Running Head: PSYCHOTHERAPY OF DEPENDENT PERSONALITY DISORDER

Clarification-oriented psychotherapy of dependent personality disorder

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Abstract

Clarification-oriented psychotherapy, an integrative form of psychotherapy for dependent personality disorder, is presented. Based on a generic theoretical model, a specific model of the psychological functioning of dependent personality disorder is developed. This model serves as a rationale to developing therapeutic intervention strategies aiming at addressing the specific problems related with the disorder. Special therapeutic problems which may occur in the process are discussed. The theoretical elaboration is illustrated by means of a clinical case presenting with dependent personality disorder.

Key-notes: Dependent Personality Disorder; Psychotherapy; Clarification-Oriented Psychotherapy; Psychotherapy Integration; Personality Disorder

CLARIFICATION-ORIENTED PSYCHOTHERAPY OF DEPENDENT PERSONALITY DISORDER

The present article is a narrative account on the application of clarification-oriented psychotherapy to the specific problems related with dependent personality disorder. As such, we aim at describing the underlying theory, by reviewing the relevant origins and developments, then describing the specific application to client with dependent personality disorder, and finally illustrate our elaboration with a short case description of a client's psychotherapy. We also place clarification-oriented psychotherapy within the broader current landscape of treatments for personality disorders.

1 What is clarification-oriented psychotherapy?

1.1 Introduction

Clarification-oriented psychotherapy (COP) is a psychologically founded, empirically validated psychotherapy form that pursues two major assignments. One of these assignments relates to clarification: On the basis of a trustful therapist-client relationship actively established by the therapist, the client's real motives he/she is presently unaware of are clarified aiming at eliminating the client's state of alienation. Clarification also aims at representing and clarifying dysfunctional client schemas that are co-determining the problems encountered. The second major task of COP deals with processing and modifying these clarified schemas therapeutically which enables the client to behave more constructively and flexibly during daily routines, exhibit less or no disturbing "symptoms", better face up to everyday situations both cognitively and affectively, and thus lead a more satisfied self-regulative life.

The evidence base of clarification-oriented psychotherapy is mostly based on process research and process-to-outcome research, as it is described in humanistic therapies more generally (Elliott et al., 2013; Sachse & Takens, 2002). From the outcome perspective, several studies have shown clinically significant pre-post effects for clients presenting with personal-

ity disorders. In a randomized controlled trial for Cluster C personality disorder (avoidant, dependent and obsessive-compulsive), Bamelis et al. (2014) compared schema-focused, clarification-oriented psychotherapy with treatment as usual over three years of treatment. The results showed comparable drop-out rates and large recovery rates for both active treatments (varying between 60% and 80%) and for specific outcome measures a superiority of schema-focused therapy, over the two other conditions. It remains unclear what the condition described as "clarification-oriented psychotherapy" in this particular study exactly entailed, as there were no adherence checks being performed for this treatment condition. In addition to this major methodological problem, it remains unclear whether the training investment was equivalent between the two active conditions. In conclusion, effects in the study by Bamelis may have been affected by a number of major methological problems in the design and implementation of the study. In two process-outcome studies which take into account the critical assessment of treatment adherence to COP principles and state-of-the art training in COP, Kramer et al. (2016, 2018) described pre-post effects for clarification-oriented psychotherapy for mostly narcissistic and dependent personality disorders varying between .54 and .66, considered in the moderate range. Finally, several naturalistic trials were published recently, describing large pre-post effects for clarification-oriented psychotherapy, varying between 1.21 and 2.31. For clients with dependent personality disorders specifically, Sachse and Sachse (2016; N = 15 clients), observed a decrease in obsessional traits, in dependency traits, in the tendency to submission, as well as an incrase in self-efficacy and in action-orientedness across clarification-oriented psychotherapy.

1.2 Tasks in clarification-oriented psychotherapy

In order to attain the treatment objectives of COP outlined above, the therapist needs to accomplish a number of tasks, which require expertise on several levels.

1.3 Relationship Formation: general and motive-oriented therapeutic relationship

One tasks concerns the therapist's active and focused approach to establish a therapeutic relationship. For this purpose, a therapist may adopt strategies of the general relationship formation or conditions (Rogers, 1957) or strategies consistent with a motive-oriented therapeutic relationship formation (Caspar, 1996). By adopting these strategies, the therapists will build up a trustful therapist-client relationship that forms the basis for all clarification and processing work that follows (Sachse, 1995, 2006b). A particularly important aspect is the motive-oriented therapeutic relationship formation. This concept was developed by Caspar and Grawe in the context of Plan Analysis (Caspar, 1996): it states that with respect to the client's interactional Plans, a therapist should act in a complementary way, i.e. satisfying the client's underlying motives, and avoid intervening complementarily to the client's (dysfunctional) interaction strategies. The concept is based on the assumption that clients learn, in their biographies, interactional Plans (Caspar, 1996) or interactional schemas (Soygüt, Nelson & Safran, 2001), which they "bring into the interaction", and which strongly influence the relationship behavior of the clients towards the therapist. A motive-oriented therapeutic intervention means that a therapist recognizes and reconstructs the client's central motives for relationships and proactively constructs his or her relationship offer in such a way that these motives are satisfied as best as possible, within the framework of the therapeutic rules. While COP is consistent with these basic assumptions, the application may differ slightly from the one found in the literature on Plan Analysis.

