 USING A DELPHI STUDY TO ESTABLISH CONTENT VALIDATION OF EMOTIONAL DEPRIVATION DISORDER: PHASE ONE

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DEDICATION

It is with much love and gratitude that I dedicate this to my family. Without your love and support, I would not be the person I am.
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Research regarding adults with antecedents of childhood abuse and/or neglect is broad, but there is no prior research regarding Emotional Deprivation Disorder (EDD). According to Terruwe and Baars (1976), Emotional Deprivation Disorder can develop in adulthood due to a deficit of unconditional love occurring as early as infancy. Symptoms include an inability to relate to others, feelings of inferiority, inadequacy, uncertainty and insecurity. Clinicians need knowledge of Emotional Deprivation Disorder in order to improve treatment outcomes for persons presenting with these symptoms.

The purpose of this Delphi study (Phase 1) was to determine whether therapists experienced in the treatment of Emotional Deprivation Disorder could establish provisional content validity for the criteria of this syndrome. This researcher also sought to determine whether these therapists could differentiate Emotional Deprivation Disorder from two other personality disorders and insecure attachment. Eleven therapists participated in a Delphi study, answering three rounds of open-ended questions. Data regarding criteria for Emotional Deprivation Disorder were coded and themes emerged. The three subthemes include: *Inability to establish rapport with adults, Undeveloped emotional life, and History of abuse and/or neglect in childhood*; each theme had at least
one subtheme. These three themes matched criteria established by Terruwe and Baars for EDD, supporting provisional content validity.
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CHAPTER I

INTRODUCTION

Humans develop largely within the confines of families. The family system ideally provides nurture, protection and direction. As the first developmental context for the child, the family is the milieu within which a sense of worth, lovableness and identity for the child may be sown. When the family is successful in its consistent, loving presence and its gratification of the child’s needs, growth over all human dimensions – physical, intellectual, moral, spiritual and emotional -- is facilitated and the child moves from one developmental stage to another towards mature adulthood. Erikson (1997), Piaget and Inhelder (1969), Kohlberg (1987), and Maslow (1968) all noted that human development is hierarchical, each phase necessary for the next. Similarly, Terruwe and Baars (1976) observed that no developmental phase may be omitted, as each phase builds on the successful completion of those prior. They further stated that when a baby’s psychic needs for its mother’s love are not gratified, the baby experiences “a feeling of frustration or deprivation which, involving as it does its most primitive and fundamental striving, affects the child’s entire psychic being and distorts its growth” (p. 6). They termed this syndrome Emotional Deprivation Disorder, as it arises from a deprivation of the child’s natural sensitive needs.

Authors Terruwe and Baars (1976) used the term affirmation to describe the unconditional love given to children by their parents, which they concluded is a necessary
condition for development (p. 74). These authors stated “Frustration of the child’s essential need for loving acceptance leads to a standstill in his emotional growth” (Terruwe & Baars, 1972, p. 207). The authors observed that when the family fails the child in some fundamental way, such as providing unconditional love, as adults these persons may manifest an inability to develop and maintain relationships with other adults. These adults also experience deep feelings of inferiority, inadequacy, uncertainty and insecurity. The authors noted that many such persons even disclosed that emotionally they felt like children, even babies, which profoundly contributed to their sense of worthlessness and hopelessness, as they had always felt that no one could understand or accept them. In addition, Terruwe and Baars (1976) noted that some of these persons might exhibit a need to collect useless things, have severe guilt feelings, feel overwhelmed in the face of a change of circumstances, and even have undeveloped external senses. These observations by Terruwe and Baars delineate such symptoms of an underdeveloped emotional life and its sequelae; they trace these symptoms to the lack of unconditional love or affirmation necessary for the emotional life of the child to develop along a natural trajectory. Important to the work of Terruwe and Baars is their conclusion that this deficit of love may give rise to a syndrome in adulthood that they named Emotional Deprivation Disorder.

The family provides a foundation for the child’s development into a mature adult not merely by providing food and shelter. On a more profoundly important level, loving familial relationships are themselves the context within which children may grow into happy and secure adults who are confident and competent (Bowlby, 1988; Terruwe &
Findings from Attachment Theory

Attachment theorists have noted that secure and attentive relationships facilitate the child’s ability to regulate emotion (Gross & Thompson, 2007) and provide an internal working model of security that persists into adulthood (Bowlby, 1988) as attitudes and expectation about interpersonal relationships (see also Brisch, 2012). Ainsworth (1970) observed that when children feel safe they feel free to explore their environment. Even more importantly, she reported that “It is interaction that seems to be most important, not mere care, and particularly conspicuous in mother-child pairs who have achieved good interaction is the quality of mutual delight which characterizes their exchanges” (Ainsworth, 1967, p. 397). Emotional attunement to a child’s emotions, thoughts, and sensations provides him or her with a coherent narrative for self-awareness, which is a basic building block for decision-making, affect regulation and coping with difficulties. Cozolino (2006) theorized that when parents cannot do this, children may not develop the capacity of self-reflection and so cannot manage their world. This internalization of interactions with caregivers informs the nature of the child’s future adult relationships (Glaser, 2002; Muller, Sicoli, & Lemieux, 2000; Stansfeld, Head, Bartley, & Fonagy, 2008; Unger & De Luca, 2014). Additionally, the ability to link words and feelings comes through emotionally attuned relationships with adult caregivers who through conversation and modeling assist the child to be able to identify and verbalize his or her internal experiences (Cozolino).
Children have a primary need to form a secure attachment with a significant caretaker in order to develop an internal working model for themselves through relationship with others (Bowlby, 1955, 1973, 1988). Bowlby proposed that this secure attachment comes about in a particular manner, and, thus, strongly advocated that parents willing to sacrifice their own interests in favor of giving time and attention to their children would produce “healthy, happy, and self-reliant adolescents and young adults” (1988, p. 2). Bowlby (1973) identified the influence of a child’s parents on his or her maturation, who provide a stable sense of security, or secure base. Interestingly, however, Bowlby and other attachment researchers do not use the term ‘love’ when referring to the core factor that enables attachment to occur.

When children’s physical, emotional and attachment needs are met consistently and appropriately, such children become more independent (Ainsworth, 1970; Ainsworth & Bell, 1970), which leads to the conclusion that adults who have been reared in this way will also be independent (Mikulincer & Shaver, 2008). Caregivers who are responsive and available provide a secure base for children to internalize a feeling of security (Bowlby, 1988). This ‘felt’ sense of security arises out of the attachment system (Feeney & Noller, 1996) which becomes part of an internal working model (Bowlby, 1988) of seeing others as trustworthy and available, and the self as worthy of love (Karakurt & Silver, 2014). Bowlby (1988) theorized that attachment patterns begun in childhood continue across the lifespan (see also Stansfeld et al., 2008; Unger & De Luca, 2014); he also believed that early relationship patterns in childhood directly affect how a person later enters into relationships with future partners, as well as his or her own children.
Effects of Failure to Feel Loved

In some cases, families do not provide sufficient love and emotional nurture for children. Much research over the past several decades has identified a connection between childhood neglect and/or abuse and later psychological difficulties in adulthood (Briere & Jordan, 2009). Where adults did not receive adequate emotional nurturing and support as children due to being raised with abuse or neglect, they tend to manifest insecurity and difficulties in relationships, poor affect regulation, and maladaptive or self-endangering behaviors (Briere & Jordan, 2009; Parker, Johnson, & Ketring, 2012).

Researchers who have conducted retrospective studies have found associations between a lack of parental warmth and support with anxiety in women (Laraia, Stuart, Frye, Lydiard, & Ballenger, 1994); other researchers have found that parental overprotection is associated with anxiety and depression in adults (Parker, 1983). Maltreatment in childhood may manifest itself in adulthood as negative working models of relationships (Bowlby, 1988) or poor interrelationships in women (Briere & Jordan, 2009). Stansfeld, Head, Barley, and Fonagy (2008) note that childhood emotional and physical deprivation is associated with lower parental warmth. Specific cognitive and emotional consequences of physical, sexual, and psychological abuse or neglect include low self-esteem, lack of self-awareness, identity disturbances, self-blame, hopelessness, anxiety, depression, and anticipation of rejection or abandonment (Briere & Jordan, 2009). Along with symptoms of anxiety, depression, posttraumatic stress, dysfunctional behavior, and dissociation, Briere and Rickards (2007) identify other major effects of childhood maltreatment: impaired self-capacities, that is, identity disturbances or difficulties with sense of self,
affect dysregulation, and interrelational difficulties, all of which lead to significant psychosocial problems in adults (see also Stansfeld et al., 2008). Some major difficulties identified in adulthood include Avoidant Personality Disorder (Joyce et al., 2003), Dependent Personality Disorder (American Psychiatric Association, 2013), as well as insecure attachment.

Personality disorders are defined as “an enduring pattern of inner experience and behavior that deviate markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (American Psychiatric Association, 2013, p. 645). Generally, they are considered to have childhood antecedents (Bierer et al., 2003; Grover et al., 2007; Rademaker, Vermetten, Geuze, Muijilwijk, & Kleber, 2008) that are manifested in late adolescence and adulthood as maladaptive traits in personality through ten specific disorders. These personality disorders include Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, and Obsessive-Compulsive Personality Disorder. This study will consider only two personality disorders, Dependent and Avoidant Personality Disorders, because the criteria for these two disorders appear to be most similar to the criteria identified for Emotional Deprivation Disorder (see Appendix E for EDD diagnostic criteria), which Terruwe and Baars (1976) state has childhood antecedents.

Avoidant Personality Disorder (APD) (American Psychiatric Association, 2013) is characterized by a pattern of social reticence, deep feelings of inadequacy, and hypersensitivity to the judgments of others (see Appendix F for diagnostic criteria for
APD). Sensitive temperament, negative childhood experiences, as well as both cognitive and affective responses to anticipated rejection all interact to increase the likelihood of avoidant behaviors (Meyer, Ajchenbrenner, & Bowles, 2005).

Dependent Personality Disorder (DPD) (American Psychiatric Association, 2013) manifests itself in compliant and anxious behavior related to an extreme need to be taken care of (see Appendix G for DPD diagnostic criteria). While all human beings are dependent to some extent throughout life, extreme forms of dependency can manifest as a personality disorder in adulthood (Disney, 2013), which then affects adult relationships. Disney’s review of the literature on DPD revealed that this disorder is often linked to overprotective and authoritarian parenting styles. In addition, this article notes fearful attachment style, lack of assertiveness and strong social anxiety were strong predictors of DPD in adulthood. However, a negative problem-solving orientation characterizes both Avoidant and Dependent Personality Disorders (McMurran, Duggan, Christopher, & Huband, 2007), inasmuch as problems pose a threat due to a low sense of capability to resolve these problems, which further evoke feelings of frustration.

Use of the Delphi In MFT Research

The Delphi method is a research approach used to gather formal consensus using expert or knowledgeable judgement in an area where there is limited evidence (Koekkoek, Meijel, Schene, & Hutschemaekers, 2009; Vernon, 2009). The name Delphi refers to the Oracle at Delphi in ancient Greece who was able to predict the future. Hence, the name Delphi method originally referred to forecasting answers to future problems. This technique was initially developed by the RAND Corporation in the 1950s
in defense research to estimate the probability of an atomic bomb attack on the United States. This method was not made public until this research study was declassified (Dalkey & Helmer, 1962). Stone Fish and Busby (2005) noted that the use of the Delphi method today is more concerned with improving knowledge.

Since its inception, use of the Delphi method has been used in fields such as psychology (Niemeyer, Taylor, Rozensky, & Roberts, 2012), nursing education (Lindeman, 1975; Sullivan & Brye, 1983), determining research priorities in clinical nursing (Mitchell, 1998), establishing validity for a nursing assessment tool (Löfmark & Mårtensson, 2017), ecological economics for estimating the value of protecting the Amazon rainforest (Strand, Carson, Navrud, Ortiz-Bobea, & Vincent, 2017), and gynecology for estimating best recuperation practices (Vonk, Noordegraaf, Huirne, Imann, van Mechelen, & Anema, 2011). These are only a few of the uses for the Delphi method found in the literature.

The Delphi method offers a structured process designed to elicit critical discussion and examination of an issue rather than demand quick concessions in order to come to an agreement (Dawson & Brucker, 2001; Linstone & Turoff, 1975; Mease et al., 2008). Dalkey (1969) observed that the Delphi is used to stimulate and refine group conclusions. Stone Fish and Busby (2005) discussed the use of the Delphi method “to move a particular field forward” (p. 239). By using the opinions of experts on a subject to gather consensus regarding a particular issue, researchers hope to improve decision-making (Dawson & Brucker, 2001) rather than forecast the future.
The Delphi method is a procedure for refining the opinions of a group of people who are knowledgeable about a particular topic. Typically, this technique involves administering a succession of questionnaires to a group of experts until a consensus is reached (Sori & Sprenkle, 2004). This approach is useful in situations where the problem to be studied does not lend itself to precise analytical procedures and which the individuals who will contribute cannot feasibly be brought to one location for discussion (Linstone & Turoff, 1975).

The Delphi method is a procedure for having a panel of experts or knowledgeable people answer a set of questions that are then correlated and sent back to these experts to refine their answers further (Davidson, 2013; Hsu & Sandford, 2007). This method is typically anonymous so that group members are prevented from knowing who the other participants are, thus avoiding issues of intimidation or persuasive coercion that can affect opinions when in the presence of others. It also helps ensure independent thought. The Delphi method enables participants to express their thoughts anonymously, receive comments from the rest of the group, read and disagree with the opinions of others, and be able to amend their own views (Stone Fish & Busby, 2005), all without fear of repercussion (Sori & Sprenkle, 2004).

Dalkey (1972) observed that the Delphi technique prevents certain difficulties inherent in more traditional ways of collecting opinions. For example, it eliminates forceful personalities, irrelevant information and coercion for conformity while permitting participants to consider the responses of others along with their own (Dawson & Brucker, 2001). Along with these advantages, it permits participation from a number of
people without a great expenditure of time or cost, while helping to build consensus on
the subject being studied. On the other hand, Linstone and Turoff (1975) reported that
there are certain problems that can affect the outcome of Delphi studies: researchers may
discount the idea that participants can change their minds, predict too much from the
results, and rely on ‘experts’ who may not want new ideas.

Panel selection is a critical feature of the Delphi method, as the expertise of the
participants offers the most potential for a valid outcome (Blow & Sprenkle, 2001).
Therefore, the participants’ knowledge must be applicable to the area being studied and
the questions asked (Dawson & Brucker, 2001; Linstone & Turoff, 1975). As a result, in
Delphi studies panelists are selected to participate based on their area of expertise and
knowledge, rather than by random sample (Sori & Sprenkle, 2004). There are no
prescribed numbers for how many participants must be a part of a Delphi method study
(Dawson & Brucker, 2001; Vernon, 2009). Vernon reports that published Delphi studies
have used panels ranging in number from four to over 1000 experts. However, when
larger numbers are used this technique can produce unmanageable data (Dawson &
Brucker, 2001).

