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Adaptive and Maladaptive Dependency in Bereavement: Distinguishing Prolonged and Resolved Grief Trajectories

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Abstract

Interpersonal dependency is typically viewed as a risk factor for prolonged grief among conjugally bereaved adults. However, emerging empirical evidence and theoretical advances suggest that one manifestation of interpersonal dependency--adaptive dependency--may serve as a protective factor in coping with loss. This study compared adaptive and maladaptive dependency across three matched groups: prolonged grievers, asymptotically bereaved adults, and a married comparison group. Results suggest a link between adaptive dependency and asymptomatic bereavement, and between maladaptive dependency and prolonged grief.

Keywords

dependency; detachment; healthy dependency; bereavement; grief

1. Introduction

Of the many risk and resilience factors predicting individual response to loss of a loved one, studies have focused on qualities of the conjugal relationship to better understand the behavioral, affective, and cognitive correlates that determine resilient outcomes (Mancini & Bonanno, 2009; Stroebe, Schut, & Stroebe, 2007). In particular, interpersonal dependency (the tendency to look to others for nurturance, guidance and support, even in situations where autonomous functioning is warranted) is frequently examined. Though dependency has traditionally been identified as a risk factor for prolonged grief, empirical findings have been mixed: While some studies identify interpersonal dependency as a risk factor (Bonanno et al., 2002; Prigerson, Maciejewski, & Rosenheck, 2000; Stroebe, Stroebe, & Domittner, 1988), others suggest that interpersonal dependency may be a protective factor, associated with a more adaptive grief trajectory (Blake-Mortimer, Koopman, Spiegel, Field, & Horowitz, 2003). Given the complexity of coping with loss and the multidimensional nature of dependency, it may be that the construct of interpersonal dependency encompasses both risk and resilience factors in the context of bereavement.

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1.1 Theoretical Background

Emerging consensus around dependency's multifaceted qualities suggests that it plays a role in both adaptation and dysfunction (Morgan & Clark, 2010). Clinical descriptions of dependency focus on a helpless self-schema, which causes individuals to exhibit needy, clingy behavior even in situations where autonomous functioning is warranted (Bornstein, 1992; Millon & Davis, 1996). For example, maladaptive dependency is linked with increased risk for depression (Blatt & Zuroff, 1992), eating disorders (Pritchard & Yalch, 2009), and anxiety disorders (Ng & Bornstein, 2005). However, clinicians and researchers increasingly agree that the dependency related motivation to obtain and maintain nurturing and supportive relationships is neither positive nor negative, but may enhance functioning in certain contexts while undermining it in others (Bornstein, 1992; Pincus & Wilson, 2001). Supporting this reconceptualization of dependency, empirical evidence suggests that although it leads to impairment in certain situations, interpersonal dependency also captures an array of adaptive traits and behaviors, including the ability to utilize social support (Mongrain, 1998), conscientious compliance with medical treatment (Bornstein, 1988), and experiencing a high number of positive life events (Shahar & Priel, 2003).

Moving beyond the traditional trait view of dependency, Bornstein's (1992, 2005, 2011) cognitive/interactionist (C/I) model suggests that dependency is best understood as a personality orientation wherein cognitive, motivational, and affective tendencies interact to determine behavior across varying contexts (see also Bornstein, Riggs, Hill, & Calabrese, 1996). This model provides a framework for conceptualizing the shifting behavior associated with the dependent person's perceptions of the social environment (Bornstein, 1992; Morf & Horvath, 2007), and is consistent with Mischel's (1979) and Morf's (2006) view that personality-driven responding is best understood as proactive and directed by underlying beliefs and expectancies. Consistent with tenets of the C/I model, evidence suggests that the behavior of individuals with high dependency shifts from passive submission to active assertion when they are in the presence of someone whom they perceive to be in a position to provide assistance toward a desired goal (Bornstein, 2006; Shilkret & Masling, 1981).