Sachse (Sachse, Sachse & Fasbender, 2010) has assumed that humans have fundamental motives for relationships which they seek to satisfy through their actions. These motives are elementary and positive. Satisfying them has a positive effect on the client's system: The client is contented, feels well treated and understood. According to our formulation, significant relationship motives (described in more detail below) are: appreciation, importance, reliability, solidarity, autonomy, boundaries. COP theory assumes these motives are not all equally important for all people: While appreciation is central to some, it is less important to

others, and there are people to whom autonomy is extremely important, while solidarity is significant to others and so on. Therapists who intervene in a complementary manner must first determine which motive of the relationship is of central importance for the respective client and then try to act complementary to *this* specific motive of the relationship.

More specifically, the motive for appreciation implies the need *to receive positive feedback from other people about one's own person*. The motive *"importance"* implies the need *to play a significant role in another person's life*, to receive signals that say to be an enrichment for another person. The motive for a reliable relationship is the need to receive signals *that a relationship is stable, lasting and predictable*. The motive for a solidary relationship is a need *to get help and support when you need it*. The motive for autonomy is the need (even *in* relationships) to be able to exist and be allowed to exist as an independent person, to be able to make and be allowed to make one's own decisions, and to be able and allowed to have one's own spheres of life. The motive for safe boundaries is the need *to define your own territory, which has safe borders and you can decide yourself who is allowed to enter this territory and who is not.* This level of differentiation in the therapeutic relationship offer, using the motive-oriented therapeutic relationship is quite specific to this treatment form and requires on part of the therapist intensive training in case formulation and relationship formation with this particular interpersonal focus.

1.4 Confrontation of "costs": increasing the client's motivation to change

Clients with personality disorders may generate "costs" – negative consequences – of their actions and behaviors without realizing that they are responsible for these costs themselves. Accordingly, motivation for specific internal change through psychotherapy is low, because these clients do not perceive the link between their behavior and the costs of this behavior. As such, personality disorders may be understood *as ego-syntonic;* thus, these disorders do not necessarily disturb the person who has them, but their interaction partners. As

such, some clients with personality disorders may come to therapy and at the same time considere that their behavior is not problematic and does not have to be changed. These clients do *not have a working mission* with regard to this disorder: They do not want to work on changing the personality disorder and they do not demonstrate much compliance with the therapist's corresponding interventions. Without a specifically formulated working mission, however, a therapist cannot work on changing a disorder at all: We think that, *without a working mission, there is no meaningful therapy*.

To make this clear to the client, the therapist *must make* appropriate confrontative interventions, (a) that they *actually have* costs; (b) that *they do not want* these costs; (c) that they *generate these costs themselves* through schemas/internal determinants, etc.; (d) that they can reduce the costs by changing these internal determinants, etc.; (e) and that they can do this in therapy with the therapist.

If one looks at these tasks the therapist has to accomplish, it becomes clear that the therapist via his/her interventions may draw the client's attention to aspects which the client does not recognize and does not want to recognize at all, but rather wants to avoid. However, this makes it clear that all interventions that a therapist can carry out here are, by definition, *confrontational interventions and therefore all these interventions result in the relationship credit to reduce*: A therapist who carries out such confrontational interventions must have sufficient relationship credit in order to be able to afford such strategies at all! This rigorous building of motivation related to the actual internal origins of the client's costs is specific to COP and may prove particularly useful in psychotherapy for clients with personality disorders.

1.5 Clarification of dysfunctional internal determinants

Clarification, i.e. the conscious and valid representation of internal determinants (e.g., dysfunctional schemas), is the central part of COP. We assume that many problems are

caused by the fact that clients develop dysfunctional schemas in their biographies, that is, certain assumptions (or "basic beliefs") that are unfavorable and result in costs the client incurs. COP theory assumes that people have a number of *assumptions*: Assumptions about reality, assumptions about themselves, assumptions about relationships, etc. Some of the assumptions are *realistic*, derived from experience and withstand an everyday test (an empirical test). But many assumptions are not realistic, they do not reflect reality well or are wrong. They would not stand up to an examination, but unfortunately they are no longer examined by the person; they are believed. *And some assumptions are unfavorable and lead to problems:* They lead to misinterpretation of situations, give rise to make unfavorable decisions, repeatedly cause disturbing emotions, etc. It is precisely these problem-causing or *"problem-determining"* assumptions that are to be tackled in COP: These must be identified, clarified and changed (cf. Sachse, 2003, 2005, 2006a, 2008; Sachse & Fasbender, 2010, 2014). Again, the step-by-step clarifying – fostering self-awareness in the client, emerging from the here and now experience – of dysfunctional determinants is a deep therapeutic process specific to COP. It goes well beyond the identification and modification of schemas as described in cognitive therapy.

