The results showed significant characteristic differences between the families of origin in the three group. The study revealed that the histrionic group was characterized by a family of origin that was high in control, intellectual-cultural orientation and low in cohesion while the dependent group had families of origin that were low in independence and high in control.

Head, Bakers and Williamson (1991) [22], carried out an etiological investigation to examine the family environment of persons diagnosed with dependent personality disorder in contrast to a clinical control group and a normal control group. Three groups of subjects participated in the study. Two groups of patients were included; those diagnosed with dependent personality disorder and an equivalent clinical control group with an absence of dependent personality disorder symptoms. The instrument used was the family environment scale to compare characteristics of the family of origin among the three groups. The results showed a unique dysfunctional family background. The distinguishing features of this family environment were low expressiveness and high control in the families of the dependent personality group.

Slowik (2013) [35] carried out a study on the effect of sex and gender role orientations on attitudes toward individuals with dependent personality disorder. The study sampled 240 undergraduates (99males, 141 females) from Indian state university using on online survey. Social roles questionnaire (SRQ) was employed to examine participant's attitudes towards gender role. The data collected was analyzed using one way ANNOVA which indicated that female participants were significantly less traditional, less sex-linked and more gender transient indicating a significant effect on participant gender role attitudes.

Loas, Cormier and Perez-Diaz (2009) [23], conducted a study titled "Dependent personality disorder and physical abuse". The sample was made up of 305 subjects who were consecutively admitted at the outpatient department of legal medicine in Amiens Hospital Novels. All the subjects were from Amiens city and Picardy region in France. In the sample under study, were 178 men (58.36%) and 127 women (41.64%) with a mean age of 31.15 years (S.D = 11.15, range 18-74). 198 out of the sample under study had a high school certificate, which is similar to secondary school studies, that is 12 years of accredited education after age 6 (65.78%), 44 with a high school leaving certificate (14.62%) and 59 with tertiary education (19.6%). A total of 136 subjects (45.03%) were unemployed and 204 lived alone (67.55%). A history of previous physical abuse was reported in 94(31.33%) and 82 subjects (27.15%), respectively. Previous demographic data and background characteristics were collected through semi-structured interview. The subjects filled the SCID-11 screen questionnaires which has 119 questions, allowing the diagnosis of DSM-IV personality disorders. Reliability was evaluated using the Kuder Richardson formula 20 (KR-20), a special form of the Cronbach alpha coefficient for dichotomous variables. For the DPD the KR-20 was 0.59. To analyze the data, subjects were classified into: without personality disorder (WPD), with non-dependent personality disorders (NDPD) and with DPD. Then the three groups were compared using chi-square tests, analysis of variance and univariate logistic regressions sequentially. The study revealed that DPD subjects had high co-morbidities with other personality disorders, notably with cluster C and borderline personality disorder (BPD). Secondly, DPD had significantly more history of psychiatric disease.

From the foregoing therefore, it is very clear that majority of the past researches reviewed were conducted in foreign countries with little or none conducted in this part of the world. Hence, this present study on the effectiveness of psychodynamic, cognitive behavioural and group therapies in the management of dependent personality disorder (DPD) among secondary school students in Rivers State, Nigeria was carried out to fill the existing gap.

**Research methodology**

The study adopted a quasi-experimental design involving the pre-test and post-test design. Quasi-experimental design is a form of experimental research used extensively in the social sciences and psychology. The population of the study was 80 DPD students out of 400 senior secondary school students in the randomly selected school in Port Harcourt metropolis (PHALGA) of Rivers State during the 2017/2018 academic session.

The researchers used multi-stage and purposive sampling technique to draw a sample of 80 SSII students with DPD out of 400 students in the randomly selected mixed sex schools (male and female) in Port Harcourt Metropolis (PHALGA) for the study after field work and administration of instrument to get a baseline. The researchers used one instrument for this study, which is the Dependent Personality Disorder Questionnaire PDQ-IV-TR (DSM-IV) adapted from Hyler (2002, & 2006). The face and content validities instrument were established for clarity, to eschew ambiguity. Reliability of the instrument was ascertained through the Cronbach alpha technique. Mean and standard deviation were used to answer the research questions while the t-test, ANOVA and ANCOVA were used to test, the hypotheses.

Three treatment groups and one control group were used to carry out this study**.** These clients were randomly assigned to their various groups, and twice weekly sessions were given to each group**.** Each group received different psychotherapeutic treatment which was compared with the control group that did not receive any treatment. Group 'A' was given psychodynamic Therapy, Group 'B' received Cognitive Behavioral Therapy (CBT), Group C received Group Therapy and Group 'D' was the control group. At the end of the sessions, comparison was made with the control group and

findings noted. See Table 1

**Table 1:** Grouping of the Study

| Grouping | Treatment | Sample Size |
|---|---|---|
| Group A | Psychodynamic Therapy | 20 |
| Group B | Cognitive Behavioral Therapy (CBT) | 20 |
| Group C | Group Therapy | 20 |
| Group D | Control Group | 20 |

**Results and Discussion**

Research Question One: What are the effects of psychodynamic therapy, cognitive behavioural therapy (CBT), and group therapy (GT) in the management of Dependent Personality Disorder (DPD) among experimental groups based on their pre-test and post- test mean scores?