More specifically, the C/I model conceptualizes dependency in terms of four interrelated components (motivational, cognitive, affective, and behavioral) that capture both adaptive and maladaptive qualities. According to this model, the core motivation of the dependent person is to obtain and maintain supportive relationships. Cognitive schemas of the self as helpless and ineffective are formed early in life in the context of parenting experiences, gender role socialization, and cultural attitudes regarding achievement and relatedness (Cross, Bacon, & Morris, 2000). In turn, the helpless self-schema impels affective responses (anxiety and worry in the absence of support from others) and dependency related behaviors (tendency to seek help, affiliation, and reassurance from others) (Bornstein, Ng, Gallagher, Kloss & Regier, 2005).

Based on findings regarding the underlying motivational, cognitive, affective and behavioral correlates of dependency, Bornstein et al. (2002, 2003) distinguished three related constructs: Healthy Dependency, Destructive Overdependence, and Dysfunctional Detachment. Healthy Dependency (HD) is characterized by flexible, mindful help and support seeking that strengthens interpersonal ties rather than undermining them. Destructive Overdependence (DO) is characterized by non-reciprocal, indiscriminate dependence that leads to difficulties in various relationships. Finally, Dysfunctional Detachment (DD) is characterized by an inability to sustain social connections, rely on others for help, or utilize feedback effectively (see also Birtchnell, 1987; Kantor, 1993). Bornstein et al. (2002, 2003) developed a scale to measure these three constructs, and it has shown acceptable psychometric properties in various populations, including college students

and low income urban women seeking medical services (Bornstein, Porcerelli, Huprich, & Markova, 2009).

1.2 Dependency and Bereavement

Varying patterns of dependency are linked to individual differences in adjustment to loss (Bonanno, 2009; Bonanno et al., 2002; Stroebe, Schut, & Stroebe, 2007; Prigerson, Maciejewski, & Rosenheck, 2000). Initial studies using a case study approach suggested that interpersonal dependency was a risk factor for prolonged grief (Parkes & Weiss, 1983; Rando, 1988; Raphael, 1983). Later empirical work employing a prospective design demonstrated that dependency on the spouse, assessed using the Emotional Reliance subscale of Hirschfeld et al.'s (1977) Interpersonal Dependency Inventory (IDI), did predict a trajectory of prolonged grief (Bonanno et al., 2002); by eliminating retrospective bias and using a standardized dependency scale, Bonanno et al. (2002) provided compelling evidence that maladaptive dependency on the spouse was indeed a risk factor for prolonged grief.

In contrast to these findings, other studies exploring the link between overdependence and social loss found no strong or consistent relationship beyond the baseline maladaptive functioning associated with high levels of pathological dependency (Overholser, 1990, 1992). Moreover, in one of the few studies to examine the protective aspects of dependency among husbands anticipating the loss of their wife to breast cancer, Blake-Mortimer et al. (2003) found that husbands' dependency was associated with an increased tendency for wives to evaluate their family relations more positively. The authors suggested that those individuals who had their dependency needs met in the marital relationship tended to view the relationship more positively, and concluded that a certain amount of dependency on a loved one is adaptive when facing bereavement.

The varying findings regarding the link between dependency and adjustment to conjugal bereavement suggest that individual differences in dependency have complex effects in the aftermath of loss. By taking a perspective consistent with the C/I model, this study extends the literature on dependency and prolonged grief by investigating both adaptive and maladaptive aspects of dependency in adjustment to loss.

1.3 Hypotheses

We examined maladaptive and adaptive dependency in a cross-sectional sample of middle aged adults who lost a spouse 1.5 to 3 years prior to taking part in this study, comparing RPT assessed DO, DD and HD scores bereaved adults from three groups: Adults suffering from prolonged grief, bereaved adults free of clinical symptoms, and a married comparison group unexposed to spousal bereavement. Given the established differences between prolonged and resolved grievers (Bonanno et al., 2002; Prigerson et al., 1999), we expected to find differences in DO, DD and HD between the prolonged grief and resolved grief group. The married comparison group allowed us to establish that observed differences applied specifically to conjugal loss and were not more broadly related to other qualities of the conjugal context.