The Delphi method has also been used to consolidate criteria for a variety of
diagnoses, treatment and interventions, as well as to create taxonomies. Koekkoek,
Meijel, Schene, and Hutschemaekers (2009) used it to help identify and rank problems in
community mental health care for patients with severe Borderline Personality Disorder.
Stone Fish and Piercy (2005) used the Delphi method to examine theories and practice
related to structural and strategic family therapies, and Sori and Sprenkle (2004) used it to look at methods of training family therapists to work with children and families.

Over the past 30 years, the Delphi method has been used in marriage and family therapy research, providing evidence that it is a substantive methodological choice for research in this discipline, too. Dawson and Brucker (2001) note that Delphi studies can aid marriage and family therapy researchers to clarify areas commonly lacking definition. Jenkins and Smith (1994) examined the then extant 11 studies in family therapy that had used the Delphi design.

Stone Fish and Piercy (1987) noted that the Delphi method has been used within the field of family therapy to build curricula, to develop a feminist model of family therapy and to identify standards for instruction in this model. Since the early 1980s, the number of studies in the field of marriage and family therapy that have been conducted utilizing the Delphi method is slowly growing (Blow & Sprenkle, 2001; Stone Fish & Busby, 2005). Moreover, “the expert consensus approach has become standard in the development of practice guidelines for clinicians” (Morgan & Jorm, 2009).

Because the Delphi method is used where there is little previous research (Koekkoek, Meijel, Schene, & Hutschemaekers, 2009; Vernon, 2009), and a literature search revealed that there is little prior research on Emotional Deprivation Disorder, it is therefore an appropriate methodology for this study. Jenkins and Smith (1994) note that “any area of practice that needs additional refinement could benefit from the use of the Delphi method” (p. 428). This is certainly true of the study of Emotional Deprivation Disorder. Furthermore, although use of the Delphi method is not widespread in the
marriage and family therapy literature, there are a number of MFT studies that have used the Delphi in their methodology (Dawson & Brucker, 2001; Jenkins & Smith, 1994; Sori & Sprenkle, 2004; Stone Fish & Busby, 2005; Stone Fish & Piercy, 1987).

This study used the Delphi method through an online PsychData program. This facilitated the participation of 11 therapists from across the United States and Europe through three successive online surveys. Bringing this sample together in the same location would have been cost prohibitive, and using a teleconferencing method for an online focus group might have brought about a feeling of intimidation or coercion for some participants, possibly inhibiting them from being honest about their own opinions. Therefore, this Delphi study facilitated the opportunity for this study on EDD that would not otherwise have been possible.

**Statement of the Problem**

There is a gap in the literature regarding the classification of a syndrome or disorder arising from a deficit of unconditional love or affirmation. This may be precisely because behavioral considerations are favored over etiology as factors that are considered in developing nomenclature for new syndromes in the DSM (American Psychiatric Association, 2013). Yet this may be an important factor to consider in identifying new syndromes, which can contribute to greater identification and healing of such disorders. A literature review revealed that some of the symptoms identified by Affirmation Theory (Terruwe & Baars, 1976) in the study of adults who experienced childhood antecedents of abuse or neglect have been observed by other researchers. However, this researcher is suggesting that there is a difference between the criteria of
Emotional Deprivation Disorder, which is based on a unity of symptoms, when compared with criteria for insecure attachment, Avoidant and Dependent Personality Disorders. This unity of symptoms differs from other syndromes and diagnoses not only because there is a difference in the constellation that defines each condition, but also because the symptoms that comprise EDD have their etiology in a deficit of unconditional love or affirmation by one’s parents. In fact, Montague (1971) observed: “Tactile contact between the American mother and child expresses caretaking and nurturance rather than love and affection” (p. 246). This particular etiology is not found in the literature regarding insecure attachment and Avoidant and Dependent Personality Disorders. Identifying this lens through which to understand childhood antecedents of adult identity and relational difficulties can facilitate that these persons and their families receive more effective treatment.

Terruwe & Baars (1976) contended that every human person needs affirmation in order to grow into a mature adult. Affirmation Theory (Terruwe & Baars, 1976) begins with an understanding of the emotions, in which love as one of the primary emotions, enables parents to be moved emotionally by their child. The child in turn receives this love expressed through the parents’ eyes, tone of voice and tender touch as an affirmation of his or her goodness and lovableness. It is the consistent unconditional love by parents through which children receive the gift of themselves (Baars, 2005, 2016), thus growing in the experience of themselves as good, worthwhile and loveable. This is foundational for the healthy development and integration of physical, intellectual, moral and emotional dimensions in the growing person. Essentially, this premise is distinct from that of
Bowlby’s Attachment Theory (1988), which proposed an evolutionary basis for attachment.

Bowlby (1988) theorized that the emotional bonds between mother and child are innate functions of survival that promote attachment through maintaining ready proximity. Bowlby added that in order for such cybernetic systems to work, both mother and child have internal working models of self and other as well as of their patterns of interaction. Bowlby postulated that such a developmental theory should replace those that theorize fixation at or regression to certain developmental phases.

While affirmation theory and attachment theory have different underlying premises, and it is unlikely that their proponents were aware of each other, both seem to have arrived at similar conclusions regarding the primary relationships of life. However, the first emphasizes unconditional love or affirmation as the factor that gives emotional life to the child, while the latter views maternal sensitivity as the variable upon which secure attachment depends. Bowlby (1988) theorized that secure relational bonds early in life bring about healthy, happy and self-reliant adults, able to overcome difficulties as well as enjoy the beauty and goodness of life. Terruwe & Baars (1976) stated that it is unconditional love (affirmation) itself that enables such bonds to occur in the first place. What is most important for this study is determining that there exist criteria for a unique syndrome, Emotional Deprivation Disorder.

Terruwe and Baars (1976) observed that adults who experienced childhood antecedents of emotional neglect and lack of affirming love may exhibit emotional immaturity and lack the capacity to connect and make secure relationships with spouses,
other adults, and their own children. Precisely due to the effects of early deprivation of unconditional love, the capacity to orient oneself naturally to others does not develop (or to an inadequate degree), and such persons can only establish rapport with others once others have first extended themselves to him or her, as do children. According to these authors, such persons have difficulty in developing emotional rapport with other adults, and therefore cannot maintain marriage or adult friendships. Stansfeld, Head, Barley, and Fonagy (2008) note that the ability to elicit social support depends on the individual’s capacity to cultivate and sustain relationships, the origin of which is in the attachment relationship with his or her mother. Isolation and alienation continue to exacerbate the unmet need to be loved and accepted for oneself. In addition, these adults report deep feelings of inferiority, inadequacy, insecurity and uncertainty (Terruwe & Baars, 1976).

Because Emotional Deprivation Disorder has not been widely recognized in the family therapy or other mental health arenas due to Terruwe and Baars (1976) being clinical psychiatrists rather than researchers, few therapists can identify adults who meet its criteria. Therapists need a means by which to recognize and diagnose these clients in order to be able to treat them and their family members more effectively and appropriately. Identification of EDD and knowledge of Affirmation Theory will facilitate marriage and family therapists’ understanding of how early deficits in unconditional love may affect attachment, which in turn influences adult relational issues.

**Statement of Purpose**

This researcher believes that there is a deficit in the classification of psychiatric disorders that have antecedents in childhood that may be overcome by the introduction
and provisional confirmation of Emotional Deprivation Disorder. The purpose of this research is to establish content validity for Emotional Deprivation Disorder as a unique syndrome or disorder by utilizing a modified Delphi study drawing upon the experience of affirmation therapists. These therapists were asked questions regarding what criteria they use to identify Emotional Deprivation Disorder in order to see if a consensus could be reached. This panel of therapists was also asked whether there are unique characteristics that set this syndrome apart from the diagnoses or conditions of insecure anxious attachment representations and Dependent and Avoidant Personality Disorders. All of these disorders are thought to have their antecedents in early childhood experiences of abuse or neglect (Bierer et al., 2003; Grover et al., 2007; Rademaker et al., 2008).

It is important for family therapists and those in other clinical fields to be able to identify and distinguish this syndrome in order for these persons and their families to receive proper therapeutic treatment. An awareness of the potential impact of clients’ early lack of love, developmental attachment deficits and failures in family dynamics will improve the marriage and family therapist’s ability to conceptualize systemic difficulties in therapy with individuals, couples and families (Kozlowska & Hanney, 2002). For example, even with individuals who present with personality disorders or attachment-related relational difficulties, identifying this syndrome can facilitate marriage and family therapists’ ability to provide effective interventions utilizing systems theory (Bertalanffy, 1968), as each individual consists of a whole within herself while simultaneously being part of a larger system. Existing theories offer helpful interpretations for individuals and
families with such childhood antecedents; this study sought to enlarge the options available.

**Research Questions**

To fulfill the purpose of this study, the following questions guided this research:

1. What criteria do experts in affirmation therapy use to identify EDD?
2. What do affirmation therapists see as the difference between EDD and other diagnoses such as insecure attachment patterns and Dependent or Avoidant Personality Disorders?

**Theoretical Framework**

Humanistic psychology provides the theoretical framework for this study, as it affirms the inherent dignity and worth of the human person (Association for Humanistic Psychology, 2016). This ‘Third Force’ in psychology arose as a reaction against both behaviorism and psychoanalytic theory. Its primary founders were Rogers, Satir, Maslow and May, who examined issues of self, self-actualization, and how human beings experience themselves and events. Humanistic psychology was initially concerned with the growth of the individual person, especially related to the capacity for love, self-worth, self-actualization and autonomy.

Terruwe and Baars’ (1976) Affirmation Theory fits this humanistic framework as it also affirms the inherent dignity and worth of the human person. Terruwe and Baars believe that the balance of the person’s physical, intellectual, volitional, spiritual and emotional dimensions is in the service of the individual person’s freedom and happiness, as well as helping develop the capacity to form mature bonds in adulthood. Affirmation
Theory identifies the innate need for unconditional love as the foundation for human development. It addresses the symptomatology of Emotional Deprivation Disorder as it affects the emotional life, cognitive life, behavior, and physical condition of the patient.

Terruwe and Baars’ (1976) theory arises out of their study of the psyche of the human person as understood by St. Thomas Aquinas (1981). His theory of the integration of reason, will and emotions facilitate their assertion that unconditional love (affirmation) is an innate need of every human person. By examining the Thomistic explanation of the relationship of the emotions to reason and will, Terruwe and Baars identified the purpose and function of the emotions as providing the capacity for happiness, rooted in receiving a felt sense of one’s goodness through affirming love by another person. They then observed that the syndrome of Emotional Deprivation Disorder could arise when a child’s natural need for unconditional love is frustrated, which in turn impedes emotional growth, as well as affecting other aspects of development. Terruwe and Baars (1972) note that their intent is not merely to restore the individual and his or her family to useful functioning, but to empower their capacity for happiness, as a fundamental human desire.

**Definition of Terms**

The following terms were used in this study:

1. Emotional Deprivation Disorder is defined as “a retardation of the emotional life not due to repression” (Terruwe & Baars, 1976, p. 9), and also stated that “since this syndrome results from the frustration or deprivation of the natural sensitive need for affirmation in the infant, baby, or growing child by the mother, father, or both, we have given it the name *frustration or deprivation neurosis.*” (1976, p. vi).
However, this researcher and a colleague edited and revised this book by Terruwe and Baars (2002) and gave this syndrome a new name, Emotional Deprivation Disorder, in order to reflect changes in psychological nomenclature since the original publication of the book.

The primary symptoms of Emotional Deprivation Disorder include abnormal emotional rapport with other adults, deep feelings of uncertainty and insecurity, and deep feelings of inferiority and inadequacy (see Appendix E for criteria for EDD).

2. Unconditional love is defined as true acceptance of a person, without achievement (Diggins, 2010).

3. Affirmation is defined as a three step process or way of being: 1) being present, open and receptive to the other person, 2) allowing oneself to be moved emotionally by the other, and 3) revealing to the other how one feels, through one’s countenance, tone of voice, and touch (Baars, 2016).

4. Secure attachment is defined as a person who “is likely to possess a representational model of attachment figure(s) as being available, responsive, and helpful” (Bowlby, 1980, p. 242).

5. Insecure attachment is defined as anxious-ambivalent or anxious-avoidant patterns of attachment in which inattentive or emotionally distant or rejecting persons were a child’s caregivers (Mikulincer & Shaver, 2008).
6. Attachment is defined as “an affectional tie that one person or animal forms between himself and another specific one—a tie that hinds them together in space and endures over time” (Ainsworth & Bell, 1970, p. 50).

7. “Child abuse is defined to be when a parent or caregiver, whether through action or failing to act, causes injury, death, emotional harm or risk of serious harm to a child. There are many forms of child maltreatment, including neglect, physical abuse, sexual abuse, exploitation and emotional abuse” (ChildHelp, n.d., para 2).

8. “Child neglect is defined to be when a parent or caregiver does not give the care, supervision, affection and support needed for a child’s health, safety and well-being” (ChildHelp, n.d., Child Neglect section).

Assumptions

1. Participants volunteered to be a part of the study.

2. Participants responded openly and honestly about their therapeutic experience with clients with Emotional Deprivation Disorder.

Delimitations

1. This study was delimited to experienced affirmation therapists with at least five years’ experience in a mental health field, who were solicited by this researcher.

2. The research participants consisted of a convenience sample selected through purposive sampling.
The Researcher as Person

This researcher has long been interested in the work of Terruwe and Baars (1976), as she is the daughter of Baars and was exposed to his work early in life. As such, there is the factor of embarrassment at the obvious bias that exists in her favoring this theory. In addition, this researcher is also an experienced affirmation therapist and is aware that she is a participant-observer in this study, inasmuch as she has experience as a therapist working with clients with Emotional Deprivation Disorder. The researcher attempted to control for this by looking at research in the literature that corroborates and/or does not corroborate all or parts of Affirmation Theory and Emotional Deprivation Disorder, and by using experienced affirmation therapists to answer questions about observations made and conclusions reached by Terruwe and Baars. The researcher is aware that as a participant-observer, she both influenced the study and was influenced by it. As such, the researcher consistently monitored her own preconceived ideas and interpretations about the subject. In addition, the researcher purposely used two coders to provide analyst triangulation (Denzin, 1978; Patton, 1999) for the data provided by the experienced therapists.

Summary

Families form the emotional foundation for children’s ability to develop into mature, confident and secure adults, who later are able to form and maintain relationships with others. However, families sometimes fail in human formation of their children for different reasons, and are unable to provide the unconditional love necessary for secure attachment. This failure may bring about difficulties for these children in relationships
later in life, due to difficulties relating to identity, as well as an inability to establish emotional rapport with others, deep feelings of insecurity and uncertainty, and deep feelings of inferiority and inadequacy.