Hypothesis One: Psychodynamic therapy, CBT and group therapy do not significantly have effects on the management of DPD as determined by their pretest and post -test mean scores.

**Table 2:** Mean, standard deviation and analysis of covariance of the treatment groups based on their pretest and post test scores

| Groups | Test | N | $\bar{x}$ | Std. D |
|---|---|---|---|---|
| Psychodynamic | Pretest | | 96.65 | 18.16 |
| | Post test | 20 | 63.60 | 9.34 |
| CBT | Pretest | | 115.00 | 19.00 |
| | Post test | 20 | 60.25 | 5.54 |
| GT | Pretest | | 122.00 | 20.48 |
| | Post test | 20 | 55.75 | 7.78 |
| Total | Post test | | 55.75 | 7.78 |
| | Post test | 20 | 111.22 | 19.21 |

Test of Between-subject Effect (ANCOVA)

| Source | Type IV sum of sq. | df | Mean sq | F | ∝ | Sig. | Result |
|---|---|---|---|---|---|---|---|
| Corrected model | 637.797 | 3 | 212.599 | .3436 | | 0.023 | |
| Intercept | 4101.604 | 1 | 4101.604 | .66.286 | 0.05 | 0.000 | |
| Pretest | 17.163 | 1 | 17.163 | .0.277 | | 0.601 | |
| Groups | 551. 467 | 2 | 275.733 | 4.45 | | 0.016 | Significant reject Ho |
| Error | 3465.137 | 56 | 61.87 | | | | |
| Total | 219144.00 | 60 | | | | | |
| Corrected total | 4012.933 | 59 | | | | | |

Table 2 above shows descriptive statistics for psychodynamic, cognitive behaviour and group therapy at the pretest and post-test stages of treatment. From the results, the sample size was 20 and this was replicated at both pretest and post- test stages of the treatment. It is observed here that psychodynamic group had mean of 96.65; 63.60. CBT had mean of 115.00 and 60.25 while group therapy had mean of 122.00 and 55.75 for pre-test and post-test respectively. In all, it is seen that all the therapeutic techniques were able to reduce the dependent personality disorder scores drastically with group therapy having highest reduction effect. On the whole, a calculated mean of 111.22 was realized as pretest while 57.7 was recorded as post- test.

In testing the hypothesis, mean for the groups with pretest, post -test was 551.467 while the error score was 3465.137. Calculated F= 4.45. P – value was 0.016. Hence, since sig ($p = 0.016 < 0.05$) was less than 0.05 alpha, the null hypothesis was rejected meaning that psychodynamic therapy (PT), cognitive behaviour therapy (CBT) and group therapy (GT) had a significant effect on management of dependent personality disorder among subjects.

- **Research Question Two:** What are the differential effects of psychodynamic, CBT and group therapies in the management of DPD behaviour among female and male subjects as determined by their post-test mean scores?
- **Hypothesis Two:** There is no significant differential effect of psychodynamic, CBT and group therapies in the management of DPD among male and female subjects as determined by their post- test mean scores.

**Table 2:** Mean, standard deviation, and two- way ANOVA for effect of Psychodynamic, CBT and GT in management of DPD among female and male subjects as shown by their post test scores

| Group | Test | N | $\bar{x}$ | Std. |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Psychodynamic | Male | 8 | 70.13 | 17.27 |
| | Female | 12 | 63.58 | 7.59 |
| CBT | Male | 11 | 62.00 | 5.00 |
| | Female | 9 | 58.11 | 12.35 |
| GT | Male | 8 | 33.38 | 26.67 |
| | Female | 12 | 49.25 | 16.72 |
| Total | Male | 27 | 55.93 | 21.79 |
| | Female | 33 | 56.88 | 13.90 |

Test of Between-subject Effect (2-Way ANOVA)

| Source | Type III sum of sq. | df | Mean sq | F | ∝ | Sig. | Result |
|---|---|---|---|---|---|---|---|
| Corrected model | 7352.044 | 5 | 1470.409 | 7.091 | | 0.000 | Significant |
| Intercept | 182959.862 | 1 | 187959.862 | 882.380 | 0.05 | 0.000 | reject Ho |
| Groups | 6728.773 | 2 | | 16.226 | | 0.000 | |
| gender | 47.911 | 1 | 3364.387 | 0.231 | | 0.633 | |
| groups & Gender | 1445.078 | 2 | 47.911 | 3.485 | | 0.038 | |
| error | 11196.806 | 54 | 722.539 | | | | |
| Total | 209745.000 | 60 | 207.346 | | | | |
| Corrected total | 18518.850 | 59 | | | | | |