This is the first study to compare adaptive and maladaptive dependency associated with adjustment to loss using an established, psychometrically sound measure of overdependence, healthy dependency, and detachment. Previous findings suggest that healthy dependency (HD) is characterized by flexible, reciprocal situation specific help seeking. For example, studies demonstrate that adaptively dependent college students direct help seeking behaviors toward different persons, adjusting their responses depending on the consequences of earlier help seeking efforts (Bornstein et al. 1996, Bornstein, 1988). Findings also suggest that adaptive help seeking, secure attachment, and supportive social ties may be protective factors following loss, (Boerner, Schulz, & Horowitz, 2004; Bonanno, Westphal, & Mancini, 2011; Stroebe, Schut, & Stroebe, 2007). Therefore, we hypothesized

that HD would be associated with asymptomatic bereavement. Destructive overdependence (DO), on the other hand, is linked with submissive and clinging behavior, fears of separation, and difficulty functioning autonomously (Bornstein, 2005). Although there is conflicting evidence regarding the consequences of social loss among overly dependent individuals (Bonanno et al., 2002; Overholser, 1990), we hypothesized that our findings would be consistent with those in the literature linking dependency on the spouse with subsequent prolonged grief (Bonanno et al., 2002; Prigerson, Maciejewski, & Rosenheck, 2000). Finally, dysfunctional detachment (DD) is associated with social isolation and withdrawal (Birtchnell, 1987) poor health outcomes (Huprich, Hsiao, Porcerelli, Bornstein, & Markova, 2010) and difficulties in social and occupational functioning (Kantor, 1993). Because studies suggest that social isolation may compound grief reactions (Dyregrov, Nordanger, & Dyregrov, 2003) we hypothesized that DD would also be linked with prolonged grief.

2. Method

2.1 Data and Participants

Participants were drawn from those enrolled in a larger project examining reactions to loss. Practical and ethical issues in recruiting samples of bereaved participants are explored elsewhere (Bonanno & Kaltman, 1999), and the methods followed in this study are consistent with the most widely regarded sound practices (Penslar, 1993). This study recruited bereaved participants, stratified to include substantial numbers of prolonged bereaved adults as well as nonbereaved participants matched to the bereaved in age, gender, and annual income. Potential participants were contacted by standard methods (see Fraley & Bonanno, 2004), and those who contacted the study investigators were mailed two consent forms and telephoned one week later by a trained research assistant to describe the study in detail and review eligibility criteria (English speaking, loss of spouse in the last 1.5 to 3 years, middle aged adults, no previous Axis I diagnosis not directly related to bereavement, and no evidence of a recent substance abuse disorder).

Once enrolled, participants completed mail-in questionnaires, including the RPT. Participants then came to the lab at a scheduled time and took part in a structured clinical interview with a doctoral level trainee. Participants were paid approximately \$100 for their participation in the study. Using the prolonged bereaved group as a baseline, demographic variables such as age, gender, annual income, education, race, and years married were matched to those in the resolved and married group. Of the 185 participants enrolled in the project at the time of this study, 25 participants met criteria for prolonged grief (see Table 1). Taking the demographic variables of this group as a baseline, participants were matched from the two comparison groups by excluding participants who fell outside the age range of the baseline group. The result was that 41 resolved bereaved adults were matched with the prolonged baseline group by age, which represented 22% of the entire sample. 36 married participants matched the prolonged grief by age, which represented 19% of the sample. Comparisons along the measure of interest (the RPT) between matched participants and those not included in this analysis revealed no significant differences (all $ps > .10$).

2.2 Measures

Grief symptoms—The Structured Clinical Interview for DSM-IV-TR Axis I Disorders was used to assess symptoms of Major Depressive Disorder (MDD), Posttraumatic Stress Disorder (PTSD), and grief (SCID I/NP; First, Spitzer, Gibbon, & Janet, 2002). Trained interviewers administered a structured questionnaire corresponding to the DSM-IV criteria for symptoms of MDD (9 items, $\alpha = .84$), and symptoms of PTSD that did not overlap with the MDD items (14 items, $\alpha = .85$). Grief symptoms adapted from Horowitz et al. (1997)

were also assessed: strong yearning for the deceased; preoccupation with thoughts about the loss; recurrent regrets or self-blame about behavior toward the deceased; recurrent regrets or blame regarding the behavior of others toward the deceased; difficulty accepting the finality of the loss; marked loneliness or sense of emptiness; pervasive sense that life is meaningless; unusual difficulty developing new relations (8 items, $\alpha = .81$). Nine doctoral candidates in clinical psychology performed the interviews. Each interviewer coded a randomly selected set of five additional videotaped interviews. Inter-rater reliability was very high ($\kappa = .92$).