Unfortunately, people have not saved assumptions in the same way as "normal memories": Rather, assumptions are forming *schemas or schemata*. In addition to the contents, there are also other important *psychological characteristics* of the schemas (Beck, 1979; Norman, 1982; Power & Dalgleish, 1997; Rumelhart, 1980). They are automatically activated (triggered) by situations (i.e. in a "bottom-up" manner) – and once activated, they have a strong influence on the processing of information "top-down"). *Therefore, the assumptions of the schemas will to a large extent determine the current interpretations of situations and thus emotions, actions, and behavior.* If the schemas contain unfavorable (or dysfunctional) assumptions, then the schemas lead to wrong, problematic interpretations of situations and thus to repeatedly problematic actions and emotions. In this case, it is important (a) to let emerge in the current therapeutic interaction, then identify and make clear schemas *are involved* in a

problem, (b) to elaborate these schemas and their contents (the assumptions), i.e. to *clarify* them exactly, (c) to actively work on and change these internal determinants.

Our therapy experiences and specific process research studies suggest that individuals cannot clarify (i.e. name, express in speech) large parts of their schemas, as they emerge in their experience, without very specific therapeutic help: Often clients can name some assumptions or indicate them in questionnaires, as done in certain types of cognitive therapy; however, underlying "deeper" assumptions are not accessible to clients. Process research studies (Sachse & Takens, 2002, for a summary) have shown, (a) that it is very difficult for clients to clarify schemas, (b) that clients need special support from therapists, (c) that therapists need special therapeutic techniques to encourage clarification, (d) that clarification processes take some time.

In schemas, you can differentiate between *contents and function*: (a) Each schema has a specific *content*, e.g. *a structure of certain assumptions*: These contents make the schema specific. These are, for example, assumptions such as: "I'm a failure", "I'm unattractive", "in relationships you are not taken seriously", "I have to be the best" and so on. (b) Each schema has *psychological functions*, e.g. that it is automatically activated by stimuli and that it then controls information processing (Sachse, 2003). Schemas are activated (or "triggered") by activating stimuli ("bottom up") and then control the information processing of the person ("top down"). Schemas can influence all types of information processing: Situation interpretations, interpretations of personal relevance, coping skills, etc. Schemas must be assumed to have a *filtering function*: Schemas "let all the information pass through" or even reinforce these pieces of information that are consistent with or compatible with the contents of the schema.

We distinguish between four types of schemas (Sachse, Breil, Fasbender, Püschel & Sachse, 2009; Sachse, Fasbender, Breil & Sachse, 2011): Two types of dysfunctional schemas: (a) self-schemata, (b) relationship schemata, and two types of compensatory schemas:

(a) norm schemata, (b) rule schemata. COP assumes that a client is often unaware of the assumptions of a schema, or that they are not completely clear to him or her, that he or she is not able to express them well, that he or she cannot grasp them precisely: Although the schema contents are in a cognitive code, the client cannot express the contents in speech, not exactly, not precisely, and not validly. However, it is necessary to translate schema contents into language, express them in accurate and valid formulations, (a) to communicate the contents during the therapy process; (b) so that the contents can be fully consciously brought to the client's mind; (c) so that the contents can be checked for coherence and problem relevance; (d) and: so that the contents can be questioned, checked, and refuted by adopting cognitive techniques. The conversion (or "translation") of (mostly implicit) schema contents into explicit verbal statements is what we call *clarification or explication*, and the process that causes this is called the *clarification or explication process* (Sachse, 2003).

Both the empirical results and our therapeutic experience show very clearly that therapists have to *support* the clients in their clarification process *very actively*: Therapists have to be *process-directive*, therapists have to stimulate/incite processes, keep them "running", raise questions, guide clients back to the topic/subject and the process, etc. Therapists have to monitor the clarification process *step by step*: They have to know at which clarification step (in which subprocess) the client is at the moment and then have to try to bring the client into the next subprocess, i.e. encourage the client to go to the next clarification step. In this way, the therapist guides the client from step to step to a reconstruction of relevant schema elements. In fact, empirical results and practical experience show that the progress accomplished *is not linear*, but: (a) If a client is at level X, he or she may require several "attempts" by the therapist to take the client to the next level. (b) More often than not, clients do not remain on one level, but fall back to a lower level "by themselves". Thus, it is a laborious undertaking to lead clients to a constructive clarification process. Therapists have to carry out interventions

(as we say: make processing proposals) again and again in order to help clients in the process and keep them in the process.