The descriptive statistics reveals mean and standard deviation for male in the psychodynamic group to be 70.13; 17.27 while that of female is 63.58; 7.59. those in the CBT group had 62.00; 5.00 and 58.11; 12.35 respectively for male and female while in the GT group, male and female had mean and standard deviation of 33.38, 26.67 and 49.25; 16.72 respectively. On the whole, the mean effect was 55.93, 21.79 for male while that of female was 56.88, 13.90.

The test of between subject effects reveals calculated F of 3.48 while significant value is 0.038. Hence, since sig ($p = 0.038 < 0.05$) is less than 0.05 alpha level, the hypothesis is rejected. This means that there is actually a significant effect of psychodynamic therapy, CBT and group therapy on management of DPD among male and female participants as shown by their post test scores.

**Discussion of Findings**

Findings as revealed in table 2 showed that psychodynamic therapy, cognitive behavioural therapy and group therapy jointly taken has a significant positive effect on management of dependent personality disorder among senior secondary school students in Rivers State. The meaning here is that therapist or counsellors can adopt more than one therapeutic techniques in dealing with the clients' problems in a situation where one technique has failed to yield such result. As the mean scores has revealed, there is a significant difference of about 51.5. This indicates that all the therapies have a greater effect in managing or reducing dependent personality disorder among the children. As also seen, the findings have supported the principle of elective therapy or theory. This theory narrates that no one technique could be effective in dealing with a client's problem. As Onyekuru (2010) [28] noted, "no one therapy technique can deal with the problems of the client or patients". At one point, a therapist by implication of these findings may use cognitive therapy at a point he may as well use the psychodynamic therapy while at another he may depend on group therapy. He may as well use all of such technique simultaneously. These findings also suggest that clients' problems may be complex which with the application of multiple therapy techniques, such problems could be handled effectively.

The findings here may come because the subjects in the various groups have homogenous problems that when treated with different treatment procedures, they still maintained positive response in the process of managing dependent personality disorder. It could also come because all the treatment techniques individually taken have their independent positive effect on managing dependent personality disorder among the subjects. The findings of the study to a great extent is not surprising at all to the researcher because to the best of her knowledge, she suspects that these therapeutic technique having proven to have individual positive effect on clients can as well have a positive effect when combined. On this note, the studies quoted earlier by Gjerde *et al* (2012) [20], as well as Beitz and Bomstein (2006) all supported the present findings when they noted that all the therapy techniques jointly taken has a significant impact on reducing behaviour problems of adolescents.

Research findings two revealed that there is a significant difference in the joint effect of all the treatment on the management of dependent personality disorder among male and female students with the male showing better positive effect than the female students. These findings mean that the treatment have effect on both the male students and the female students. The study also shows that male students record significant positive difference in the management of dependent personality while the female did not show significant adjustment. The findings here could come because the female students are natural dependent in nature who always seek love, care and support. Hence, in the process of them showing such dependency, this may reflect in their level of adjustment. The male on the other hand have higher adjustment in terms of non-dependency, their desire for self-actualization etc. may inform their quick adjustment during the treatment process in order for them to be totally independent. The findings might have also arisen because the females have more emotions than their male counterparts. This is evidence by mere observation that males seem to be more authoritarian, independent and the attraction of females. It could also be justifiable in the sense that even when the

females have the intellectual abilities and the intelligence to deal with their academic life. They still rely on the emotional support from men to function efficiently. The study as reported by Reich (1990) supported the present findings when it stated that they are differences in the predisposing factors to dependent personality disorder in males and females. Also, Slowik (2013) [35] also reported similar findings when he noted that female participants (in the effect of sex and gender role orientation on attitudes towards individuals with dependent personality disorder) were significantly less traditional, less sex-linked and more gender transient than their male counterparts.

**Recommendations**

Based on the findings of the study, it is recommended that;

1. Therapists/psychologists who are conversant with the use of psychodynamic therapy technique should as well adopt that in the treatment of adolescents' behaviour problems especially in dependent personality disorder management.
2. Therapists/psychologists who are conversant with the use of cognitive behavioural therapy technique should as well adopt that in the treatment of adolescents' behaviour problems especially in dependent personality disorder management.
3. Therapists/Psychologists who are conversant with the use of group therapy technique should as well adopt that in the treatment of adolescents' behaviour problems especially in dependent personality disorder management.
4. Finally, continuous assessment of the students should be done in order to ensure their continuous retention of the treatment in managing dependent disorder. They should not be left alone because at the long run, they may show some relapse.

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