To identify persons with prolonged grief, we used an algorithm based on Prigerson et al.'s (1999) criteria. We defined prolonged grief as requiring either separation distress, intrusive thoughts, or intense distress related to reminders of the loss, as well as at least 5 grief-related PTSD symptoms (avoidance of thoughts, feelings, and talking about the loss, avoidance of people and places related to the loss, and feelings of detachment from others). To corroborate this designation, we provided participants with graphic representations and verbal descriptions of resilient, recovered, prolonged grief, and chronic distress trajectories (Bonanno, 2004). We then asked bereaved participants to identify the trajectory that best described their bereavement experience. Of the participants who were identified as prolonged grievers using Prigerson's algorithm, 84% also self-identified as prolonged grievers.

Dependency-Detachment—The Relationship Profile Test (RPT; Bornstein et al., 2003) is a rationally-derived 30-item questionnaire that asks participants to respond to a series of self-statements, each of which is rated on a 5-point scale ranging from 1 (*Not at All True of Me*) to 5 (*Very True of Me*). The RPT yields three, 10-item subscale scores: Destructive Overdependence (DO), Dysfunctional Detachment (DD), and Healthy Dependency (HD). Representative items from the DO subscale include, "I would rather give in and keep the peace than hold my ground" and "I sometimes agree with things I don't really believe so that others will like me." Representative items from the DD subscale include, "when someone gets too close to me, I tend to withdraw," and "I don't like to reveal too much information." Finally representative items from the HD subscale include, "I am able to share my innermost feelings and thoughts with people I know well," and "most of my relationships involve give-and-take, with both people contributing their share."

Preliminary construct validity data for the RPT confirm that DO, DD, and HD scores show theoretically predicted relationships with measures of attachment, identity, relatedness, and affect regulation (Bornstein et al., 2002); and with measures of alexithymia, relational-interdependent self-construal, and overall satisfaction with life (Bornstein et al., 2003). Among psychiatric outpatients, medical patients, and community adults, RPT scores also show expected relationships with measures of interpersonal problems and health-related behavior (Bornstein, Porcerelli, Huprich, & Markova, 2009; Huprich, Hsiao, Porcerelli, Bornstein, & Markova, 2010). RPT scores have acceptable levels of 3-year retest reliability, and subscale scores show acceptable levels of internal consistency (Bornstein et al., 2003); in the present sample, Cronbach's α for DO, DD, and HD were .86, .76, and .76, respectively.

3. Results

Table 1 shows demographic data across all three groups. Chi-square tests and one way ANOVAs confirmed that the three study groups did not differ along the following demographic variables: age, length of marriage, gender, education, and race. However, there were between group differences in income, where a one way ANOVA confirmed significant differences between the married, prolonged and asymptomatic group $F(2, 99) = 9.82, p < .$

001. Post-hoc analyses with Bonferroni corrections indicated that income for the married group was significantly higher than that for both bereaved groups, with no differences in income between the prolonged and the asymptomatic bereaved groups. Although it is plausible that reported income of the married participants was higher than that for the bereaved group since married participants were likely to report joint income, it is equally likely that the difference between groups occurred due to selection bias.

Table 2 shows the intercorrelations among subscales of the RPT, with rows above the diagonal representing correlations within the prolonged grief group and rows below the diagonal representing those for the pooled married and asymptomatic sample. Because there were no differences in RPT-assessed dependency between the married and asymptomatic sample, they were combined in the correlation table. As expected, HD was negatively correlated with DD and DO for the pooled/asymptomatic group (respectively $r = -.21$, ns ; $r = -.33$, $p < .05$); although correlation coefficients were in the expected direction for the prolonged grief group (respectively $r = -.08$, ns ; $r = -.35$, ns), the HD-DO correlation was nonsignificant. Correlations between DO and DD were also nonsignificant for both groups ($r = -.05$, ns for the prolonged group and $r = .14$, ns for the pooled group).