The therapist should in any case make processing proposals with a view to guiding the client's process effectively. But they should also make the appropriate offers. This means that he or she must make different interventions – make different types of deepening processing proposals – depending on the phase (subprocess) in which the client presently is in each case.

1.6 Therapeutic processing of dysfunctional internal determinants: the one-person role play

If relevant schemata have been sufficiently clarified, they must be systematically worked on therapeutically: They must be disputed, refuted and thus inhibited, and alternative functional schemata must be developed. COP uses the so-called "one-person role play" for this purpose, a version of a Gestalt-type two-chair dialogue.

One-person role play is a therapy technique in which a client is instructed to act *as his or her own therapist* and in the role of the therapist to question, dispute, and debate dysfunctional schemata and develop alternative assumptions (cf. Sachse, Püschel, Fasbender & Breil, 2008). This procedure serves the purpose of schema processing, schema clarification, resource activation and the motivation of clients (see Grawe, 1998). This procedure is a therapeutic framework in which a therapist can implement different techniques, in particular: (a) different cognitive intervention techniques for the processing of cognitive schemata, (b) different affective techniques for processing affective schemata, (c) different motivational techniques to increase the change motivation of the clients. The method can thus always be used in a meaningful way, (a) if cognitive and/or affective schemas contribute significantly to a client's problem (for example in the case of depression, anxiety, personality disorders), (b) when it comes to significantly strengthen the change motivation of clients.

After this narrative account of the central tasks of clarification-oriented psychotherapy, we show now in what way this treatment is relevant for the alleviating and solving problems

related with dependent personality disorder. In order to do, we will first describe the disorder, then show the COP application, and finally illustrate with a clinical case.

2 Characteristics of the Dependent Personality Disorder

Millon (1996, 2011; Bornstein, 1993, 1997) characterizes individuals with dependent personality disorder: The individuals show a high degree of friendliness, cooperation and helpfulness towards interaction partners. They behave strongly clinging and submissive, avoid conflicts and make themselves indispensable for partners. They have problems in making decisions and generally regard partnerships as positive, as “okay”. They will hardly see any problems and have problems with introspection. There are many empirically based characteristics of dependent personality disorder: They show a high degree of helplessness (Bornstein, 1995a, 1996, 1997, 1998), strong subordination (Bornstein et al., 1996; Main et al, 1985); they show a strong expectation orientation (Griffith, 1991), they show a certain level of guilt (Sinha & Watson, 2004, 2006), high levels of alexithymia (Loas & Cormier, 2008), consider themselves helpless (Bornstein, 1997; Overholser, 1996) and also tend to seek help (Shilkret & Masling, 1981; Sroufe et al, 1983); they try to meet the expectations of others (Agrawal & Rai, 1988; Bornstein & Masling, 1985; Main et al, 1985) and their behavior is strongly oriented towards maintaining relationships (Simpson & Gangestad, 1991); they also show comorbidity with depression and anxiety disorder (Barzega et al., 2001; Rost et al., 1992). Women are significantly more frequently diagnosed with dependent personality disorder than men (Jackson et al., 1991; Loranger, 1996) and for women, on average, higher levels of dependency are found than for men (Bornstein, 1997; Conley, 1980; Loranger, 1996). To certain therapists, clients with dependent personality disorder may appear to be “easy-care”, less problematic and cooperative for a long time, but then it becomes clear that these clients have little motivation for real internal (and external) change, hardly develop any awareness of problems and transfer a high degree of responsibility to the therapist. From our point of view, clients with dependent personality disorder initially appear to be only slightly “manipulative”

(term used in a descriptive sense); in fact, however, there may be more hidden manipulative strategies which often block therapist interventions and may conduct to treatment failures.

3 Theory of the disorder

Clients with dependent personality disorder have specific psychological characteristics described below, according to the assumptions of clarification-oriented psychotherapy (see also Sachse, 2006a, 2013a, 2013b; Sachse, Sachse & Fasbender, 2010; cf. Sachse, Breil, Sachse & Fasbender, 2013).

3.1 Central relationship motives

The central relationship motive of the dependent personality disorder may be *reliability*: It is the motive to strive for relationships that are durable, long-lasting, reliable and strong: The person wants to receive messages that attest to this. Another essential motive of the relationship is *solidarity*: It is the motive to strive for receiving protection and help, for being supported and for feeling secure. The person wants to receive such signals from interaction partners.