In Affirmation Theory, Terruwe and Baars (1976) identified what they believed was a previously undiagnosed syndrome: Emotional Deprivation Disorder. Like Bowlby’s Attachment Theory (1988), these authors attributed difficulty in relationships to a lack of consistent and secure relationships in infancy and childhood. However, Terruwe and Baars asserted that a lack of unconditional love is the source of these difficulties. The authors focused their work on adults who manifest particular symptoms of immature emotional rapport with other adults and who report deep feelings of inferiority, inadequacy, uncertainty, and insecurity. They ascribed these difficulties in a distinct way than does Attachment Theory and the research on personality disorders. Instead, Terruwe and Baars observed that these symptoms develop precisely due to insufficient affirming love by significant caregivers. This conclusion is significantly different from that of other researchers, who ascribe difficulties in adulthood to other factors but not explicitly to an early deficit of love.
CHAPTER II

REVIEW OF THE LITERATURE

Theoretical Perspectives

Most therapists are generally not familiar with the syndrome of Emotional Deprivation Disorder (EDD) in adults, originally identified by Terruwe and Baars as ‘deprivation neurosis’ or ‘frustration neurosis’ (1972/1976), and later renamed by this researcher (Terruwe & Baars, 2002). Terruwe and Baars, the developers of Affirmation Theory, contended that every human person develops the capacity to love by first having been loved unconditionally. Furthermore, these authors postulated a syndrome of deprivation in adults who suffer from inadequate affirming love. When children do not receive sufficient and unconditional affirming love, then as adults these unaffirmed persons lack the emotional capacity to develop mature, loving relationships (Terruwe & Baars, 1976).

While Affirmation Theory (Terruwe & Baars, 1976) fits into a humanistic framework, its principles are quite different from those of the ‘third force’ of Humanistic psychology. Taken at face value, both of these theories address in some way the importance of being present to the client and his or her thoughts and feelings. Affirmation Theory, with its belief that each person needs the unconditional love (or affirmation) of another to become themselves, may appear to be similar to Rogers’ (1989) Person-Centered Theory which asserts that unconditional positive regard forms a context within
which the client can come to be herself. However, while these meanings are very close, the foundational principles behind each of these theories are completely distinct; this also affects how each type of therapy is conducted.

Affirmation Theory is based on the anthropological psychology of St. Thomas Aquinas (1981), in which love as one of the primary emotions enables a person to be moved by the goodness of another person. Terruwe and Baars (1976) further developed Affirmation Theory as they identified the adult syndrome of early emotional deprivation, in which they stated that unconditional love (or affirmation) manifested in psychomotor reactions such as tone of voice, choice of words, gentleness and tender countenance could bring a felt sense of being loved which strengthens the other person to be himself or herself. As such, these authors stated that affirmation is a way of being rather than a technique or doing something to or for the person. Furthermore, Terruwe and Baars followed Aquinas’ central tenet that it is the nature of the emotions to be guided by reason. In this light, Terruwe and Baars did not believe that a person’s feelings per se are the measure of how one should act, as they viewed the human person as a spiritual being who is weakened by original sin.

Rogers (1989), on the other hand, developed his concept of unconditional positive regard as a rejection of Freudian psychoanalysis and Skinnerian behaviorism. He believed that therapy could offer a context within which people could discover answers within themselves, if only they felt accepted. While Rogers believed in the inherent goodness of people, his view of human nature rejected the belief in original sin and its effects on the individual’s choices. His view was that in therapy one must not impose authority; one merely facilitates the person’s interior journey without judgment. Rogers
stated that the individual is capable of discovering within herself the wisdom she needs and thus move towards self-actualization.

Upon close inspection, while Affirmation Theory and Person-Centered Theory initially appear very similar, they are quite distinct, as each views human nature differently; therefore, the theory and therapeutic implications derived from each view are also entirely different. While Terruwe and Baars (1976) understood affirmation as the therapist allowing himself to be present to the client, to be moved and to reveal in his countenance how he has been moved by the client, it is not clear that Rogers’ (1989) empathic unconditional positive regard conveys this meaning. In fact, it is typical for Rogers not to reveal his own thoughts but only to mirror the client’s thoughts and feelings. Therefore, the concept of being present appears to have entirely different meanings in these two theoretical approaches to therapy.

These disparate views of human nature not only ground these two approaches to therapy in different ways, but they lead to dissimilar consequences for clients. Affirmation Theory (Terruwe & Baars, 1976) focuses the therapist towards aiding the client to experience what he or she has not yet experienced, namely, the affirmation of their very being. Affirmation also aids clients to develop their emotional lives and thus grow in freedom, through education about the nature and purpose of the emotions under the guidance of reason. Person-Centered Theory (Rogers, 1989) facilitates the client’s self-actualization through unconditional acceptance, but without any direction whatsoever, including the idea of self-control. Rogers essentially encouraged the client’s self-reliance without therapeutic direction or psycho-education. Terruwe and Baars contended that self-reliance emerges from reliance on others; they also observed that
human persons need guidance and knowledge in order to become free persons, capable of acting and restraining one’s actions when necessary.

Symptoms of Emotional Deprivation Disorder

Persons with Emotional Deprivation Disorder experience deep feelings of inadequacy, inferiority, uncertainty and insecurity, all of which contribute to their internal sense of worthlessness and helplessness in the face of living in an adult world. Terruwe and Baars (1976) noted, however, that while such persons often do not experience difficulty in situations in which they can operate in a rational, business-like manner (as this does not involve their emotional life), their personal relationships suffer. As adult relationships necessitate the capacity to form mutual emotional connections with others, those who lack emotional maturity are incapable to a greater or lesser degree of being able to extend themselves to others. This is precisely the case because these persons have not been emotionally strengthened through early, loving, affirming relationships in which they could have come to experience themselves as good and worthwhile, which the authors observe brings gradual emotional development, a sense of security and the ability to establish emotional rapport with others. Moreover, due to their undeveloped emotional life, unaffirmed persons sometimes internally feel like infants, children or adolescents, which makes them feel even more inadequate in the face of the challenges of adult life. All this makes clear the importance of recognizing the systemic nature of human relationships, both in order to support the interactive nature of the parent-child bond, as well as to strengthen adult relationships in friendship, marriage and family life.

Terruwe and Baars (1976) stated that every child has an innate need to experience the very affirmation of its being, which enables the child to experience an inner security
that becomes the foundation for further emotional development. When this need is frustrated due to the absence of unconditional love, the child instead experiences profound uncertainty and insecurity that affects not only their sense of identity but continues to color their relationships into adulthood, as they strive to find the fulfillment of this fundamental need.

Terruwe and Baars (1976) noted that a deficit of unconditional love in infancy or childhood not only leads to the psychic stunting of the adult’s emotional life, but also impacts the cognitive, behavioral, and physical condition of the adult person. They defined EDD as “a retardation of the emotional life which is not due to repression” (Terruwe & Baars, 1976, p. 9) which “results from the frustration or deprivation of the natural sensitive need for affirmation in the infant, baby, or growing child by the mother, father, or both…” (Terruwe & Baars, 1976, p. vi). The authors added that because in adults an undeveloped emotional life resembles that of a child’s, the chief characteristic of EDD is abnormal emotional rapport with other adults. Terruwe and Baars reported that these persons actually describe feeling like children in their contact with other adults, as their feelings remain egocentric. Naturally, this profoundly affects their adult relationships, as others expect them to act in a manner consonant with their chronological age.

Terruwe and Baars (1976) added that the other main symptoms of EDD include deep feelings of uncertainty and insecurity, as well as feelings of inferiority and inadequacy. These symptoms naturally affect all types of relationships: friendship, marriage, and parenthood. Moreover, in the areas of life that involve their undeveloped emotions, these persons experience hesitation and indecisiveness, oversensitivity, an
intense desire to please others, and feelings of helplessness. Other symptoms may be observed in some cases, including hoarding or kleptomania.

**Other Symptoms of Emotional Deprivation Disorder**

**Fears**

Terruwe and Baars (1976) described persons with Emotional Deprivation Disorder as having an existential fear versus that of the scruples of people who do not want to transgress moral laws or who repress unacceptable emotions. The fears of persons with Emotional Deprivation Disorder are related more to their inner lack of secure sense of self, sense of uncertainty and self-doubt, and these may expand to more and varied situations as they grow older. Due to their stunted emotional development, these persons are unable to adjust easily to everyday occurrences.

**Sense Impairments**

Other symptoms which may be present in persons with Emotional Deprivation Disorder (EDD) include impairments in sense development. Terruwe and Baars (1976) noted that the more basic senses of touch, taste and smell may be affected by deficits in early tactile manifestations of love by one’s parents. They stated that the sense of touch of the person with EDD may remain undeveloped when the person did not receive adequate manifestations of tactile tenderness and affection. Montague (1971) stated that in human persons, the order of development of the senses is first tactile, then auditory and third visual. He asserted that it is more important to experience tactile and auditory sense impressions early in life than visual ones. In fact, Montague said, “a vision can only become meaningful on the basis of what it has felt and it has heard” (p. 236). Thus, Terruwe and Baars observed that as the emotional life begins to grow due to affirmation
by the therapist or some other person, the undeveloped desire to touch things may become apparent.

Regarding the sense of taste, some persons with EDD report an intense desire to eat foods that most adults would identify as more childish and unrefined, such as sticky, chewy candy. Finally, Terruwe and Baars (1976) observed that the sense of smell in these persons may awaken so that they begin to desire to smell books or cards which someone dear to them (including the therapist) has touched, in order to experience the pleasant scent of that person.

Interestingly, the higher sense of sight may be also affected by early emotional deprivation inasmuch as some persons cannot recall what the therapist looks like, while being very aware of the feeling of clothing or furniture or the smell of the soap that the therapist used. Terruwe and Baars (1976) noted that these persons ‘retain only tactile impressions’ as their higher sense of vision is undeveloped. The authors stated, “As far as the visual sense is concerned in these cases, only visual perception is adequate, while visual engram formation is apparently impaired and the function of ekphorizing (recalling the visual engrams) is altogether lacking” (p. 53). This confirms what developmental psychology has observed, namely, that children observe diffusely (Diamond, 2009; Resnick, 1969); they see the whole without noticing the details. Terruwe and Baars concluded that their observation of these symptoms in some clients seems to confirm further that retarded emotional development can affect normal physiological development. It should be noted that no other studies regarding insecure attachment or personality disorders were found to have reported these observations.
Lack of Order

Terruwe and Baars (1976) identified an incredible lack of order and organization in some persons with EDD in selected areas of their lives. While they are usually personally neat, their homes may be unbelievably chaotic and disorganized, with clothes and items scattered everywhere. The authors concluded that this symptom directly relates to early emotional deprivation, because “to bring order into things is a matter of arranging concrete things according to a plan, of the intellectual order dealing with the sensory order” (p. 60). These authors asserted that because the emotional life has not yet been integrated with the intellect, the intellect cannot bring order into the sensory life. Just as children cannot do this, neither can adults with EDD.

Fatigue

Finally, Terruwe and Baars (1976) reported that fatigue is a frequent complaint of persons with EDD. If organic causes for fatigue are found, treatment only slightly alleviates it, as these are incidental to the effect of early emotional deprivation of love upon the person. The authors reflected that because of the energetic strivings of these persons in their efforts to find love and approval through achievement and pleasing people, it is not surprising that they report constant fatigue.

Research on the Effects of Childhood Antecedents of Early Abuse and Neglect

Other researchers make a distinction between effects of abuse and neglect in children in two areas: cognitive and moral development and social, emotional, and behavioral development. Hildyard and Wolfe (2002) described children of ‘neglectful’ and ‘psychologically unavailable’ mothers as having “poor impulse control and…less flexibility and creativity in problem-solving than control and other maltreated children”
These authors associated neglect with lower cognitive development in these children in early years, as well as with problems in expressive and receptive language.

With regard to social, emotional and behavioral development, Hildyard and Wolfe (2002) stated that “neglected children are more likely to have anxiously insecure attachments to their caregivers than nonmaltreated children” (p. 683). They cited the fact that these children, experiencing danger in the very caregivers that should be their source of safety, often develop disorganized attachment styles. “The unresponsive, insensitive, or traumatizing care that the children have experienced often leaves them with models of themselves as unworthy of love and others as unavailable or rejecting” (Hildyard & Wolfe, p. 684). The researchers stressed that early emotional nurturance is particularly important in its effect on later psychological development. This conclusion is consistent with the failure to thrive literature, wherein mothers of these infants dismiss the importance of relationships, including the early attachment relationship and related emotional needs (Attie & Brooks-Gunn, 1995; Benoit, Zeanah, & Barton, 1989).

**Attachment Theory**

Attachment theory is known for several patterns of attachment that were identified by Ainsworth (1970) whose research showed that each pattern is related to how one or both parents treated the child. Ainsworth saw that securely attached children have a parent who is sensitive and responds affectionately to the child’s distress and desire for safety and comfort. Conversely, the anxious resistant child is uncertain about the availability of his parent’s responsiveness (Ainsworth) and so hesitates to explore the world. This child’s parent may be available sometimes but not always. The anxiously avoidant child anticipates rejection when he approaches his parent for comfort or help;
Ainsworth saw these children as trying to be emotionally self-sufficient. She concluded that the attachment pattern displayed by the child was diagnostic of the parent’s treatment of him.

Bowlby (1955) noted the importance of tenderness and affection in the care of young children. He reported that when these factors are lacking, children’s development is physically, intellectually and socially retarded. Bowlby did sound a hopeful note, as “extra mothering from a substitute will diminish the ill-effects” (p. 22) of maternal deprivation. Other researchers noted that parental warmth is an important factor in decreased risk of insecure attachment patterns (Stansfeld et al., 2008). Another study showed that less emotionally warm and supportive parenting was associated with children who had greater incidence of later acting out behaviors (McCarty, Zimmerman, Digiuseppe, & Christakis, 2005). However, Bowlby concluded that, “complete deprivation…has…far-reaching effects on character development and may entirely cripple the capacity to make relationships with other people” (Bowlby, 1955, p. 12).

Bowlby’s work in identification of secure and insecure attachments laid groundwork for further studies of human relationships and factors that affect them. In their study of couples with attachment distress, Parker, Johnson, and Ketring (2012) observed that insecurely attached individuals had difficulty meeting their own as well as their partner’s needs, and persons who lacked early attunement with their parents had difficulty in negative affect regulation, which in turn affects their adult relationships. Parker et al.’s study (2012) regarding anxious and avoidant attachment styles in couples concluded that understanding one’s partner’s negative affect and attachment style may help the couple reduce symptom distress as they learn how to offer emotional support.
Attachment Theory is also used in Emotionally Focused Therapy by helping couples to identify insecure attachment styles in order to repair these through emotional responsiveness (Johnson, 2007, 2008).

Although Attachment Theory elucidates much through its observations and conclusions, it does not address the full complement of symptoms that may be observed in the anxious, avoidant or dependent adult. Affirmation Theory elucidates further the sequelae in adults of early deprivation of the innate need for unconditional love. For example, one of the most important differences cited by Terruwe and Baars (1976) is their view of the role of interpersonal love rather than simply attachment.

Mikulincer and Shaver (2007) elaborated on Bowlby’s Attachment theory (Bowlby, 1988) in their examination of the attachment bases of psychopathology:

…the broaden-and-build cycle of attachment security provides the foundation for mental health and is built from repeated experiences with loving, caring, and sensitive attachment figures. On the other side of the security coin, attachment insecurities, negative models of self and others, and both intra- and interpersonal regulatory deficits rooted in discouraging experiences with unavailable, rejecting, or neglectful attachment figures put a person at risk for psychological disorders.