Table 3 and Figure 1 show data for between group comparisons along each of the three RPT subscales: HD, DD, and DO. One way ANOVA's comparing means of the three RPT subscales revealed significant differences between groups for DD, $F(2, 99) = 5.43$, $p = .006$ and HD, $F(2, 99) = 5.12$, $p = .008$. Bonferroni corrected post hoc comparisons, also shown in Table 3, revealed that mean DD score for the prolonged grief group was significantly higher in comparison to the resolved group ($MD = 5.26$, $p = .01$), and the married group ($MD = 5.16$, $p = .015$). Similar comparisons showed that HD was significantly lower for the prolonged group in comparison to both the resolved group ($MD = -4.73$, $p = .015$) and the married group ($MD = -4.83$, $p = .015$).

4. Discussion

The present study tested the hypotheses that prolonged grief is associated with maladaptive dependency, and that resolved grief is associated with adaptive dependency. Findings revealed a significant association between adaptive dependency scores and resolved grief: Asymptomatically bereaved individuals had higher HD when compared to a prolonged bereaved group. The associations with respect to maladaptive dependency showed unexpected patterns: While no differences were found between groups in DO, there were differences in DD. Specifically, those individuals with prolonged grief scored higher on DD than either the resolved grief or married group. Therefore, findings partially supported our hypotheses: HD was associated with non-clinical grief whereas DD was associated with prolonged grief.

This study extends the literature linking dependency and prolonged grief by examining the previously unexplored link between adaptive dependency and adjustment to loss. The C/I model highlights the role that context plays with respect to affiliative, nurturance-seeking behaviors (Bornstein, 2011), presenting the interesting possibility that in the aftermath of loss of a loved one an adaptive variant of interpersonal dependency may be a protective factor against prolonged grief. A plausible mechanism for this link may be that adaptively dependent individuals are able to effectively recruit assistance and support from others at a time when such help may be particularly essential to adjustment. Future studies should more specifically investigate the mechanisms by which adaptive detachment may function as a protective factor following conjugal loss.

The present results further indicated that DD rather than DO was associated with prolonged grief. In certain respects these findings are consistent with literature suggesting that highly dependent individuals do not show uniquely poor adjustment to loss (Overholser, 1990). In other respects, our findings add an alternate perspective to those studies which have found a predictive relationship between emotional reliance and prolonged grief (Bonanno et al., 2002). These seemingly contradictory patterns can be reconciled by considering that the behavior of both detached and overdependent individuals is reflective of underlying difficulties with autonomous functioning. One possibility is that maladaptively dependent individuals may vacillate between overdependence and detachment, specific to the demands of the social milieu (see Bornstein, 2005, for a discussion of this issue). An alternative explanation is that the social isolation and withdrawal associated with detachment compounds prolonged grief by restricting adaptive support seeking. Though speculative, it may also be that the link between DD and prolonged grief can be explained by an inability to evoke internal representations of the deceased for mood repair and emotional self-regulation. Finally, a plausible explanation for the absence of a link between DO and prolonged grief may be that because overdependent individuals are more likely to seek medical services, early engagement with external support provides some protective features. Though beyond the scope of this study, it may be that mediators explain the specific pattern of results found, and future studies should examine hypothesized intervening variables.

Several limitations of this study should be taken into consideration when interpreting the present findings. Most important, preloss dependency was not evaluated making it impossible to identify causal links. A second limitation is that dependency was assessed by self-report, and therefore relied on participants' self-attributions. Though not necessarily a limitation in the sense that self-assessed dependency predicts a broad array of real-world behaviors (Bornstein, 2010), we are limited in our ability to make predictions about the role of underlying dependency strivings during the course of bereavement. Future studies should incorporate behavioral measures of dependency to increase the predictive power and generalizability of the findings (Morf, 2006).

A related limitation involves possible overlap in constructs between detachment and the avoidant features of grief related PTSD. Because the theoretical underpinnings of both the RPT and the SCID are distinct, as are their methods of administration (questionnaire vs. interview/expert rated), it is likely that these measures tap distinct features. Consistent with this assumption, correlational analyses confirmed that RPT DD scores and grief related PTSD symptoms were not correlated in the prolonged grief group (all p 's > .05). However, given the conceptual overlap, future research should focus on the ways that these constructs converge and diverge in different populations. Finally, the modest sample size limits the extent to which we can make firm conclusions regarding the generalizability of our findings.