3.2 Self-schemas in dependent personality disorder

Schemas are “condensations” of biographical experiences. They contain assumptions of which the person is subjectively convinced. They are activated in situations (automatically) and then determine to a large extent information processing and action regulation (Sachse, 2003; Sachse, Püschel et al., 2008). Self-schemas contain assumptions about one’s own person. In particular, the self-schemas in dependent personality disorder contain assumptions to the effect that it is not possible to bind other persons to yourself, e. g: I’m not worth that others stay with me. I have characteristics that repel others. I’m not worth that others are there for me. These schemas cause the person to (strongly) doubt that he or she *as a person* can make a relationship reliable: This is a basis for the compensatory schemata that assume that the per-

son *must make* relationships reliable *through actions*. These clients often have still other assumptions such as: I can't manage on my own. I can't stand being alone. These schemata make loneliness a highly aversive state.

3.3 Relationship schemas in dependent personality disorder

Relationship schemas contain assumptions about relationships in general or assumptions about how to be treated in relationships. Primarily, these clients exhibit negative assumptions about the reliability of relationships: Relations are not reliable. Relations are not endurable. You can be left at any time without a warning. These schemas cause the person to never consider a relationship to be (sufficiently) stable, mean that the danger of being abandoned becomes a kind of permanent Damocles' Sword: There is no feeling of reliable security. This in turn is the basis of compensatory schemas, i.e. the assumption that something and *much* has to be done *constantly* in order to *achieve* reliability!

3.4 Norm schemas in dependent personality disorder

Norm schemas are "compensatory schemas"; they serve to "keep self- and relationship schemata under control". Norm schemas specify what a person should or must do, or may not do. General norm schemas are: Avoid being abandoned at any cost! Make sure your partner is strongly tied to you! This causes norm schemas to develop such as: Avoid conflicts and disputes! Accept a subordinate role! Don't do anything to upset your partner! What matters is what your partner wants; your needs don't play a role! Be absolutely solidary! These schemas lead to a highly expectation-oriented behavior: The person submits themselves, their wishes, opinions etc. to the partner and in this way avoids conflicts and arguments *and* makes themselves an "ideal" partner. However, the strong expectation orientation results in high alienation (a strong "estrangement" from one's own motive system; cf. Beckmann, 2006; Kuhl & Beckmann, 1994): The person hardly has a representation of what their desires and needs are, and this makes them highly state-oriented and greatly impairs their ability to make decisions.

At work, this can be highly disadvantageous, but in a partnership, it promotes the game: "Take decisions for me".

3.5 Rule schemas in dependent personality disorder

Rule schemas define what the person expects from other people and what expectations they are prepared to enforce. DEPs have few and weak rule schemata: Expectations exist, but they are practically never "enforced". An expectation is an implicit quid pro quo rule: "If I'm totally solidary, I expect total solidarity from my partner." and: "I expect absolute and undivided loyalty."

3.6 Manipulative actions and behavior in dependent personality disorder

Manipulative action and behavior is defined as a person performing a nontransparent act to cause an interaction partner to behave in a way that he or she "does not really" want and would not exhibit on his or her own initiative. Manipulation can be understood as "normal interactive action", and the term is used in a descriptive way, and not used in an evaluative or pejorative way (as often done when used in a colloquial way); the problem that arises for relationships is not derived from manipulation, but from the *dose* administered. Manipulative strategies are strategies of action and behavior that serve to implement the imperatives specified in the compensatory schemata for which a person requires competencies and skills.

The manipulation implemented by clients with dependent personality disorder is, in contrast to that of clients with histrionic personality disorder, less conspicuous, quiet and discrete – and thus often relatively difficult to detect. Quite often it is disguised as socially acceptable "altruism": "I'm doing this solely for my partner, and I like to do it." In fact, however, clients with dependent personality disorder may pursue very self-serving goals (e.g. to bind the partner to themselves through such "self-sacrifices"). Individuals with this disorder may use passive and active manipulative strategies. "Passive strategies" are those in which the person presents themselves as rather "small", "weak", "helpless", "needy", etc. (Bornstein, 1995b): The interaction partner is prompted to take the initiative. "Active strategies" are those

in which the person takes the initiative themselves, i.e. pursues their own goals, acts assertively, etc. But such strategies also serve to show the partner "how valuable one is as a partner" and how indispensable one is for them. Not all these clients are capable of resorting to active strategies.

3.6 Ego-syntony in dependent personality disorder

Dependent personality disorder may be a highly ego-syntonic disorder: As a rule, the respective persons do not suffer from the dependent system, but are "only" impaired through the so-called costs. Problems in the relationship, problems at work, depression, insomnia, etc. People will then see the costs, but what they do not see is that they are causing the costs themselves: Therefore, their motivation for change at the beginning of therapy is usually *very* low. For therapists, it can be very difficult to elaborate a problem awareness with the person with a view to making the clients realize that *they* should change something.