(p. 369)

In a study of how parental bonds affect self-efficacy, Mallinckrodt (1992) found that the more parents were recalled as warm and responsive by college students, the higher their levels of social self-efficacy. In their survey of the research on attachment, Mikulincer and Shaver (2007) found that “attachment-anxious people experience an unmanageable stream of negative thoughts and feelings that contribute to cognitive
disorganization” (p. 371). These authors stated that both anxious and avoidant attachment styles are related to neurotic thinking and behavior. In fact, the authors state, “many insecure people identified by our measures do not seem to suffer from a diagnosable mental disorder” (Mikulincer & Shaver, 2007, p. 373). This seems to underscore the possibility that EDD may fill a gap in the literature, as Affirmation Theory directly identifies insecurity as one of the main symptoms of Emotional Deprivation Disorder.

Mikulincer and Shaver (2007) cited multiple studies that have identified “low self-esteem, low self-efficacy expectancies, perceptions of lack of social support, maladaptive perfectionism, self-splitting and hopelessness” (p. 386) as factors that mediate the relation of attachment style and affective disorders. These researchers concluded that “from an attachment perspective, disorders of interpersonal relatedness can be construed as constellations of insecure attachment strategies” (p. 398). In fact, Mikulincer and Shaver identified difficulties in relationships such as problems in being assertive, desiring reassurance, loneliness and inability to express emotions as factors that relate attachment insecurities and affective disorders. Kaperleris and Paivio (2011) found that severe emotional maltreatment in childhood had long-term effects on self-esteem and self-identity as evidenced by insecure attachment, fear and lack of trust in others, difficulties in identifying and expressing emotions, feelings of worthlessness, unhappiness, and fear of abandonment. These findings support Terruwe and Baars’ (1976) observation that childhood antecedents of abuse and/or neglect (i.e., in Terruwe and Baars’ terms, lack of love) can manifest in adulthood as difficulty in establishing rapport in interpersonal relationships (therefore loneliness), feelings of uncertainty and insecurity, and feelings of inferiority and inadequacy.
Other Theories and Therapies

In their study of whether adoptees maintain early attachment representations over time, Schoenmaker et al. (2015) noted in their findings that while early parent-child relationships mediate a continuity of attachment patterns over the first 14 years, maternal sensitivity to the child was particularly important. These researchers agreed with Ainsworth, Bell, and Stayton (1974) who identified maternal sensitivity as the correct, prompt and responsive recognition of the child’s needs and emotions. Schoenmaker et al. stated that maternal sensitivity promotes a secure attachment relationship and imbues a sense of competence in the child, all of which has a long-term impact on the child’s capacity for attachment.

Young, Klosko, and Weishaar (2003) offered another theory regarding early attachment patterns in Schema Therapy, which concerns itself with early maladaptive schemas that result from unmet needs for safety, connection, autonomy and self-worth in childhood. Adverse experiences in early significant relationships interfere with the fulfillment of basic psychological needs that can create a vulnerability to developing distressing maladaptive schemas. One of Young et al.’s early maladaptive schemas is emotional deprivation, which they described as not feeling special to or supported by others emotionally (see also McLean, Bailey, & Lumley, 2014). This is a symptom also identified in Emotional Deprivation Disorder (Terruwe & Baars, 1976).

Studies from Allied Fields

Examining research in allied fields for information related to the concepts within Emotional Deprivation Disorder uncovered much that was helpful. Related ideas from the field of occupational therapy regarding dysfunction in sensory integration (Ayres,
Terruwe and Baars (1976) described the emotional result of deprivation of the natural sensitive need for love in the infant, child or adolescent as a neurotic syndrome sometimes associated with concomitant impairments in the senses themselves. Anthropologist Ashley Montague (1971) emphasized the critical importance of early tactile stimulation for its continued growth (referring to increase in dimension) and development (increase in complexity). Montague stated, “emotionally deprived children everywhere suffer serious retardations in growth, both physical and behavioral” (p.191). He further emphasized the critical importance of early tactile stimulation for continued growth: “Personal identity has substance and structure only insofar as it based on the reality of bodily feeling” (Montague, 1971, p. 206).

Terruwe and Baars (1976) observed that persons with EDD often use their willpower to establish rapport with other people, because they do not feel this rapport. Fenichel (1945) said, “Sometimes these individuals ‘seem normal because they have succeeded in substituting ‘pseudo contact’ of manifold kinds for a real feeling contact with other people; they behave ‘as if’ they had feeling relations with people”’ (p. 445).

**Studies from Neurobiology and Psychobiology**

Recent work in the fields of neurobiology by Schore (2003b) confirmed observations by Terruwe and Baars (1976). Schore links right brain to right brain
entrainment within the attachment bond as responsible for the child’s developing and ongoing capacity for affect regulation. Referring to early interactions, he stated:

“deprivations of interactive affective experiences…act as a source generator for insecure attachments….such events predispose the vulnerable individual to future psychopathology…” (2003b, p. 6). This corroborated what other researchers have found (Mikulincer & Shaver, 2007; Roberts, Gotlib, & Kassel, 1996).

Perry and Szalavitz (2006) reported their observation that severe neglect can even result in atrophy of the cerebral cortex, along with severe (and sometimes permanent) developmental delays. They “found that orphans who were left to languish in institutional settings without receiving enough affection and individual attention do indeed have visibly smaller head sizes and tinier brains. The brains show obvious abnormalities…” (p. 129). He added that just as the developing brain is sensitive to consistent and nurturing experiences, so too is it sensitive to unfavorable experiences (Perry, 2009).

Using neurobiological and psychobiological terminology, Schore (2003b) echoed the contention of Terruwe and Baars (1976) that affirming love between parent and child strengthens the child and brings a sense of security. Schore (2003b) noted “the dyadic nature of this system is seen in the fact that the mother’s face, the child’s ‘emotional’ or ‘biological’ mirror, reflects back her baby’s ‘aliveness’ in a ‘positively amplifying circuit mutually affirming both partners’” (p. 8). In this way, Schore linked attachment to neurobiological and neuropsychological states necessary for the child’s development of capacities to self-regulate.

Schore (2002) confirmed the assertion of stage theory in the field of developmental psychology that each stage of human development naturally builds on the
successful completion of the prior stage. When this does not occur, the child grows physically and intellectually, but his or her emotional growth remains stunted. Schore says,

Traumatic attachment experiences negatively impact the early organization of the right brain, and thereby produce deficits in its adaptive functions of emotionally understanding and reacting to bodily and environmental stimuli, identifying a corporeal image of self and its relation to the environment, distinguishing the self from the other, and generating self-awareness. Optimal attachment experiences allow for the emergence of self-awareness, the ability to sense, attend to, and reflect upon the dynamic changes of one’s subjective self states, but traumatic attachments in childhood lead to self-modulation of painful affect by directing attention away from internal emotional states. (Schore, 2002, p. 22)

In a discussion of how relationships affect the human brain, Cozolino (2006) used terminology closer to that of Terruwe and Baars (1976) when he stated,

Loving relationships help our brains to develop, integrate, and remain flexible. Through love we regulate each other’s brain chemistry, sense of well-being, and immunological functioning. And when the drive to love is thwarted – when we are frightened, abused, or neglected – our mental health is compromised. Adults who thrive despite childhood neglect and abuse often describe life-affirming experiences with others who made them feel cared for and worthwhile…If we are fortunate enough to find someone who loves us, we have an opportunity to heal. (p. 314)
These assertions concomitantly reflect the contentions of Terruwe and Baars (1976), who focused more on the maturity and happiness of the child-turned-adult rather than on affect regulation. Nonetheless, they did emphasize lack of dyadic attunement – what they would term affirmation of the child or adult by a loving person – as responsible for the effects seen in the syndrome of Emotional Deprivation Disorder. Schore (2002, 2003a, 2003b), Perry (2009), and Cozolino (2006) appeared to agree with Terruwe and Baars that unconditional love is a necessary factor for the child and adult to feel secure, safe, strong and worthwhile, although the former researchers would call this dyadic attunement. In essence, while Schore’s work examined attachment as the means to effect emotional regulation in the child, Terruwe and Baars looked at this same relationship between child and parent through a different lens: one that necessarily engenders a sense of self-worth, security, identity and lovableness. Terruwe and Baars contended that a mature sense of self and identity and a sense of worth and lovableness arise from being loved early in life. It is not only their theory but also their identification of a lack of unconditional love as the etiology of adult difficulties that gives their work a uniqueness in the literature.

**Personality Disorders**

At the time Baars and Terruwe wrote about Emotional Deprivation Disorder, DSM-II (American Psychiatric Association, 1968) was in print. This edition did not contain all the personality disorders that DSM-5 now lists, and until DSM-III (American Psychiatric Association, 1980) there were no Avoidant or Dependent Personality Disorders (Mayes & Horwitz, 2005). In their early theory of personality, Millon, Grossman, Millon, Meagher, and Ramnath (2004) stated that personality disorders are
distinguished by three pathological features: “personality disorders tend to exhibit a tenuous stability, or lack of resilience, under conditions of stress…personality-disordered subjects are adaptively inflexible (p. 13).” Third, “because the subjects fail to change, the pathological themes that dominate their lives tend to repeat as vicious circles” (Millon et al., 2004, p. 14). In recent years Millon et al. (2004) proposed that evolution is the best pattern for “an integrated science of the person” (p. 58), because the evolutionary success of most organisms is dependent on the fit between the entire configuration of their characteristics and potentials and those of the environment. Likewise, psychological health is dependent on the fit between the entire configuration of a person’s characteristics and potentials with those of the environments in which the person functions (p. 59).

Millon introduced his evolutionary-neurodevelopmental perspective, with its three polarities of sensory-attachment, sensorimotor-autonomy, and intracortical-reproductive identity as a foundation for understanding personality development and psychopathology. Mikulincer and Shaver (2007) noted that personality disorders may be seen as disorders of interpersonal relatedness which, seen through an attachment lens, are insecure attachment patterns. These denote problems in emotion regulation, identity, unmet developmental tasks and of course difficulties in close relationships.

According to DSM-5 (American Psychiatric Association, 2013), personality disorders are characterized by “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (p. 645). The general criteria for Personality Disorder says that
this pattern manifests itself “in two (or more) of these areas: cognition (i.e., ways of perceiving and interpreting self, other people, and events); affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response); interpersonal functioning; and impulse control” (p. 646). These symptoms may certainly also characterize the person with Emotional Deprivation Disorder. Williams and Simms (2016) noted that personality disorders generally are related to interpersonal disturbance. However, while some may believe that a diagnosis of Personality Disorder could identify persons who fit the diagnostic criteria for EDD, it seems that the criteria for EDD pinpoint with greater accuracy this syndrome of emotional deprivation (see Appendix E for criteria for EDD). That is, there may be an overlap in some of the criteria for both of these disorders, but that of EDD is more descriptive of the inner life of these persons. For example, while experiencing deep feelings of inferiority, inadequacy, insecurity and uncertainty, persons with EDD are unable to establish normal emotional rapport with others due to stunted emotional growth, which causes them to experience the world as a child might. One might say that how these persons view the world as threatening is actually a realistic one, as the person has never developed a mature capacity to manage life as an adult. While this may also be true for the person with a personality disorder, it is not explicitly part of that diagnosis.

Avoidant Personality Disorder (APD; see Appendix F for APD criteria) “is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation” (American Psychiatric Association, 2013, p. 645). While identified as representative of personality disorders in general, Snir, Bar-Kalifa, Berenson, Downey, and Rafaeli (2016) found affective instability to characterize individuals who have
Avoidant Personality Disorder. A study by Rettew, Zanarini, Yen, Grilo, Skodol, Shea, McGlashan, Morey, Culhane, and Gunderson (2003) assessed childhood social abilities and dysfunctional early life experiences by comparing 146 adults diagnosed with APD with 371 adults with other personality disorders and a group of 83 adults with major depressive disorder, using Chi Square analyses. While the group of APD participants reported poor athletic performance in childhood and adolescence, less popularity and less involvement with the other groups, Rettew et al. concluded that different types of abuse are not correlated with APD. While these researchers could not provide evidence that APD always begins in childhood, it was clear that such avoidance begins early in life. Moreover, the participants in this study identified their parents as less skilled socially; this group also reported fewer positive relationships with adults than did persons with other personality disorders.

APD might be used to describe someone with EDD, but its criteria are lacking in comparison of the two disorders, as DSM-5 (American Psychiatric Association, 2013) does not state that the person is unable to establish emotional rapport with other adults. Rather, this criterion says the person is unwilling to become involved with people. In addition, one of the criteria includes the person avoiding occupational activities. Mikulincer and Shaver (2007) noted that avoidant attachment style is associated with Avoidant Personality Disorder. These are significant differences between the two diagnoses of APD and EDD. For example, some persons with EDD are capable of participating in occupational activities without fear of rejection, as long as these do not involve the emotional aspect of relationships (and therefore would be difficult for them). Terruwe and Baars (1976) observed “a very intelligent and successful businessman who
has not the slightest difficulty in managing his affairs in spite of his emotional
deprivation disorder, for the simple reason that his emotions are not involved in his
work” (p. 23). Therefore, in some cases, Avoidant Personality Disorder could truly be
EDD, but in other cases, specific symptoms would have to be present to discriminate
between the two. This study will endeavor to demonstrate that Avoidant Personality
Disorder and EDD are similar but significantly distinct.

DSM-5 (American Psychiatric Association, 2013) defines Dependent Personality
Disorder (DPD; see Appendix G for DPD criteria) as “a pattern of submissive and
clinging behavior related to an excessive need to be taken care of” (p. 645). Disney’s
(2013) review of the literature on DPD revealed that it is often linked to overprotective
and authoritarian parenting styles. In addition, this article notes fearful attachment style,
lack of assertiveness and strong social anxiety were strong predictors of DPD in
adulthood. However, a negative problem-solving orientation characterizes both avoidant
and dependent personality disorders (McMurran et al., 2007), inasmuch as problems pose
a threat due to a low sense of capacity to resolve these problems, which further evoke
feelings of frustration.

DPD might also be confused with Emotional Deprivation Disorder in some cases
where the person lacks self-confidence and believes himself or herself incapable of
functioning without the help of another person. These persons can certainly be very self-
effacing in order to elicit help. Mikulincer and Shaver (2007) state that an insecure
anxious attachment style is associated with Dependent Personality Disorder. However, an
important distinction between DPD and EDD, as with that between Avoidant Personality
Disorder and EDD, is that criteria for the latter requires that the person is incapable of
normal emotional rapport with other adults (Terruwe & Baars, 1976). While this may be the case in Dependent Personality Disorder, it is not explicitly stated. This is the inner experience of the person with EDD, who then feels insecure, inadequate, uncertain and inferior precisely because of this inner emotional deficit. It is this deficit in itself that is significant, which in turn leads to other behaviors such as avoidance or dependence. Therefore, in distinguishing between DPD and EDD, one again observes that Terruwe and Baars present a greater nuance in identifying the inner emotional deficits and resulting turmoil which may be manifested differently, depending on the temperament and disposition of the person (i.e., more asthenic personalities being more avoidant or dependent, stronger personalities more self-centered, etc.).