In conclusion, the present study showed that adults suffering from prolonged grief endorse greater detachment and less healthy dependency when compared to both married and resolved bereaved adults. This pattern is consistent with previous investigations which suggest that dependency is best conceptualized as a multifaceted construct (Bornstein, 2005; Pincus & Wilson, 2001), comprised of both resilience and risk factors. Findings extend the literature on qualities of the marital relationship as predictors of prolonged grief, and suggest the importance of evaluating both the adaptive and more problematic features associated with interpersonal dependency, in this and other contexts.

References

- Birtchnell J. Attachment-detachment, directiveness-receptiveness: A system for classifying interpersonal attitudes and behavior. *British Journal of Medical Psychology*. 1987; 60:217–227. [PubMed: 3676129]
- Blake-Mortimer J, Koopman C, Spiegel D, Field N, Horowitz M. Perceptions of family relationships associated with husband's ambivalence and dependency in anticipating losing their wives to metastatic/recurrent breast cancer. *Journal of Loss and Trauma*. 2003; 8:139–147.
- Blatt S, Zuroff D. Interpersonal relatedness and self-definition: Two prototypes for depression. *Clinical Psychology Review*. 1992; 12:527–562.
- Boerner K, Schulz R, Horowitz A. Positive Aspects of Caregiving and Adaptation to Bereavement. *Psychology and Aging*. 2004; 19:668–675. [PubMed: 15584791]
- Bonanno GA. Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*. 2004; 59:20–28. [PubMed: 14736317]
- Bonanno, GA. The other side of sadness: What the new science of bereavement tells us about life after loss. New York: Basic Books; 2009.
- Bonanno GA, Kaltman S. Toward an integrated perspective on bereavement. *Psychological Bulletin*. 1999; 125:760–776. [PubMed: 10589301]
- Bonanno GA, Westphal M, Mancini AD. Resilience to loss and potential trauma. *Annual Review of Clinical Psychology*. 2011; 7:511–535.
- Bonanno GA, Wortman CB, Lehman DR, Tweed RG, Haring M, Sonnega J, et al. Resilience to loss and prolonged grief: a prospective study from preloss to 18-months postloss. *Journal of Personality and Social Psychology*. 2002; 83:1150–1164. [PubMed: 12416919]
- Bornstein RF. Depathologizing dependency. *Journal of Nervous and Mental Disease*. 1988; 186:67–73. [PubMed: 9484305]
- Bornstein RF. The dependent personality: Developmental, social, and clinical perspectives. *Psychological Bulletin*. 1992; 112:3–23. [PubMed: 1529038]
- Bornstein RF. The dependent patient: Diagnosis, assessment, and treatment. *Professional Psychology: Research and Practice*. 2005; 36:82–89.
- Bornstein RF. The complex relationship between dependency and domestic violence: Converging psychological factors and social forces. *American Psychologist*. 2006; 61:595–606. [PubMed: 16953747]
- Bornstein RF. Psychoanalytic theory as a unifying framework for 21st century personality assessment. *Psychoanalytic Psychology*. 2010; 27:133–152.
- Bornstein RF. An interactionist perspective on interpersonal dependency. *Current Directions in Psychological Science*. 2011; 20:124–128.
- Bornstein RF, Geiselman KJ, Eisenhart EA, Languirand MA. Construct validity of the Relationship Profile Test: Links with attachment, identity, relatedness, and affect. *Assessment*. 2002; 9:373–381. [PubMed: 12462757]
- Bornstein RF, Languirand MA, Geiselman, Creighton JA, West MA, Gallagher HA, Eisenhart EA. Construct validity of the Relationship Profile Test: A self-report measure of dependency-detachment. *Journal of Personality Assessment*. 2003; 80:64–74.
- Bornstein RF, Ng MH, Gallagher HA, Kloss DM, Regier NG. Contrasting effects of self-schema priming on lexical decisions and interpersonal Stroop task performance: Evidence for a cognitive/interactionist model of interpersonal dependency. *Journal of Personality*. 2005; 73:731–761. [PubMed: 15854012]
- Bornstein RF, Porcerelli JH, Huprich SK, Markova T. Construct validity of the Relationship Profile Test: Correlates of overdependence, detachment, and healthy dependency in low income urban women seeking medical services. *Journal of Personality Assessment*. 2009; 91:537–544. [PubMed: 19838903]
- Bornstein RF, Riggs JM, Hill EL, Calabrese C. Activity, passivity, self-denigration, and self-promotion: Toward an interactionist model of interpersonal dependency. *Journal of Personality*. 1996; 64:64–74.

