Delusional Dominating Personality Disorder

Delusional Dominating Personality Disorder (DDPD) was proposed by Paula Caplan in 1991, in response to the proposed category of Self Defeating Personality Disorder (also known as Masochistic Personality Disorder).

This category was criticised by feminists and was not formally accepted to the DSM on the grounds that it overlapped with borderline, avoidant and dependent personality disorders.

Caplan described the proposed category of Self-defeating PD as 'virulently misogynistic'. She argues that it pathologised women who conform to societal expectations regarding femininity, such as putting other people's needs before your own. She questioned why there was not a parallel diagnosis for individual men who acted out macho norms for masculinity.

Together with Margrit Eichler she put together a proposal for Delusional Dominating Personality Disorder. This was published in Canadian Psychology with the subtitle: 'Consequences of Rigid Masculine Socialisation'. Caplan urged the APA to recognise the suffering of people who suffer from DDPD and those with whom they live and work. It was formally submitted for publication in the DSM-IV but was rejected by the DSM committee.

Although Self-defeating Personality Disorder was not made an official diagnosis either, DSM V continues to include the controversial category 'Borderline Personality Disorder' which is equally misogynistic. The use of this category and its status as an official and supposedly scientific diagnosis causes harm to women who seek help for trauma recovery and distress and perpetuates the wider social harms of systemic misogyny.

As with other systemic oppressions, incaresed harms is caused if an individual exists at the intersections of different forms of marginalisation. ICD-11 states that: 'Personlaity disorder may be confused with responses to discrimination, social exclusion, and acculturative stress among ethnic minority, immigrant, and refugee communities e.g. suspiciousness or mistrust may be common in situations of endemic racism and discrimination'.

Although ICD 11 has introduced the category of 'Complex PTSD' and a dimensional model of 'personality disorder', they have retained a 'borderline

pattern', as some treatments can only be accessed in the US and UK using this identifier. This can be recognised as a reflection of the unacknowledged and unaddressed systemic misogyny within mental health professions in the US and Europe. Paula Caplan challenged misogyny within psychiatric and psychotherapeutic professions throughout her career as well as challenging the medicalisation of distress more widely.

Here is the content of Caplan and Eichler's proposed category of DDPD. Caplan urged clinicians who have patients who fill criteria for DDPD to write them up and submit them for publication.

The Taxonomy of Delusional Dominating Personality Disorder (DDPD):

Individuals having this disorder are characterised by at least 6 of the following 14 criteria (note that such individuals nearly always suffer from at least one of the delusions listed):

1. Inability to establish and maintain meaningful interpersonal relationships
2. Inability to identify and express a range of feelings in oneself (typically accompanied by an inability to identify accurately the feelings of other people)
3. Inability to respond appropriately and empathically to the feelings and needs of close associates and intimates (often leading to the misinterpretation of signals from others)
4. Tends to use power, silence, withdrawal, and/or avoidance rather than negotiation in the face of interpersonal conflict or difficulty.
5. Gender specific locus of control (belief that women are responsible for the bad things that happen to oneself, and the good things are due to one's own abilities, achievements or efforts)
6. An excessive need to inflate the importance and achievements of oneself, males in general, or both. This is often associated with a need to deflate the importance of one's intimate female partner, females in general, or both.
7. The presence of one of the following delusions:
    a. The delusion of personal entitlement to the services of (1) any woman with whom one is personally associated, (2) females in general for males in general, (3) both of the above

b. The delusion that women like to suffer and be ordered around
c. The delusion that physical force is the best method of solving interpersonal problems
d. The delusion that sexual and aggressive impulses are uncontrollable in (1) oneself (2) males in general (3) both of the above
e. The delusion that pornography and erotica are identical
f. The delusion that women control most of the world's wealth and/or power but do little of the world's work
g. The delusion that existing inequalities in the distribution of power and wealth are a product of the survival of the fittest and that, therefore, allocation of greater social and economic rewards to the already privileged is merited.

(Note: the simultaneous presence of several of these delusions in one individual is very common and frequently constitutes a profoundly distorted belief system.)

8. A pronounced tendency to categorize spheres of functioning and sets of behaviours rigidly according to sex, e.g. belief that housework is women's work.
9. A pronounced tendency to use a gender-based double standard in interpreting or evaluating situations or behaviour (eg. A man who makes breakfast sometimes is considered to be extraordinarily good, but a woman who sometimes neglects to make breakfast is considered deficient).
10. A pathological need to affirm one's social importance by displaying oneself in the company of females who meet any of the following three criteria (a) are conventionally physically attractive (b) are younger than oneself (c) are shorter in stature than oneself (d) weigh less than oneself (e) appear to be lower on socioeconomic criteria than oneself (f) are more submissive than oneself
11. A distorted approach to sexuality, displaying itself in one or both of these ways (a) a pathological need for flattery about one's sexual performance

and/or the size of one's genitalia (b) an infantile tendency to equate large breasts on women with their sexual attractiveness

12. A tendency to feel inordinately threatened by women who fail to disguise their intelligence.
13. Is unable to derive pleasure from doing things for others.
14. Emotionally uncontrolled resistance to reform efforts that are oriented toward gender equity: (a) the tendency to consider oneself "a New Man" neither proves nor disproves that the patient fits within this category (b) patients who fit this description should *not* be diagnosed as having obsessive-compulsive disorders, since obsessive-compulsive disorders affect only a limited part of the personality and functioning, whereas this disorder is a pervasive and profound maladaptive organisation of the whole personality.

Incidence

By far most commonly seen in males but occasionally present in females. Tends to characterise leaders of traditional mental health professions, military personnel, executives of large corporations, and powerful political leaders of many nations but can be found in all social strata and religious and ethnic groups.

Note:

In keeping with the stated aims of the DSM, the proposed category is atheoretical, but there is little or no evidence that it is biologically based.

In fact, there is a great deal of evidence that it is an extremely common disorder that involves a great deal of psychological upset both to the patient and to those with whom the patient deals. There is also evidence that the disorder is socially-induced and, therefore, that individual psychotherapy and group therapy are useful. As an example, it is generally recognised among practitioners working with male perpetrators of wife battering, rape, and incest – many of whom fit the description of the Delusional Dominating Personality Disorder – that group treatment can be very helpful when it includes identification of the patient's problems and provision of a milieu in which

different values and interpersonal styles are promoted. There is also some evidence that the younger the patient when such treatment is begun, the better the prognosis.

The above introduction to Paula Caplan’s text was written by Dr Anne Darcy, Specialist Clinical Psychologist, December 2024