**Conclusion**

Readers of this study or those familiar with the Affirmation Theory of Terruwe and Baars (1976) may wonder whether already distinguished diagnostic categories might better describe those persons who manifest symptoms of EDD – e.g., Avoidant or Dependent Personality Disorders, or insecure attachment styles. It appears that all of these could be related to EDD, since these disorders have similar origins as EDD. The two personality disorders may have more in common with EDD inasmuch as further assessment of these persons may reveal the broader syndrome of EDD (i.e., a broader swath of symptoms) instead of merely one predominant symptom of either avoidance or dependence. It might be postulated that EDD could be the root of these personality disorders (as well as others). Avoidant PD and Dependent PD could also be variants of EDD.
Finally, it is significant that Affirmation Theory stands alone in this literature review in identifying a deficit of unconditional love as the etiology of adult intrapsychic difficulties and interpersonal difficulties. It appears that much may be gained from validating EDD as a distinct psychiatric disorder or syndrome. EDD may be related to such DSM-5 (American Psychiatric Association, 2013) categories as Avoidant Personality Disorder and Dependent Personality Disorder as well as insecure attachment due to sharing similar childhood antecedents of abuse and neglect.

**Summary**

Affirmation Theory adds much to the literature regarding both adult attachment patterns and Avoidant and Dependent Personality Disorders inasmuch as it contains descriptive information that no other research has identified regarding a grouping of symptoms experienced by the person with Emotional Deprivation Disorder. This study sought to show that there is a need for this new classification of EDD, as there is a gap in the literature regarding the full spectrum of symptoms identified by Terruwe and Baars (1976) in Affirmation Theory. EDD offers a unique constellation of symptoms not identified by other researchers. It also seeks to demonstrate that Affirmation therapists with at least five years’ experience can provide support for content validity for criteria of Emotional Deprivation Disorder, and being able to discriminate it from adult insecure attachment patterns as well as from Avoidant and Dependent Personality Disorders.
CHAPTER III

METHODOLOGY

The purpose of this study was to have therapists experienced in treating persons with Emotional Deprivation Disorder establish a consensus of opinion regarding its criteria. A second purpose was to determine if these therapists could differentiate between EDD and Avoidant Personality Disorder, Dependent Personality Disorder, and insecure attachment. The Delphi method (Dalkey & Helmer, 1962; Linstone & Turoff, 1975) was used to collect this information.

Delphi Method

The Delphi method is a research approach used to gather formal consensus using expert or knowledgeable judgement in an area where there is limited evidence (Koekkoek et al., 2009; Vernon, 2009). The name Delphi refers to the Oracle at Delphi in ancient Greece who was able to predict the future. Hence, the name Delphi method refers to forecasting answers to future problems. This technique was initially developed by the RAND Corporation in the 1950s in defense research to estimate the probability of an atomic bomb attack on the United States. This method was not made public until this research study was declassified (Dalkey & Helmer, 1962). Stone Fish and Busby (2005) noted that the use of the Delphi method today is more concerned with improving knowledge.
The Delphi method offers a structured process designed to elicit critical discussion and examination of an issue rather than demand quick concessions in order to come to an agreement (Dawson & Brucker, 2001; Linstone & Turoff, 1975; Mease et al., 2008). Stone Fish and Busby (2005) discussed the use of the Delphi method “to move a particular field forward” (p. 239). By using the opinions of experts on a subject to gather consensus regarding a particular issue, researchers hope to improve decision-making (Dawson & Brucker, 2001) rather than forecast the future.

The Delphi method is often used in the fields of psychology, sociology and political science (Stone Fish & Busby, 2005). Stone Fish and Piercy (1987) noted that it has been used within the field of family therapy to build curricula, to develop a feminist model of family therapy, and to identify standards for instruction in this model. Since the early 1980s, the number of studies in the field of marriage and family therapy that have been conducted utilizing the Delphi method is slowly growing (Blow & Sprenkle, 2001; Stone Fish & Busby, 2005). Moreover, “the expert consensus approach has become standard in the development of practice guidelines for clinicians” (Morgan & Jorm, 2009, p. 197).

The Delphi method is a procedure for refining the opinions of a group of people who are knowledgeable about a particular topic. Typically, this technique involves administering a succession of questionnaires to a group of experts until a consensus is reached (Sori & Sprenkle, 2004). This approach is useful in situations where the problem to be studied does not lend itself to precise analytical procedures and which the individuals who will contribute cannot feasibly be brought to one location for discussion (Linstone & Turoff, 1975).
The Delphi method is a procedure for having a panel of experts or knowledgeable people answer a set of questions that are then correlated and sent back to these experts to refine their answers further (Davidson, 2013; Hsu & Sandford, 2007). This method is typically anonymous so that group members are prevented from knowing who the other participants are, thus avoiding issues of intimidation or persuasive coercion that can affect opinions when in the presence of others. It also helps ensure independent thought. The Delphi method enables participants to express their thoughts anonymously, receive comments from the rest of the group, read and disagree with the opinions of others, and be able to amend their own views (Stone Fish & Busby, 2005), all without fear of repercussion (Sori & Sprenkle, 2004).

Dalkey (1972) further observed that the Delphi technique prevents certain difficulties inherent in more traditional ways of collecting opinions. For example, it eliminates forceful personalities, irrelevant information and coercion for conformity while permitting participants to consider the responses of others along with their own (Dawson & Brucker, 2001). Along with these advantages, it permits participation from a number of people without a great expenditure of time or cost, while helping to build consensus on the subject being studied. On the other hand, Linstone and Turoff (1975) reported that there are certain problems that can affect the outcome of Delphi studies: discounting the idea that participants can change their minds, the possibility of predicting too much from the results, and reliance on ‘experts’ who may not want new ideas.

Panel selection is a critical feature of the Delphi method, as the expertise of the participants offers the most potential for a valid outcome (Blow & Sprenkle, 2001). Therefore, the participants’ knowledge must be applicable to the area being studied and
the questions asked (Dawson & Brucker, 2001; Linstone & Turoff, 1975). As a result, in Delphi studies panelists are selected to participate based on their area of expertise and knowledge, rather than by random sample (Sori & Sprenkle, 2004).

There are no prescribed numbers for how many participants must be a part of a Delphi method study (Dawson & Brucker, 2001; Vernon, 2009). Vernon reports that published Delphi studies have used panels ranging in number from four to over 1000 experts. However, when larger numbers are used this technique can produce unmanageable data (Dawson & Brucker, 2001). This study solicited 12 therapists experienced in treating persons with Emotional Deprivation Disorder for participation.

The Delphi method traditionally has four phases (Dawson & Brucker, 2001; Linstone & Turoff, 1975), not identical with the iterations given to participants. There are usually a minimum of three iterations or rounds of questionnaires, the first of which is usually qualitative. In the first phase, each participant contributes their thoughts on the subject through answering open-ended questions. Care should be taken in the wording of questions, as well as the type and number of questions, as these can affect the responses of the participants (Jenkins & Smith, 1994). In this study, the first round of questions were open-ended and addressed what criteria participants use to diagnose Emotional Deprivation Disorder. Other open-ended questions were added to solicit information on demographic variables, relational factors, as well as what participants saw as unique challenges in diagnosing, treating and training therapists to treat EDD. The last question asked the panel whether they thought that EDD replicates or overlaps any other diagnostic category.
The second phase is the process of analysis whereby the researcher gains an understanding of how the group of participants see the issue, and in what areas they agree and disagree. Responses are coded into themes, redundant answers eliminated, and questions regarding criteria for the second round developed. Participants’ own wording is preserved as much as possible, to safeguard their thinking. Once coding is complete, these responses are then returned to the participants, who are asked to rate the importance of the items regarding the initial questions of the first phase on a Likert-type scale (Dawson & Brucker, 2001; Jenkins & Smith, 1994). In this study, responses were coded into themes and subthemes, and these were then returned to the participants who were asked whether they agreed or disagreed with these themes and subthemes. A Likert-type scale was not used in this study.

In the third phase, the researcher explores any disagreement between responses. This data is evaluated using median and interquartile ranges (Jenkins & Smith, 1994). Participants are then given the statistical results and asked to compare their own rating of each item with those of other members of the panel (Dawson & Brucker, 2001). They are told they have the opportunity to reevaluate their own rating; this can go on until the researcher believes a consensus has been reached or not. In this study, the researcher examined disagreement between responses but found that this was minimal. This indicated that the panel had reached a consensus, and so the Delphi was concluded.

The fourth phase occurs when all the information gathered has been evaluated and given back to the participants for deliberation. The researcher sends back only those items that meet the final condition for inclusion (Dawson & Brucker, 2001). Then the panelists are asked to discuss why they agree or disagree with the final results from the
fourth phase. These conclusions are included in the final report. There was no need to include a fourth phase in this study, as a consensus had been reached by the third phase.

This study endeavored to identify participants’ experience of treating EDD and its associated challenges, as well as determining what criteria they use to diagnosis EDD and how they distinguish it from other diagnoses and/or conditions. Towards this end, this researcher used open-ended questions in all three Delphi rounds, following the example of Brady (2015) and Fletcher and Marchildon (2014), who explained their use of Delphi in a qualitative study without the use of statistical consensus. This study used frequencies instead of descriptive statistics. Additionally, Brady (2015) discussed the major control of rigor in Delphi studies being “the ability of the participants to extend and revise data during the course of the study, along with the use of consensus in determining what responses and data are valid” (p. 4). Moreover, using a rigorous thematic analysis and member checking added greater trustworthiness to the final results.

**Description of the Sample**

Purposive sampling was used in selecting 12 participants for an expert therapist online panel, each of whom was asked to provide information regarding criteria for Emotional Deprivation Disorder, in order to help provide clarity for the definition of this syndrome. These subjects were selected from therapists with at least five years’ experience in a mental health field who have treated persons with Emotional Deprivation Disorder. These therapists were known to the primary researcher through acquaintanceship at conferences on Affirmation Theory, or had been made known to this researcher by others.
Jenkins and Smith (1994) note that it is characteristic of Delphi family therapy studies that researchers choose their participants on the basis of “publications, presentations, and/or years teaching of practicing clinical work on the topic area” (p. 423). Each of the therapists solicited for this study were known to the primary researcher through conferences regarding affirmation therapy, or had been referred to this researcher by others who recognized them as someone with expertise in working with clients presenting with symptoms of Emotional Deprivation Disorder.

The number of participants solicited for this study is considered adequate because this group of experts was homogeneous enough to focus on the same syndrome (i.e., mental health professionals familiar with affirmation therapy and Emotional Deprivation Disorder). At the same time the group was heterogeneous enough to permit differences in identification of applicable criteria (i.e., multiple disciplines and locations were represented by the participants) (Koekkoek et al., 2009). In addition, because Affirmation Theory is not well known, and no method of training in its therapeutic application is available at the present time, the sample of affirmation therapists who participated in this study comprises all those available to this researcher.

By definition, for this study, a therapist experienced in affirmation therapy has been using this model of therapy for at least five years, and holds a license (including provisional license) or certification in their state. Those who reside in states or countries that do not require licensure were exempt from this qualification.

Protection of Human Subjects

Participants in this study were asked to sign an informed consent that met criteria approved by the Institutional Review Board. The consent to participate in research (see
Appendix C for the consent to participate in research) explained the measures taken in order to protect the participants’ confidentiality and identify possible risks. The following measures were taken to ensure confidentiality and identify these risks.

To comply with the requirements of the IRB, every participant was informed in writing of the nature of the study and what he or she would be doing. Two potential risks to participants included fatigue and loss of time. Each participant was informed that they could withdraw from the study at any time and that if they became fatigued they could pause. Participants were also encouraged to be succinct in their answers. Another risk in this study was loss of confidentiality. Confidentiality was protected to the extent that is allowed by law. Furthermore, this Delphi study depended on assurance of anonymity, in order to prevent participants from experiencing any sense of coercion from other participants. Anonymity was provided through sending a link to the Psych Data site where each participant could complete the survey questions at their leisure. Additionally, each participant’s questionnaire was assigned a number to ensure anonymity during coding. Only the researcher knew the identity of the participants.

**Instruments**

This Delphi study used a questionnaire which was sent by a link in an email invitation to 11 therapists experienced in affirmation therapy, to obtain a baseline understanding of identifying and diagnosing Emotional Deprivation Disorder. The 12th therapist was sent an invitation by U.S. mail, as she did not use email. Conducting a Delphi study using an online PsychData program enabled this sample to participate from varied locations across the U.S. and Europe. The questions that were asked of these therapists are found in Appendices I, J, and K. These subjects also answered demographic
questions (see Appendix D for these questions). The Delphi consisted of three iterations or rounds of questions administered two to three weeks apart through the PsychData online survey program. Participants answered questions regarding criteria for EDD, as well as how they distinguish between Emotional Deprivation Disorder and insecure attachment, Avoidant Personality Disorder and Dependent Personality Disorder.

Procedure

Content validity refers to whether a measure effectively represents the content of a construct (Krathwohl, 2009). This Delphi study was used to establish provisional content validity for the criteria for Emotional Deprivation Disorder, defined by Terruwe and Baars (1976) as “a retardation of the emotional life not due to repression” (p. 9) which “results from the frustration or deprivation of the natural sensitive need for affirmation in the infant, baby, or growing child by the mother, father, or both…” (p. vi). Information was collected from the expert panel of affirmation therapists regarding the criteria of Emotional Deprivation Disorder. These therapists were invited by this researcher to participate in the Delphi study on EDD through an email invitation with a link to the first iteration survey questions (see Appendix I for Round One questions). The 12th therapist was sent an invitation by U.S. mail with instructions on how to participate, but she did not respond.

Delphi studies begin with open-ended questions in the first iteration (Dawson & Brucker, 2001) to obtain information, so that the panel can freely voice their thoughts on the subject. In this study, once the questionnaires were returned by a predetermined date, data were synthesized into themes and subthemes that then became the items for the second questionnaire used for the next iteration. These were then returned to the panel to
refine further the criteria for Emotional Deprivation Disorder. Delphi studies typically analyze data in this manner. In this study, participants were asked to indicate whether they agreed or disagreed with the criteria generated by the entire panel. It was evident that by Round Two the expert panel had reached a consensus on the criteria for EDD. The third iteration therefore asked questions regarding whether or not participants saw personality disorders as a substrate of EDD, and also how participants differentiate EDD from Avoidant or Dependent Personality Disorders and from insecure attachment. Once the third round was finished, the Delphi was concluded. Frequencies were used to describe results.

Participants were provided the criteria for Avoidant Personality Disorder (see Appendix F for criteria for APD) and Dependent Personality Disorder (see Appendix G for criteria for DPD), as well as criteria for insecure attachment (see Appendix H for criteria for insecure attachment). Each participant was assigned a number to maintain anonymity during data analysis.

**Data Analysis**

In qualitative studies, the value of research depends on its trustworthiness, which is provided by the study’s credibility, confirmability, and dependability (Sheperis, Young, & Daniels, 2010). Brady (2015) and Fletcher and Marchildon (2014) reported on how to use the Delphi Method in qualitative research. In this Delphi study, analyses were conducted by using coding and frequencies to identify group participant answers. Identifying codes is a central feature of qualitative studies (Kvale & Brinkmann, 2009). Coding permits meanings to develop that aid in providing validity. Frequencies were
used to ascertain how many items were listed in each category of a theme, denoting how many therapists chose a specific theme, subtheme, or example of the subtheme.