- Cross SE, Bacon PL, Morris ML. The relational-interdependent self-construal and relationships. *Journal of Personality and Social Psychology*. 2000; 78:791–808. [PubMed: 10794381]
- Dyregrov K, Nordanger D, Dyregrov A. Predictors of psychosocial distress after suicide, SIDS and accidents. *Death Studies*. 2003; 27:143–65. [PubMed: 12678058]
- First, MB.; Spitzer, RL.; Gibbon, M.; Janet, WB. Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Non-patient Edition. (SCID-I/NP). New York: Biometrics Research, New York State Psychiatric Institute; 2002.
- Fraley RC, Bonanno GA. Attachment and loss: A test of three competing models on the association between attachment-related avoidance and adaptation to bereavement. *Personality and Social Psychology Bulletin*. 2004; 30:878–890. [PubMed: 15200694]
- Hirschfeld RM, Klerman GL, Gough HG, Barrett J, Korchin SJ, Chodoff P, et al. A measure of interpersonal dependency. *Journal of Personality Assessment*. 1977; 41:610–618. [PubMed: 592089]
- Horowitz MJ, Siegal B, Holen A, Bonanno GA, Milbrath C, Stinson CH. Diagnostic criteria for complicated grief disorder. *American Journal of Psychiatry*. 1997; 154:904–910. [PubMed: 9210739]
- Huprich SK, Hsiao W, Porcerelli JH, Bornstein RF, Markova T. Expanding the construct validity of the Relationship Profile Test: Associations with physical health and anaclitic and introjective traits. *Assessment*. 2010; 17:81–88. [PubMed: 19700737]
- Kantor, M. *Distancing*. Westport, CT: Praeger; 1993.
- Mancini AD, Bonanno GA. Predictors and parameters of resilience to loss: Toward an individual differences model. *Journal of Personality*. 2009; 77:1805–1832. [PubMed: 19807863]
- Millon, T.; Davis, R. An evolutionary theory of personality disorders. In: Clarkin, JF.; Lenzenweger, MF., editors. *Major Theories of Personality Disorders*. New York: Guilford Press; 1996. p. 221-346.
- Mischel W. On the interface of cognition and personality: Beyond the person-situation debate. *American Psychologist*. 1979; 34:740–754.
- Mongrain M. Parental representations and support-seeking behaviors related to dependency and self-criticism. *Journal of Personality*. 1998; 66:151–173. [PubMed: 9529661]
- Morf CC. Personality reflected in a coherent idiosyncratic interplay of intra- and interpersonal self-regulatory processes. *Journal of Personality*. 2006; 74:1527–1556. [PubMed: 17083657]
- Morf CC, Horvath S. Connectionism as metaphor: Toward an integrated, unified conception of self-system and individual differences. *Psychological Inquiry*. 2007; 18:108–113.
- Morgan TA, Clark LA. Passive-submissive and active-emotional trait dependency: Evidence for a two-factor model. *Journal of Personality*. 2010; 78:1325–1352. [PubMed: 20545822]
- Ng HM, Bornstein RF. Comorbidity of dependent personality disorder and anxiety disorders: a meta-analytic review. *Clinical Psychology: Science and Practice*. 2005; 12:395–406.
- Overholser JC. Emotional reliance and social loss: Effects on depressive symptomatology. *Journal of Personality Assessment*. 1990; 55:618–629. [PubMed: 2280327]
- Overholser JC. Interpersonal dependency and social loss. *Personality and Individual Differences*. 1992; 13:17–23.
- Parkes, CM.; Weiss, RS. *Recovery from bereavement*. New York: Basic Books; 1983.
- Penslar, RL. *Protecting human subjects: Institutional review board guidebook*. Rockville, MD: Office for Human Research Protections, U.S. Department of Health and Human Services; 1993.
- Pincus AL, Wilson KR. Interpersonal variability in dependent personality. *Journal of Personality*. 2001; 69:223–251. [PubMed: 11339797]
- Prigerson HG, Maciejewski PK, Rosenheck RA. Preliminary explorations of the harmful interactive effects of widowhood and marital harmony on health, health service use, and health care costs. *Gerontologist*. 2000; 40:349–357. [PubMed: 10853529]
- Prigerson HG, Shear MK, Jacobs SC, Reynolds CF, Maciejewski PK, Davidson JR, et al. Consensus criteria for traumatic grief: A preliminary empirical test. *British Journal of Psychiatry*. 1999; 174:67–73. [PubMed: 10211154]