4 Clarification-oriented psychotherapy for dependent personality disorder

4.1 Complementarity with relationship motives

To intervene in a complementary (or motive-oriented) way to the motive level means that a therapist understands the client's central relationship motives and tries to satisfy them proactively in the therapy process, within the framework of the therapeutic rules (cf. Sachse, 2006b, 2013a, 2013b). Complementarity is difficult to implement in treatments with clients with dependent personality disorder, because the clients easily misunderstand therapeutic messages due to their internal determinants: The therapist is therefore advised to send *therapeutic double messages*. On the one hand, therapists must make it clear to the clients that they are loyal and that they help and support them, do not leave them alone, but on the other hand that they do not assume responsibility *for them*: They help them to make their own decisions; they help them to recognize what they really want; the therapists provide help and assistance but the clients should cooperate, otherwise the therapy success is questioned. The therapists also help the clients by questioning or challenging assumptions and making problems obvious

to them; they do this to help the clients to make problems solvable; but they cannot solve problems for the clients. A therapist communicates to the client: I, the therapist, am there for you in therapy and I will support you. I see my job as helping you to find out for yourself what you want and what you don't want, to clarify what your problems are and to help you solve them. I don't see my job as solving problems for you or making decisions for you, because that would make you dependent on me and I don't want to achieve that. I am entirely on your side, but to help you, I have to scrutinize and question your assumptions; this is not to annoy you, but to help you understand your problems. I am reliable in the therapy, which means that I offer you a therapeutic relationship regardless of what you do or don't do in the therapy.

4.2 No complementarity to the game level

According to COP theory, "games" are manipulative actions or behavior of persons with the help of which interaction partners are to be induced to take actions which they would not themselves realize. "Images" and "appeals" are used by the clients for this purpose: The person presents himself/herself in a certain way (e.g. as weak, helpless) and asks their interaction partner implicitly or explicitly to perform certain actions. Clients with dependent personality disorder often "play a game" with the therapist that might be called "giving away responsibility": The client makes it clear that they cannot solve a problem and therefore the therapist should tell the client what he/she can and should do. If the therapist does this, they only increase the client's dependency and sabotage the client's motivation to become independent and autonomous. The therapist can use a double strategy here again: In order to meet the clients 'where they currently stand' and to avoid frustrations and discussions, the therapist officially takes over the role offered to them: Yes, he or she is the expert, he or she shows the client where to go, and the client can rely on the therapist to help them! That means, the therapist will assume his/her share of responsibility. At the same time, however, the therapist uses

his or her expertise to induce the clients to take over their own responsibility and to constructively work on topics; i.e., the therapist always intervenes in such a way that the clients are encouraged to clarify *themselves*, make *their own decisions*, and to work *self-dependent*.

4.3 Activating resources

The COP therapist is advised to enable the client to deal with aversive, avoided contents step by step and in this way (slowly, but increasingly central) face up to problems. In order to do this, it is necessary to *strengthen* the clients: They must gain greater confidence in themselves, perceive their own competences and opportunities, build up a higher self-efficiency expectation. This increases their motivation for real change (see Sachse, Langens & Sachse, 2012) and their willingness to deal with problems and - very fundamentally - their willingness to face unpleasant contents. Resource activation means that therapists (a) emphasize and always make salient again and again all aspects that the clients are *capable of doing or achieving*: What they can do in actions, the skills they have, what they can endure, etc.; (b) emphasize all aspects that clients have already (positively) realized and in this way proved that they will continue to be able to do so in the future; (c) praise clients for all the aspects that they are dealing with well and constructively at the moment. In addition, the therapist and client work out, (a) which strategies a client can concretely develop and learn, (b) where, how, from whom a client can get the help they need.

Since clients may often be “caught” in their thinking and interpretations, it may also be helpful that therapists *offer alternatives*. In this context, the therapists propose concrete alternatives, for example (a) concrete interpretations of alternatives: “You could also interpret it as XY”, “You could also see it that way”; (b) concrete alternative actions: “You could also do XY”, “You could also choose XY”.

4.4 Making the client’s game level transparent

According to COP theory, the “games” that a client realizes usually generate high costs because they annoy interaction partners; however, the clients are usually not aware of

this or the clients do not represent that the costs are due to their relevant actions or behavior. This should therefore be made transparent to clients. The therapist should make it clear to the client that they not only experience costs, but that *they generate costs*; they should make it clear to the client that he or she has adopted unfavorable norms and rules, that he or she realizes manipulative actions and that all these aspects lead to costs and problems. And the therapist should thus make it clear to the client that they must and can do something *themselves* if they want to solve relevant problems. It is quite difficult for therapists to confront DEP persons with these aspects: Since the people have difficulty in understanding that they are manipulative due to their disposition, and because it contradicts their self-concept, they strongly resort to avoidance. Therefore, the therapist has to make these confrontations over and over again, first relatively gentle, then more and more distinct. Preferably, the therapist should make confrontations according to the *"it is my impression"* strategy: The therapist makes a confrontation, the client rejects it; the therapist leaves it stand as their impression, but concedes that they could have made a mistake or be wrong but does not discuss it with the client and does not force the client to deal with it either. The following always applies to making the game level transparent: Do not discuss with the client and do not impose an interpretation on the client: The client should accept relevant aspects and be able to integrate them into their system.