What was expected in the present study is that the panel of experienced affirmation therapists would identify similar characteristics of Emotional Deprivation Disorder, and through coding themes would emerge that are representative of EDD, thereby adding to content validity. Saldaña (2009) notes that coding generates the primary information of analysis. Creswell (2009) states, “it involves taking text data or pictures gathered during data collection, segmenting sentences (or paragraphs) or images into categories, and labeling those categories with a term, often a term based in the actual language of the participant” (p. 186).

An important aspect of data analysis is analyst triangulation (Creswell, 2007; Denzin, 1978; Patton, 1999), or use of more than one analysts who review the findings. This can aid in decreasing bias of a particular coder. This study used three coders. The researcher, her advisor, and one provisionally licensed therapist who had been trained in qualitative analysis coded the data that constituted the first questionnaire’s answers, by reducing sentences to shorter units of meaning. Two coders assisted the researcher to see whether similar meanings and themes emerged and whether coders could identify these themes. This provided a certain level of trustworthiness of the meaning conveyed by the participants, inasmuch as these coders identified similar themes (Creswell, 2007), and interrater reliability improved after their discussion of these themes (specific information on interrater reliability is found in Chapter IV).

The second iteration questionnaire was developed using a content analysis of the answers to the open-ended questions from the first round. Kvale and Brinkman (2009)
state that content analysis “is a technique for a systematic quantitative description of the manifest content of communication” (p. 203). All unique responses were included in the second questionnaire, to permit participants to identify the level of agreement with the answers (Blow & Sprenkle, 2001) of the first iteration. This type of coding enables researchers to categorize the text’s meaning and see how frequently specific themes emerge. The researcher then used the final round questionnaire to ask the panel how they differentiate EDD from Avoidant and Dependent Personality Disorders and from insecure attachment.

**Summary**

The purpose of this research was to use the Delphi method to determine what a panel of affirmation therapists identify as criteria for Emotional Deprivation Disorder that could provide provisional content validity for this syndrome. Twelve experienced affirmation therapists were solicited to participate in an online Web-based survey (11 participated in the first round, and 10 in the second) in which they answered three rounds of questions. The researchers then coded the data from the first round of open-ended questions by conducting a content analysis to identify themes that emerged. These were then put into the second round questionnaire and sent back to the participants as a form of member checking. By the end of the second round, the participants had come to a consensus of opinion regarding the criteria for EDD. The third questionnaire was composed of questions asking participants how they differentiate EDD from Avoidant and Dependent Personality Disorders and from insecure attachment.
CHAPTER IV
RESULTS

The purpose of this Delphi study was to provide provisional content validation for Emotional Deprivation Disorder by asking a panel of expert therapists to answer two questions: (1) What criteria do experts in affirmation therapy use to identify Emotional Deprivation Disorder? and (2) What do affirmation therapists see as the difference between EDD and other diagnoses such as insecure attachment patterns and Dependent Or Avoidant Personality Disorders? Evidence of content validity is derived from measures that effectively represent the content of a construct (Krathwohl, 2009). It was hoped that these therapists could come to a consensus about the criteria of EDD.

This chapter reports the analysis of the data collected from an online Delphi survey of eleven therapists who work with clients who present with Emotional Deprivation Disorder. Participants completed three PsychData surveys over a period of five weeks. In this chapter, a description of the sample and the themes that emerged through the three iterations of questions are presented. Finally, the researcher describes the expert opinions of the final group of ten affirmation therapists regarding the differences between Emotional Deprivation Disorder and two DSM-5 (American Psychiatric Association, 2013) diagnoses, Dependent and Avoidant Personality Disorders, as well as a condition, insecure attachment.
Description of the Sample

Participant Demographics

The initial research sample consisted of 11 therapists who identified themselves as affirmation therapists; one therapist dropped out after Round One due to personal reasons. Their ages ranged from 35 to 76 years, with a mean age of 58.7. Four of the initial participants were female (one female dropped out) and seven were male. Licenses and certifications held by participants include: three Certified Social Workers (CSW), four Licensed Professional Counselors (LPC), three Marriage and Family Therapists (LMFT), one Licensed Psychologist (LP), one Certified Alcohol and Drug Addiction Counselor (CADAC), two Licensed Mental Health Counselors (LMHC), and one participant who lives in a foreign country and is not required to be licensed. Four participants hold multiple licenses or certifications. Participants reported that their years in practice ranged from 10 to 38, with the median number of years they have practiced being 21.2 years. They reported that their years practicing Affirmation therapy ranged from 5 to 38 years, with the average length being 19.5 years (see Table 1).
Table 1

Participant Demographics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Years as Therapist</th>
<th>Years doing Affirmation Therapy</th>
<th>M/F</th>
<th>Age</th>
<th>License</th>
</tr>
</thead>
<tbody>
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<td>14</td>
<td>F</td>
<td>67</td>
<td>M.F.T.</td>
</tr>
<tr>
<td>2</td>
<td>27</td>
<td>26</td>
<td>F</td>
<td>57</td>
<td>L.M.H.C.</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>12</td>
<td>M</td>
<td>50</td>
<td>L.P.C., C.A.D.A.C.</td>
</tr>
<tr>
<td>4</td>
<td>33</td>
<td>25</td>
<td>M</td>
<td>65</td>
<td>Psychologist, M.F.T., C.S.W.</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>6</td>
<td>F</td>
<td>35</td>
<td>L.P.C.</td>
</tr>
<tr>
<td>6</td>
<td>20</td>
<td>20</td>
<td>F</td>
<td>53</td>
<td>L.P.C.</td>
</tr>
<tr>
<td>7</td>
<td>38</td>
<td>38</td>
<td>M</td>
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<td>L.P.C., L.M.F.T.</td>
</tr>
<tr>
<td>8</td>
<td>25</td>
<td>25</td>
<td>M</td>
<td>66</td>
<td>C.S.W.</td>
</tr>
<tr>
<td>9</td>
<td>11</td>
<td>5</td>
<td>M</td>
<td>55</td>
<td>L.P.C.C.-S, L.M.H.C.</td>
</tr>
<tr>
<td>10</td>
<td>22</td>
<td>22</td>
<td>M</td>
<td>50</td>
<td>No license (France)</td>
</tr>
<tr>
<td>11</td>
<td>21</td>
<td>21</td>
<td>M</td>
<td>72</td>
<td>L.C.S.W.</td>
</tr>
</tbody>
</table>

Participant Clinical Practice

Participants reported using other theoretical models: Affirmation therapy (2), Gottman therapy (1), Cognitive behavioral therapy (CBT) (6), Dialectical behavioral therapy (DBT) (1), Structural family therapy (SFT) (1), Eye movement desensitization and reprocessing (EMDR) (2), and Psycho-sensory therapies (1). Clinical specialties ranged across a wide spectrum, including: marital therapy (3), couples therapy (1), family therapy (2), emotional deprivation disorder (2), affirmation therapy (2) and the Baars/Terruwe Model (1), addiction or substance use treatment (2), pastoral psychodynamic (1), psychoanalytic (1), eclectic (2), Twelve Step (1), attachment theory
(1), drug and alcohol treatment (1), existential (1), Neuroaffective relational model (1), counseling (1), clinical psychology (1), trauma (1), DBT (1), Obsessive compulsive disorder (1), and cognitive therapies (1) (see Table 2).

Table 2

**Participant Clinical Practice**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Clients Seen</th>
<th>Use of Other Theoretical Models</th>
<th>Clinical Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ages 12 -60; Anxiety, OCD, Depression, Personality disorders</td>
<td>Primary Affirmation therapy; Gottman for marriage</td>
<td>Individuals, Couples, Trauma, Attachment, Addiction</td>
</tr>
<tr>
<td>2</td>
<td>Individuals, couples, adults, depressive and anxiety disorders, marital, grief and loss</td>
<td>Cognitive, psychodynamic</td>
<td>Affirmation Therapy, Baars/Terruwe Model</td>
</tr>
<tr>
<td>3</td>
<td>Couples, individuals, children; depression and anxiety disorders; personality disorders; RAD; Dependent Personality Disorder; Avoidant Personality Disorder</td>
<td>Attachment theory, Drug and Alcohol treatment, Existential, Psychoanalytic, Cognitive models</td>
<td>Substance Use Disorder Treatment; Attachment Theory, EMDR, DBT</td>
</tr>
<tr>
<td>4</td>
<td>Individuals and couples now; For 20 years children ages 6 -14 and parents in school setting</td>
<td>Cognitive behavioral; Twelve Step; EMDR</td>
<td>Clinical Psychology, Marriage &amp; Family Therapist</td>
</tr>
<tr>
<td>5</td>
<td>Ages 12 - 70</td>
<td>Structural family therapy</td>
<td>Marriage &amp; Family Therapist</td>
</tr>
<tr>
<td>6</td>
<td>Teens, adults, couples, families, individuals, Anxiety and depression</td>
<td>CBT, DBT</td>
<td>Pastoral Counseling</td>
</tr>
<tr>
<td>7</td>
<td>Individuals, couples, age 17+</td>
<td>Eclectic</td>
<td>Emotional Deprivation Disorder</td>
</tr>
<tr>
<td>8</td>
<td>Couples, families, individuals</td>
<td>Cognitive</td>
<td>Marital Therapy</td>
</tr>
<tr>
<td>Participant</td>
<td>Clients Seen</td>
<td>Use of Other Theoretical Models</td>
<td>Clinical Specialty</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>9</td>
<td>Individuals, couples, Ages 16 – 80; Depression, anxiety, OCD, gambling, sex/pornography addiction and more</td>
<td>Eclectic: picking from CBT, some Rogers, EMDR, Affirmation therapy, psychodynamic</td>
<td>Christian counseling</td>
</tr>
<tr>
<td>10</td>
<td>All ages except children. Couples, families. All psychological disorders except substance abuse</td>
<td>Neuroaffective Relational Model</td>
<td>Emotional Deprivation Disorder; Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>11</td>
<td>18 – 90’s; individuals, Some couples, Anxiety, depression, identity and relationship issues.</td>
<td>Some psycho-sensory therapies for fear-laden behaviors from trauma and stressors.</td>
<td>Affirmation Therapy; Cognitive therapies</td>
</tr>
</tbody>
</table>

**Data Analysis**

**Delphi Method Coding Procedures**

Coding is a method of culling data to obtain major categories or themes (Creswell, 2007). Creswell discusses axial coding as a form of coding in which the researcher identifies one major category to focus on, then re-examines the data to create categories around what is called the “‘core’ phenomenon” (p. 64). The researcher used this method to classify the data from Round One under two major themes each of which had several subthemes. Round Two was then used to send these themes and subthemes back to the panel of therapists as a form of member checking, which Creswell states is a way to obtaining participants’ assessments of the credibility of the interpretation of the data. Lincoln and Guba (1985) consider this to be “the most critical technique for establishing credibility” (p. 314), which is an important purpose of this study. Round
Three served to answer the second research question regarding whether (and how) the participants see a distinction between Emotional Deprivation Disorder and two other diagnoses and one syndrome. These answers are recorded in Appendix K.

**Round One Coding**

The researcher read the answers to Round One questions (see Appendix L for these answers) several times and identified significant statements and themes that identified criteria for Emotional Deprivation Disorder. The principal author was the primary researcher; she chose to use a second coder as the assistant researcher. She chose to use as the second coder a master’s degree intern in counseling from another university who is familiar with Affirmation Theory. This second coder completed the NIH training required by TWU for researchers. A third coder was also used who was the researcher’s adviser; along with the second coder, the third coder provided analyst triangulation (Creswell, 2007; Denzin, 1978; Krathwohl, 2009) for the identification of themes.

The primary researcher instructed the second coder to look for prominent words or phrases that were common to the participants’ answers in the first round. The assistant coder was tested on the first of the participants’ answers and was able to demonstrate understanding of the instructions for coding. Each coder independently read the participants’ answers and identified major statements or words that provided themes regarding criteria for EDD. The second time they read through the list of items, each coder used a color coding system in order to distinguish how phrases were categorized under different themes. Both coders then met to discuss their reasoning regarding categorizing of phrases and to conduct interrater reliability. The initial percentage of agreement was calculated and after discussion of their analyses and arriving at mutual
agreement for the names of the themes and the statements listed therein, the percentage of interrater reliability was calculated. In each area, interrater reliability improved.

The next step of the coding procedure was to meet with the third researcher to provide analyst triangulation (Denzin, 1978; Patton, 1999) of the data. The third researcher had questions regarding the coding procedures and data analysis. The three researchers discussed how the categories, themes and sub-themes were developed and coded, as were the participants’ answers for the other Round One questions. Once the researchers were satisfied with the procedures, discussion moved to developing questions for Round Two from this data. The researcher developed those questions with the assistance of the second coder and the dissertation advisor.

**Round Two Questions and Data Analysis**

Round Two questions were designed to confirm the findings yielded from participant responses in Round One that provided initial supportive content validity for the criteria for EDD. At this time, the panel dropped to ten participants as one female participant dropped out for personal reasons.

**Questions.** In questions 1-7 of Round Two, the panel of therapists were asked if they agreed or disagreed with the criteria for the two themes and subsequent subthemes identified for Emotional Deprivation Disorder; they were also asked to provide specific feedback for their answers. (See Appendix J for Round Two questions). The following questions in Round Two were designed to focus on how the expert therapists utilize EDD in their practice. Question 8 asked about the importance of the therapeutic relationship in successfully treating EDD. Participants were asked if they treat the person with EDD differently than a client who does not have the symptoms of EDD, and if so, how
treatment is different. Question 9 asked a follow-up question based on Round One that referred to affirming companions or mentors outside the therapeutic relationship. The question asked: “What would these affirming companions or mentors need in order to facilitate the healing process?”

**Data analysis.** Once all participants had finished the Round Two survey, the primary researcher and her assistant read through all the responses, noting the general consensus of the expert panel that they agreed with the names of the themes, subthemes and their criteria. This ensured support for content validation for the criteria for Emotional Deprivation Disorder. Responses to the remaining two questions were collated by the researcher and discussed with the assistant researcher. The second round of data analysis and final questions for Round Three were approved by the dissertation advisor.

**Round Three Questions and Data Compilation**

Round Three questions were designed to answer the second research question, “What do affirmation therapists see as the difference between EDD and other diagnoses such as insecure/anxious attachment patterns and Dependent Or Avoidant Personality Disorders?” The primary researcher considered that this question was another way of providing confirmability that EDD offers a unique presentation of symptoms, which can contribute to the marriage and family therapy literature.

**Questions.** The first of these questions was “It has been suggested that Emotional Deprivation Disorder is a primary diagnosis and at least three personality disorders, Avoidant, Dependent and Borderline, are subtypes that fall under EDD. Would you agree with this? Why or why not?” The second question was “Do you ever need to differentiate
between EDD and Avoidant Personality Disorder? If yes, please explain using the criteria below” (criteria provided in Appendices D and E). The third question was “Do you ever need to differentiate between EDD and Dependent Personality Disorder? If yes, please explain using the criteria below” (criteria provided in Appendices E and G). The final question was, “Do you ever need to differentiate between EDD and insecure attachment? If yes, please explain using the criteria below.” (criteria provided in Appendices E and H).