- Pritchard ME, Yalch KL. Relationships among loneliness, interpersonal dependency, and disordered eating in young adults. *Personality and Individual Differences*. 2009; 46:341–346.
- Rando T. Anticipatory grief: The term is a misnomer but the phenomenon exists. *Journal of Palliative Care*. 1988; 4:70–73. [PubMed: 3171779]
- Raphael, B. *The anatomy of bereavement*. New York: Basic Books; 1983.
- Shahar G, Priel B. Active vulnerability, adolescent distress, and the mediating/suppressing role of life events. *Personality and Individual Differences*. 2003; 35:199–218.
- Shilkret CJ, Masling JM. Oral dependence and dependent behavior. *Journal of Personality Assessment*. 1981; 45:125–129. [PubMed: 16370730]
- Stroebe M, Schut H, Stroebe W. Health outcomes of bereavement. *Lancet*. 2007;1960–1973. [PubMed: 18068517]
- Stroebe W, Stroebe M, Domittner G. Individual and Situational Differences in Recovery from Bereavement: A Risk Group Identified. *Journal of Social Issues*. 1988; 44:143–158.

Figure 1. Mean scores on RPT-assessed Dysfunctional Detachment (DD), Destructive Overdependence (DO), and Healthy Dependency (HD) across three study groups. Error bars represent 95% confidence interval.

Table 1

Descriptive Statistics for Sample Demographic Variables.

Variables	Married (<i>n</i> =36)		Prolonged (<i>n</i> =25)		Resolved (<i>n</i> =41)		Test Statistic
	<i>M</i> (<i>SD</i>)	%	<i>M</i> (<i>SD</i>)	%	<i>M</i> (<i>SD</i>)	%	
Age	47.5 (4.2)		46.2 (8.0)		48.1 (8.1)		$F(2, 99) = 0.57$
Sex (% Fem.)		55		44		51	$\chi^2(2) = 0.79$
Race (% White)		55		52		56	$\chi^2(12) = 3.76$
Years Educ.	3.6 (1.3)		3.7 (1.3)		3.7 (1.7)		$F(2, 99) = 0.03$
Years Married	16.2 (8.5)		14.7 (11.2)		14.9 (8.8)		$F(2, 99) = 0.24$
Family Income (\$1000)	83.9 (37.6)		44.5 (44.0)		55.1 (30.0)		$F(2, 99) = 9.82^*$

* $p < .001$

Table 2

RPT Subscale Intercorrelations.

Subscale	HD	DD	DO
Healthy Dependency (HD)	–	–.08	–.35
Dysfunctional Detachment (DD)	–.21	–	–.05
Destructive Overdependence (DO)	–.33*	.14	–

Note. Rows above the diagonal are correlations for the prolonged grief group (n=25), and rows below diagonal are for pooled married and asymptomatic grief sample (n=77).

*
 $p < .05$

Table 3

Means, Standard Deviations, and Univariate F-tests for RPT Assessed Dependency.

Scale	Married		Prolonged		Resolved		F	p	Post hoc comparisons
	M (SD)		M (SD)		M (SD)				
Healthy Dependency (HD)	35.83 (6.53)		31.00 (6.52)		35.73 (6.44)		5.12	.008	1 < 2, 3*
Dysfunctional Detachment (DD)	32.08 (7.06)		37.24 (6.28)		31.98 (7.06)		5.43	.006	1 > 2*, 3*
Destructive Overdependence (DO)	26.67 (9.34)		27.36 (9.39)		26.22 (8.46)		0.12	.883	1 > 2, 3

Note. 1=Prolonged group, 2=Resolved group, 3=Married comparison group.

* $p < .05$