Therefore, the therapist guides the client step by step towards the game structure, for example: "You want your husband to make decisions for you." "You want this because you can't make up your own mind." "But it's also important for you to submit to your husband." "By submitting you want to show him that he has a special partner in you." "You're in fact trying to show him that you're basically indispensable for him." "Actually, the whole thing serves to tie your husband to you." "Basically, you think you have to act and behave like this because if you don't, you are afraid he might leave you." "Actually, this is an indirect strategy, you don't openly tell your partner what you want." It may take a very long time to go

through these processing stages and it may be necessary to keep the focus on certain points again and again.

4.5 Working on the process: breaking through the client's avoidance

According to COP theory, we assume that as soon as the client has sufficient trust in the therapist, the therapist can begin to actively work on the client's avoidance tendencies (cf. Sachse, 2003; Sachse, Fasbender, Breil & Sachse, 2011). As a rule, the therapist can do this by adopting a strategy of "taking countermeasures". Taking countermeasures means that if the client shows avoidance, the therapist either immediately repeats the intervention (according to the motto "the whole thing again from the beginning") or by briefly going along with the client and then making the intervention again (possibly in a slightly altered form). In this way, the therapist keeps the client "in the area of conflict": According to Dollard and Miller (1950) one can assume that clients have an "rapprochement tendency", a tendency to clarify problematic contents and face up to these contents, as well as an avoidance tendency, that is to evade relevant contents. Both techniques become more and more relevant as respective contents are approached, with the avoidance tendency intensifying faster than the rapprochement tendency. Where the tendencies intersect is the "point of conflict", and around the point of conflict is the "area of conflict". When a client enters this area of conflict, the *active avoidance behavior* begins, indicating that the therapist has now reached "the limit of what is possible". If the therapist continued at this point, this would trigger reactance and the client would leave the process for the time being.

"Holding on to the conflict area" now means that the therapist leads the client back to the "hot topic area" again and again. This will bring the client to finally recognize (a) that the contents are not so bad at all, (b) that nothing bad happens, (c) that he or she is not flooded with emotions, (c) that he or she can endure and process the contents.

If the client systematically undergoes these experiences through therapeutic interventions, this will cause the conflict area to shift and the client will be ready to deal with more and more problematic contents.

4.6 Clarification of internal determinants

Clarification of dysfunctional internal determinants (e.g., schemas) constitutes the central phase of a clarification-oriented treatment: This involves reconstructing the problem-relevant schemata with the client step by step and validly. This is for the most part a very difficult process for clients, during which clients need systematic guidance and support from the therapist. To achieve this, the therapist can apply specific strategies to promote the clarification processes of clients. The clarification of the relevant schemas is essential for clients with dependent personality disorder, since understanding the relevant schemas enables the client to gain insight into the nature of the respective problem. In addition, the schemata must be validly represented cognitively so that they can be treated therapeutically in the next step (as regards clarification processes refer to Sachse, 2003, 2008; Sachse & Fasbender, 2010). The problem of clarification for clients with dependent personality disorder is that they exhibit a strong external perspective and have great difficulty to adopt an internal perspective. Therefore, it is recommended that therapists help clients to adopt an increasingly internal perspective by again and again guiding them back to internal aspects. At the beginning, this approach has hardly any effect. However, it is important to place markers time and time again and in this way show the client what to do in the therapy process. To this effect, therapists ask internalizing questions again and again, not because they believe that the clients can answer them, but because they want (a) the client to recognize that such questions can be asked, (b) the client to recognize that such questions are important, (c) the client to recognize that it makes sense to address such questions, (d) the client to gradually learn to pay attention to internal aspects.

That the therapist asks these questions again and again serves to train the client. In addition, the therapist also explains why they asks these questions, why it is important to pay attention to internal aspects, why a client should follow such questions and the like. A therapist must be aware of the fact that he or she has to implement such an approach over a long period of time before clients actually start with internalizing their perspective. But they will only do so *if* the therapist consistently and strictly follows this procedure for a long time!