Once the participants completed the questions in Round Three, the information was collated by the first and second researchers and put into a table (see Appendix L). The answers lend confirmability to the idea that EDD presents a unique syndrome that adds to the marriage and family therapy literature.

**Findings**

**Content Validation of Criteria that Describes Emotional Deprivation Disorder**

In order to provide support for content validity for Emotional Deprivation Disorder, this researcher solicited information from 11 expert therapists knowledgeable about EDD. In addition, in order to provide initial discriminant validity, these therapists were asked questions about the difference between EDD and insecure attachment, Avoidant Personality Disorder and Dependent Personality Disorder. Discriminant validity enables one to identify one measure as distinct from another (Krathwohl, 2009).

**Round One: Theme Development**

Criteria for diagnosing Emotional Deprivation Disorder was solicited by the first question of Round One: “What criteria do you use to diagnose Emotional Deprivation Disorder?” The researcher’s intent was to gather information from the expert panel of
affirmation therapists to support content validation for criteria for EDD. The answers to the first iteration (Round One) were coded by the primary researcher and her assistant. The initial interrater reliability for question 1 regarding the theme Relationships/Poor relational connections and item criteria was 71% agreement. The coders agreed on 12 items and disagreed on three. Following discussion, interrater reliability regarding categories and item criteria rose to 81%, with the coders agreeing on 13 of the phrases, disagreeing on three, and moving one to another category/theme. The coders agreed on the title Poor relational connections with others for this theme.

The coders identified the second theme as Feelings/Poor understanding and expression of emotions. The coders agreed on 23 items and disagreed on nine, with an interrater reliability score of 71%. Following discussion, interrater reliability regarding categories and item criteria rose to 89%, with the coders agreeing on 26 of the phrases, disagreeing on three, and moving three to other categories/themes. It was agreed that the second theme was to be titled Poor understanding of own emotions or lack of expression of emotion.

The coders identified the third theme as Stage of psychological development/Stages of development, poor self-esteem, feeling unloved. Initial interrater reliability was 73%, with 16 items agreed upon, and six in disagreement. Following discussion, interrater reliability rose to 89%, with 19 items in agreement, and three in disagreement. The coders agreed to combine this theme with two others under the title, Poor sense of self.

The final theme, History of neglect and abuse in childhood, was agreed upon 100%, as it only had two items in it, Family neglect/abuse and Emotional neglect and
abuse in childhood/family/school. One more item, History of denial of own lovability, was added to it in the interrater discussion. This theme also appeared to be consistent with answers to the second question in this round regarding variables that participants associate with EDD.

As the coders moved into discussion of how to phrase Round Two questions, it became clear that the first theme emerging from Round One answers could be renamed Poor relational connection with others, with two subthemes (see Table 3). It also became apparent that the second and third themes which had emerged could be combined into one theme entitled Undeveloped emotional life. Several sub-themes emerged from the data analysis (see Table 4). The third coder discussed these newly emerged themes and subthemes and expressed agreement with the two coders. Tables 3 and 4 delineate themes 1, 2 and 3 and their sub-themes established by the two coders, which provide the initial content validation of the criteria for Emotional Deprivation Disorder. The third theme, History of abuse and/or neglect in childhood, has one subtheme, history of abuse or neglect, with two items as its criteria (see Table 5; also Appendix M for Theme 1 and its subthemes).

Table 3

<table>
<thead>
<tr>
<th>Theme One and Subthemes for Emotional Deprivation Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme One. Poor relational connections with others</strong></td>
</tr>
<tr>
<td><strong>Sub-themes</strong></td>
</tr>
<tr>
<td>Disconnect from others</td>
</tr>
<tr>
<td>Criteria (number of participants)</td>
</tr>
<tr>
<td>Inability to establish rapport with other adults. (3)</td>
</tr>
<tr>
<td>Difficulty in maintaining relationships. (2)</td>
</tr>
<tr>
<td>Not spontaneous in relationships unless feels accepted of his/her childlike behavior/comments. (1)</td>
</tr>
<tr>
<td>Disconnection from others’ feelings. (1)</td>
</tr>
<tr>
<td>Dependent on others</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Table 4

**Theme Two and Subthemes for Emotional Deprivation Disorder**

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Criteria (number of participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childish feelings</strong></td>
<td>Depression (4)</td>
</tr>
<tr>
<td></td>
<td>Poor understanding and/or expression of the emotions (4)</td>
</tr>
<tr>
<td></td>
<td>Anxiety (2)</td>
</tr>
<tr>
<td></td>
<td>Lack of trust of his/her own emotions (1)</td>
</tr>
<tr>
<td></td>
<td>Over sensitive (2)</td>
</tr>
<tr>
<td></td>
<td>Disconnect from own feelings (1)</td>
</tr>
<tr>
<td></td>
<td>Feeling like a child (in an adult body) (1)</td>
</tr>
<tr>
<td></td>
<td>Operating only on fear and anger (1)</td>
</tr>
<tr>
<td></td>
<td>Poor development of the senses (1)</td>
</tr>
<tr>
<td></td>
<td>Stage of psychological development (1)</td>
</tr>
<tr>
<td></td>
<td>Fear of being themselves (1)</td>
</tr>
<tr>
<td></td>
<td>Feel like a child in an adult world (1)</td>
</tr>
<tr>
<td></td>
<td>Fear of being embarrassed (1)</td>
</tr>
<tr>
<td></td>
<td>Poor sense of self (1)</td>
</tr>
<tr>
<td></td>
<td>Lack of self-worth (1)</td>
</tr>
<tr>
<td><strong>Feelings of inadequacy and inferiority</strong></td>
<td>Feelings of inferiority and inadequacy (5)</td>
</tr>
<tr>
<td></td>
<td>Fear of being exposed as immature or inadequate (3)</td>
</tr>
<tr>
<td></td>
<td>Lack of assertiveness (3)</td>
</tr>
<tr>
<td></td>
<td>Social anxiety (2)</td>
</tr>
<tr>
<td></td>
<td>Feeling unloved/not worthy of being loved (2)</td>
</tr>
<tr>
<td></td>
<td>Shame laden (1)</td>
</tr>
<tr>
<td></td>
<td>Poor eye contact (1)</td>
</tr>
<tr>
<td><strong>Feelings of uncertainty and insecurity</strong></td>
<td>Feelings of uncertainty and insecurity/inability to make decisions (3)</td>
</tr>
<tr>
<td></td>
<td>Cannot fully feel their emotions and use these to help them (2)</td>
</tr>
<tr>
<td></td>
<td>Insecure (1)</td>
</tr>
<tr>
<td></td>
<td>Inability to articulate own likes and dislike (1)</td>
</tr>
<tr>
<td></td>
<td>Feelings of lack of self-confidence. (1)</td>
</tr>
</tbody>
</table>
Theme Two. Undeveloped emotional life

<table>
<thead>
<tr>
<th>Self-affirming behaviors</th>
<th>Operating only on logic (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Temperament may make them more aggressive in expressing emotion (1)</td>
</tr>
<tr>
<td></td>
<td>Self-affirming behaviors that attempt to hide client’s insecurities (1)</td>
</tr>
<tr>
<td></td>
<td>Self-defeating attempts to feel worthwhile: keeping busy/productive/helpful (1)</td>
</tr>
</tbody>
</table>

Table 5

*Theme Three and Subtheme for Emotional Deprivation Disorder*

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Criteria (number of participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of abuse or neglect</td>
<td>Family neglect or abuse (2)</td>
</tr>
<tr>
<td></td>
<td>History of denial of own lovability (1)</td>
</tr>
</tbody>
</table>

**Round Two: Theme Refinement**

The researchers analyzed Round One criteria for Emotional Deprivation Disorder identified by the expert panel and developed three themes, each with several sub-themes (the exception was the third theme which had only one subtheme). The principal researcher and her assistant reviewed the participant responses for each theme and subtheme and summarized the responses. The principal researcher met with the third coder to confirm plans for Round Two questions which were developed to refine those themes and subthemes by asking the ten participants if they agreed with the criteria and names of the themes and sub-themes that had emerged from the data analysis from Round One responses. The third coder agreed with the final themes and subthemes.
Theme One. Poor Relational Connections with Others

Subtheme A: Disconnect with others. In Round Two, the first question asked:

Regarding the criteria of Emotional Deprivation Disorder, the responses of the participants appeared to fall into two themes, each with several sub-themes. Would you agree with the names of these themes? Would you agree with the names of the subthemes? Do you agree with the criteria listed under each theme and subtheme?

Nine of ten participants agreed with the name of the theme *Poor relational connections with others* and the name and criteria for subtheme *Disconnect from others*.

Several of the participants had suggestions for refining the criteria as follows:

a. I would not include the last statement: Not spontaneous in relationships unless feels accepted of his/her childlike behavior/comments. I would leave it as “Not spontaneous in relationships. From my observation, EDD causes the person to generally be unable to sense acceptance of their childlike behavior.

b. The third criteria "Difficulty Establishing Rapport" seems repetitive and criteria #2 seems to include criteria #3.

c. Also, many of them [names of the subthemes] are redundant, but I assume that you know that.

Appendix M lists the first theme and the two subthemes.

Subtheme B: Dependent on others. Participants were asked the question:

Would you agree with the name of this subtheme? Do you agree with the criteria listed under each theme and subtheme? Nine of the ten participants agreed with this subtheme; the tenth participant did not answer directly and appeared to misunderstand the question.
While they agreed with the criteria, four participants had suggestions for refining the subtheme, as follows:

a. I do not agree that ‘relating to others who confirm lack of self-worth’ is a common behavior in these patients. While this sometimes happens, more often than not, patients usually make every [effort] to avoid such “denying” other people.

b. I would add “fear of ridicule or rejection of others.”

c. I agree with the subtheme. Perhaps there could be one theme added where the person upon which the client is dependent is visibly more developed: i.e. older individual, boss etc.

d. Feeling of desperation and isolation.

While not answering the question of agreement except indirectly, these answers are thoughtful responses that add to the richness of the data and help refine the criteria for EDD.

**Theme Two. Undeveloped Emotional Life**

**Subtheme A: Childish feelings.** As for theme 1 and its subthemes, the same question was posed for theme 2 in Round Two: Regarding the criteria of Emotional Deprivation Disorder, do you agree with the criteria listed under each theme and subtheme? Would you agree with the name of this theme? Would you agree with the name of the subtheme?

Nine of ten participants agreed with the name of the theme, *Undeveloped emotional life* and subtheme *Childish feelings*. One participant did not answer the question, again appearing to misunderstand what was being asked. Eight of the nine made
clarifying comments about the criteria. Appendix S lists the second theme and its subtheme, *Childish feelings*.

**Subtheme B: Feelings of inadequacy and inferiority.** The fourth question in Round Two asked whether the participants agreed with Theme 2, *Undeveloped emotional life*, Subtheme b: Regarding the criteria of Emotional Deprivation Disorder, do you agree with the criteria listed under each theme and subtheme? Would you agree with the name of this theme? Would you agree with the name of the subtheme? Nine of the ten participants agreed with this subtheme, *Feelings of inadequacy and inferiority*. The tenth participant again did not answer the question clearly. Six made comments to clarify or support the criteria. See Appendix T for therapists’ comments.

**Subtheme C: Feelings of uncertainty and insecurity.** The fifth question targeted whether participants agreed with Theme 2, *Undeveloped emotional life*, Subtheme c: Regarding the criteria of Emotional Deprivation Disorder, do you agree with the criteria listed under each theme and subtheme? Would you agree with the name of this theme? Would you agree with the name of the subtheme? Seven of the ten participants agreed with this subtheme, *Feelings of uncertainty and insecurity*. One participant did not answer it at all; two others did not answer the question clearly. Comments made by several participants may be found in Appendix U.

**Subtheme D: Self-affirming behaviors.** The sixth question in Round Two addressed whether participants agreed with Theme 2, *Undeveloped emotional life*, Subtheme d: Regarding the criteria of Emotional Deprivation Disorder, do you agree with the criteria listed under each theme and subtheme? Would you agree with the name of this theme? Would you agree with the name of the subtheme? Six of the ten participants
clearly agreed with this subtheme *Self-affirming behaviors*. One participant did not understand the question, and seven made extra comments in clarification. These comments may be found in Appendix V.

**Questions to Expand the Validation of Emotional Deprivation Disorder**

In Rounds One and Three, participants were asked several open-ended questions to gather information about their use of the affirmation therapy model and specifically their application of it to treatment of Emotional Deprivation Disorder. Findings from those questions are reported in the sections below.

**Demographic Characteristics of Clients Served by This Sample**

**Variables Associated with Emotional Deprivation Disorder**

In Round One, question 2, participants were asked: Are there variables you associate with Emotional Deprivation Disorder (EDD)? Such as socioeconomic status, gender, ethnicity, clients coming from single-parent family? Clients who have siblings (two or more)? Clients who are an only child? Abuse? Neglect? Other factors?

Participant answers were collated and four categories were identified as variables being associated with EDD: (1) Parental issues & rules, (2) Neglect, abuse, trauma, (3) Socioeconomic status, and (4) Siblings/no siblings. In the category Parental issues and rules, only two issues gained more than 50% of the responses from the 11 respondents: (a) single parent/divorce (7/11) and (b) parents not present to child (8/11). In the category Neglect, abuse and trauma, only two issues gained more than 50% of the responses: (a) Neglected child (6/11) and (b) Abused child (5/11). In category Socioeconomic status, less than half of the participants noted that EDD affects every socioeconomic status (3/11). In the final category named Siblings/no siblings, less than half of the respondents
(4/11) identified the variable “only child” as associated with EDD. Participants generally agreed that neither gender nor ethnicity are factors in the development of EDD. Table 6 describes variables associated with EDD (see Appendix O for variables associated with EDD).