4.7 The processing of dysfunctional internal determinants

Strategies from the one-person role play are used in clarification-oriented psychotherapy for the purpose of processing dysfunctional schemas. In one-person role-playing, a client is instructed by their therapist to be their own therapist and discuss and contest his or her dysfunctional affective or cognitive schemata. In this context, this intervention uses the methods of “exchanging roles”, in which the client is requested to take on the role of their own therapist, when the client in the role of therapist imagines themselves as a client on the empty chair and addresses themselves directly. The one-person role play is an *intervention framework* in which a variety of different strategies can be implemented in order to work on both cognitive and affective schemata components with a view to motivating the client. The one-person role play thus offers the possibility to integrate additional elements such as resource activation or imagination, for example. This method thus fulfils the essential requirements of a constructive therapy process: It serves to motivate the client, it involves clarification and processing work, it takes into account affective aspects of the schemata and affective change processes; it causes the client to change their perspective, to critically deal with his or her assumptions and to act as his or her own therapist; it activates targeted resources and positive schemas of the client and in this way enables clients to come to terms with the negative, dysfunctional schema to be processed.

5 A Case: Clara

The present case aims at illustrating the clarification-oriented case formulation and some of the psychotherapy process involved in clarification-oriented psychotherapy. It represents a synthesis of an effective psychotherapy over one and a half year.

A 32-year-old married female client, Clara, a social worker by profession, came into therapy because she was experiencing increasing problems in her marriage: Her husband told her that she should be more independent and become a more active “counterpart”. Moreover, she was exploited by colleagues and clients for lack of assertiveness and shying away from conflicts in the workplace, which put her under increasing stress.

An analysis showed that Clara had a very strong motivation for reliability and solidarity, but also schemata of the kind: “Relations are not reliable”, “I can be left at any time without a warning”, and “I have hardly any positive qualities that bind partners to me”, “I have negative characteristics that drive partners out of the relationship”. Central schemata were also “Conflicts endanger the relationship!” “If you annoy others, you will be rejected and excluded!” And above all, she assumes “If I fight back, things will get worse”. Compensatory norm schemas developed, such as “Avoid conflicts at all costs!” “Defer your own wishes, needs and views!” “Never annoy your partner!” “Try to fulfill all the expectations placed on you!” The client did not exhibit rule schemas, only the hope that her own solidary actions would lead to solidarity on the part of the partner.

The client avoided conflicts in the partnership, tried to do everything right for her partner, tried to submit to him and agreed to all his suggestions: But she presented this as if it were her own wish and as if she were happy to do so. At the workplace she let herself be saddled with additional work, took over responsibility for customers where this was unfavorable, etc. The costs were becoming increasingly clear to her: The increasing dissatisfaction and criticism of her husband, the stress in the workplace, the onset of psychosomatic complaints. Otherwise, however, the disorder was highly ego-syntonic: The client did not realize that the costs *were due to her behavior*.

The therapist realized a motive-oriented relationship formation, but from the very beginning they tried to make costs salient and emphasize to the client what costs her system actually has. As soon as a trusting relationship had been established, the therapist began to confront the client cautiously, e.g. the therapist pointed out carefully that she claimed her relationship was in order, but her husband constantly criticized her: The therapist was very consistent in again and again pointing out contradictions, costs and correlations of her behavior and costs, but did not enforce the client to share this opinion. It took about 11 weekly sessions for the client to begin to deal with the therapeutic interventions and to consider that she could be the cause of the problem. Following this, the therapist systematically began to elaborate explicitly dysfunctional internal determinants: This was difficult for the client; several attempts were necessary before she was able to put words to her internal determinants of her behavior.

The reconstructions then caused even violent emotional reactions, such as the assumption: “If I fight back, everything gets worse”: The client remembered biographical experiences, which caused strong mourning reactions that were treated therapeutically. After sufficient clarification of the internal determinants, they were worked on in the one-person role play, which in comparison with the clarification processes was comparatively easy in the present situation: The client was able to dispute the schemas and develop alternatives. Since Clara had no experience and knowledge of how to enforce her own claims, say “no” in a friendly way, enter into conflicts etc., relevant exercises were carried out in role-playing games. In the final phase of treatment, the transfer phase, Clara was given homework assignments to try out the new schemata and actions/behavior in real life. This improved the Clara’s relationship and towards the end of the therapy a short, successful couple therapy was added. The client also learned to assert herself and keep her distance at work and all psychosomatic complaints disappeared.

6 Conclusions

The present narrative account aimed at providing a clarification-oriented perspective to the formulation and treatment of clients with dependent personality disorder. As such, we were able to demonstrate that the general model of clarification-oriented psychotherapy is applicable to the specific features of clients with dependent personality disorder. We showed that, since this disorder may be ego-syntonic, therapists are advised to adopt a double approach to psychotherapy: (a) a specific focus on the therapeutic relationship, by using general and specific relationship offers, such as empathy and patience on the one hand, as well as a focus on the individual's underlying motives, *and* (b) a consistent process-guidance, based on the clarification-oriented case formulation, as well as consistency in the therapeutic stringency. As illustrated with a case, this double approach to psychotherapy may contribute to the improvement of clients with dependent personality disorder, and significantly improve their quality of life.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

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