Table 6

Variables Associated with Emotional Deprivation Disorder

<table>
<thead>
<tr>
<th>Category</th>
<th>Issues that received at least four responses</th>
<th>Issues that received less than half of the responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental issues and rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7/11 Single parent, divorced</td>
<td>3/11 Issues: Addiction, Laissez-faire family system, Poor compromised attachments, Child of parent with EDD</td>
<td></td>
</tr>
<tr>
<td>8/11 Parents not present to child</td>
<td>2/11 Issues: Mentally ill parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/11 Issues: Death of parents, Religion based on fear, Parents with history of trauma, Parents overly stressed – marital, Authoritarian parents, Clients spoiled, Lack of affective touch, Too much responsibility too early, Both parents working, Family system with denial of emotion, Rules against sharing emotions, Denial of needs of individual child</td>
<td></td>
</tr>
<tr>
<td>Neglect, abuse, and trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/11 Neglected child</td>
<td>3/11 Issues: Trauma, Emotional abuse</td>
<td></td>
</tr>
<tr>
<td>5/11 Abused child</td>
<td>2/11 Issues: Physical abuse, Sexual abuse, Emotional abuse in family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/11 Issues: Abandoned child, Lack of stable upbringing, Death or debilitating illness of spouse of another child, Wealthy parents who focused more on their business or pleasures</td>
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<tr>
<td>Socioeconomic Status</td>
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<td>3/11 EDD affects every socioeconomic status</td>
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<td></td>
<td>1/11 Issues: Poverty-stricken, Economic instability for child’s family</td>
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<td>Sibling/no sibling</td>
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<td>4/11 Only child</td>
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<td>2/11 Multiple siblings</td>
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<tr>
<td>1/11 Issues: Number of siblings/being the only child not predictive of EDD, One child favored over another</td>
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Factors Commonly Associated with Emotional Deprivation Disorder

Participants were asked this question: Do you see factors which are commonly associated with Emotional Deprivation Disorder (EDD) (e.g., little attention paid to the feelings of family members; use of television or other devices as a child; families not having a designated place and time to eat a meal together regularly, where there is opportunity for discussion and enjoyment of each other’s company, etc.)? At least half of the participants identified three factors: (1) Denial of feelings (10/11), (2) Lack of time for sharing/time to talk (6/11), and (3) Overuse of technology (5/11). (For a full list of factors, see Appendix P).

Unique Challenges in Diagnosing Emotional Deprivation Disorder

Participants were asked this question: What do you think are some of the unique challenges in diagnosing Emotional Deprivation Disorder (EDD)? Participants identified the following challenges in diagnosing EDD: (1) Distinguishing EDD from other co-morbid disorders (8/11), (2) Co-morbid disorders (3/11), (3) Clients unable to articulate the problem (2/11), and (4) the mental health field emphasizes behavioral or cognitive changes or issues (2/11).
Challenges in Treatment of Emotional Deprivation Disorder

Participants were asked the following question: In your experience, what are some of the unique challenges in treating Emotional Deprivation Disorder (EDD)? Participants noted these challenges in treating EDD: (1) Therapeutic relationship (9/11); (2) Client has dependency needs/self-affirmation (5/11); (3) Client lives in the structure which gave rise to EDD, yet needs healthy relationships (2/11); and (4) Clients self-medicate (1/11).

A related question in Round Two was, “All of the participants emphasized the importance of the therapeutic relationship in successfully treating EDD. Do you treat the person with EDD differently than a client who does not have symptoms of EDD? If so, how so?” The answers of all ten participants are in Appendix R.

Challenge in Training Therapists to Treat Emotional Deprivation Disorder

Participants were asked the following question in Round One: In your opinion, what are the challenges in training therapists to treat Emotional Deprivation Disorder (EDD)? Participants noted the following challenges in training therapists to treat EDD: (1) Therapist must be affirmed himself/herself (3/11); (2) Mentoring regarding what affirmation means (3/11); (3) The mental health field favors CBT (3/11) and doing-oriented vs. being-oriented (3/11); (4) Therapists need to be taught the origin of EDD (3/11); and, (5) Helping therapists to distinguish EDD from other disorders (2/11). Curiously, two people stated that one of the challenges in training therapists to treat EDD is the Catholic origins of Affirmation Theory.
Emotional Deprivation Disorder and Overlap with Other Diagnoses

Participants were asked the following question: Do you think Emotional Deprivation Disorder replicates or overlaps any other diagnostic category (e.g. DSM-5)? If so, which ones?

In responses, participants identified (1) Personality disorders (7/11); (2) Mood disorders (3/11); (3) Attachment disorders (3/11), (4) Obsessive-Compulsive disorder (3/11), (5) Autism Spectrum disorders (2/11), (6) Social anxiety (2/11), (7) Generalized anxiety (2/11), and (8) Schizoaffective/symptoms or Schizophrenia (2/11).

Further Considerations

The final question of Round Two was, “Some participants noted that having people outside the therapeutic alliance who would be affirming companions or mentors might help facilitate the healing process of the person with EDD. What would these affirming companions or mentors need in order to facilitate the healing process?” Half of the participants noted the importance of these persons to (1) Possess emotional maturity (5/10) and (2) the ability to love unconditionally (5/10). Four of the ten participants stated the importance of (3) Training to understand true affirmation (4/10), (4) Have time to be present to the client (3/10), and (5) Have been affirmed themselves (3/10). The rest of the answers were stated by one person: (6) Understand the boundaries of this relationship (1/10), (7) Consult with therapist (with release) (1/10), (8) Understand their own emotions (1/10), (9) Have their own support system (1/10), and (10) Have a motherly or fatherly presence/role (1/10). In order to do full justice to the participants’ responses, all ten are listed in Appendix Q (see Appendix Q for suggestions from expert therapists for mentoring people with EDD).
It was clear by the end of Round Two that the panel of affirmation therapists had reached a consensus on the criteria for Emotional Deprivation Disorder. Round Three therefore focused on establishing divergent validity.

**EDD and Other Diagnoses: Round Three**

The questions in Round Three were designed to answer the second research question, “What do affirmation therapists see as the difference between EDD and other diagnoses such as insecure/anxious attachment patterns and Dependent Or Avoidant Personality Disorders?” Four questions were developed to elicit information; the first of these was “It has been suggested that EDD is a primary diagnosis and at least three personality disorders, Avoidant, Dependent and Borderline, are subtypes that fall under EDD. Would you agree with this? Why or why not?” 9/10 participants agreed in general with this statement; one disagreed, citing definite differences. One participant answered twice; however, these were identical, so the second set of answers was dropped (the panel’s answers are listed in Appendix L).

The second question in Round Three was, “Do you ever need to differentiate between EDD and Avoidant Personality Disorder? If yes, please explain using the criteria below” (Criteria for both EDD and APD were provided; see Appendices E and F, respectively). One participant stated ‘no,’ two stated ‘yes,’ and the majority (7/10) listed specific answers. Appendix L includes the participants’ answers to this question.

The third question in Round Three was, “Do you ever need to differentiate between EDD and Dependent Personality Disorder? If yes, please explain using the criteria below.” (Criteria for both EDD and DPD were provided; see Appendices E and
Two participants simply said, “no.” The rest of the panel (8/10) answered in specific ways (see Appendix L for a full list of participants’ answers).

The final question of Round Three was, “Do you ever need to differentiate between EDD and insecure attachment? If yes, please explain using the criteria below.” Criteria for both EDD and insecure attachment were provided (see Appendices E and G for criteria for EDD and insecure attachment, respectively). One participant said, “yes,” one said, “no” and two said, “I don’t know” or “Perhaps I should make such a distinction, but in all honesty I do not.” The other six participants’ answers as are listed in Appendix L.

**Summary**

The purpose of this study was to determine if a panel of affirmation therapists could reach a consensus of opinion through a Delphi study. To guide this study, the researcher focused on the questions, “What criteria do experts in affirmation therapy use to identify Emotional Deprivation Disorder? and “What do affirmation therapists see as the difference between EDD and other diagnoses such as insecure attachment patterns and Dependent Or Avoidant Personality Disorders?” Three rounds of questions were administered through a link in an email invitation to participate in this PsychData survey. Eleven affirmation therapists participated in the first round; in Rounds Two and Three, there were 10 participants. Demographic characteristics of the sample, three emergent themes and multiple subthemes identifying criteria for Emotional Deprivation Disorder and verbatim quotes of the participants to illustrate answers were included in this chapter.
CHAPTER V
DISCUSSION

The purpose of this Delphi study was to provide provisional content validation for Emotional Deprivation Disorder by asking a panel of affirmation therapists to answer two questions: (1) What criteria do experts in affirmation therapy use to identify Emotional Deprivation Disorder? and (2) What do affirmation therapists see as the difference between EDD and other diagnoses such as insecure attachment patterns and Dependent or Avoidant Personality Disorders? A humanistic framework was used to focus the study on Terruwe and Baars’ (1976) belief that the balance of the human person’s physical, intellectual, volitional, spiritual and emotional dimensions is in the service of the individual person’s freedom and happiness, as well as helping develop the capacity to form mature bonds in adulthood.

A sample of 11 therapists experienced in affirmation therapy and knowledgeable about Emotional Deprivation Disorder were administered three surveys through an online Delphi study over a course of five weeks. This panel of therapists reached a consensus regarding the criteria of EDD, and provided insight into how they distinguish between EDD and three other disorders or syndromes. They also reported their thoughts on whether EDD replicates or overlaps other disorders. This chapter reviews the conclusions and a discussion of the findings of this study as well as implications and limitations. Recommendations for future research are also made.
Discussion

This sample of therapists were chosen for this study because they all had at least five years of experience in working with clients presenting with symptoms of Emotional Deprivation Disorder. Aside from this specific professional expertise, this was a heterogeneous group. Use of the Delphi method in an online survey permitted anonymity, thus enabling participants to express themselves freely by decreasing the possibility of coercion or intimidation. The Delphi also enabled this study to be conducted with therapists from across the U.S. and Europe.

Discussion of Themes/Criteria of EDD

The sample’s expert knowledge of this disorder strengthened support for provisional content validity of the criteria for EDD. Evidence of content validity is derived from measures that effectively represent the content of a construct (Krathwohl, 2009). This study provides initial content validity for EDD criteria inasmuch as this is a preliminary analysis of this syndrome and further research remains to be conducted. The results of this study demonstrate that affirmation therapists with 5 years’ experience in treating EDD can identify and expand Terruwe and Baars’ (1976) criteria for EDD. Future studies providing both convergent and discriminant evidence (Krathwohl) would further strengthen content validity for the criteria for EDD. In this study, the sample of 11 therapists identified criteria for EDD in Round One and 10 therapists (one dropped out due to personal reasons) came to a consensus in Round Two regarding the themes which emerged. The following themes were identified:
Inability to Establish Rapport With Adults

More than half of the expert therapists who participated in this study identified *inability to establish rapport with adults* as the primary criteria or theme of Emotional Deprivation Disorder as they described the difficulties that the adult with EDD experiences in relationships. These therapists then refined this theme further by describing two additional subthemes or criteria: *Disconnect from others* and *Dependent on others*. Taken together, the majority of respondents noted that such persons have difficulty or inability in establishing and maintaining relationships with others, have excessive fear of hurting others’ feelings for fear of loss of their love, and are dependent on others emotionally. This theme and its subthemes express the interrelational difficulties experienced by persons with EDD, which is then underscored by their correlates in the second theme, *Undeveloped emotional life*.

Undeveloped Emotional Life

The expert therapists identified *Undeveloped emotional life* as the second theme or criteria of Emotional Deprivation Disorder as it describes the internal emotional life of the person. Further exploration of the client’s internal emotional life led to the identification of four subthemes: *Childish feelings, Feelings of inadequacy and inferiority, Feelings of uncertainty and insecurity,* and *Self-affirming behaviors.* Moreover, these subthemes support the evidence that internally persons with EDD experience feelings that prevent them from being at ease with themselves, let alone with others. While the criterion *depression* was mentioned most often by participants, other criteria under *Childish feelings* were noteworthy: *Poor understanding of, or inability to name and/or express the emotions.* Participants noted multiple reasons that the person
with EDD may feel childish: they have a poor development of the senses due to their stage of psychological development; they feel like a child in an adult world; they possess an immature emotional life; and they have a poor sense of self and lack of self-worth.

The second subtheme or criteria under Undeveloped emotional life was agreed upon by the participants as Feelings of inadequacy and inferiority. Participants reported observations of clients reporting criteria of shame, social anxiety, low self-worth, feeling unloved/unlovable, feeling inferior and inadequate, and non-assertiveness. These criteria illustrate what participants mean by an undeveloped or immature emotional life: one that precludes the sense of self necessary for adulthood.

The third subtheme agreed upon is Feelings of uncertainty and insecurity. This subtheme included items such as the feeling of lack of self-confidence, and feelings of uncertainty and insecurity, which are related to the inability to make decisions. In addition, participants noted that such persons cannot fully feel their emotions and use these to help them, and are unable to articulate their own likes and dislikes. Each item in this subtheme provides evidence of this aspect of this subtheme criterion for EDD.

The fourth subtheme is Self-affirming behaviors. Participants noted that these include self-defeating attempts to feel worthwhile: keeping busy/productive/helpful, as well as self-affirming behaviors to hide one’s own insecurities. In addition, the criterion self-esteem is based on what they do, not who they are was an example clarifying this subtheme.

History of Abuse and/or Neglect in Childhood

The third theme identified by the panel of therapists is History of abuse and/or neglect in childhood. This theme reflects the environmental causes that the therapists
believe engenders EDD. Only one subtheme, *history of abuse/neglect*, was identified; three items were listed under this subtheme: *family history of abuse/neglect, emotional abuse and neglect in childhood/family/school, and history of denial of own lovability*.

The consensus reached by the participants regarding criteria for EDD provides a well-defined picture of what constitutes this syndrome. Agreement by the panel regarding the themes and subthemes that emerged from analysis of the data supports provisional content validation for criteria for EDD. It is important to note that this panel provided criteria that matched much of the criteria listed for EDD (see Appendix E for Terruwe and Baars’ criteria for EDD) by Terruwe and Baars (1976), specifically the first two themes. These are: *Inability to establish rapport with adults* and its subthemes *disconnect from others* and *dependent on others*, and the theme *Undeveloped emotional life* and its subthemes *childish feelings, feelings of inadequacy and inferiority, feelings of uncertainty and insecurity* and *self-affirming behaviors*. This confirmation of the above criteria moves knowledge about Emotional Deprivation Disorder forward and fills a gap in the literature on adult conditions and disorders with childhood antecedents of abuse and/or neglect.

The panel of therapists added to the criteria of EDD by noting symptoms and environmental factors that Terruwe and Baars (1976) discussed throughout their work, but which they did not address specifically in the list of their criteria for EDD. This will be an important consideration for future research on this syndrome. For example, although Terruwe and Baars observed that lack of unconditional love in childhood is the source of EDD, they did not define EDD by the specific environmental variables or factors noted by the panel of experts, although Terruwe and Baars often used contextual
factors in case studies to illustrate EDD. The participants in this study thus expanded criteria of EDD by specifying a third theme: family of origin issues of abuse and neglect, and denial of own lovability by others.

In addition, some of the criteria identified by the participants expanded the evidence of the interior difficulty that adults with EDD have in their relationships, beyond what Terruwe and Baars (1976) specifically described. In relation to Inability to establish rapport with adults, the subthemes disconnection from other’s feelings and excessive dependency further illustrate how alienated these persons are from others. Moreover, disconnect from own feelings, and inability to name and/or express emotions deepens the observation that these persons have an undeveloped emotional life, and need support in learning how to identify what they experience emotionally, so that their sense of self may improve, and thereby their relationships with others. Under Feelings of inadequacy and inferiority, the criterion shame laden adds a further dimension to the criteria for EDD and provides one aspect of treatment.

This researcher considers that this panel has confirmed Terruwe and Baars’ (1976) criteria for EDD, and has expanded the understanding of the criteria of EDD in ways not specified in the criteria of Terruwe and Baars. That is, although Terruwe and Baars made extensive observations of the lack of normal development and deprivation of unconditional love in persons with EDD and how this affects their behaviors, the panel provided further criteria descriptive of the interior emotional state of these persons, as well as identifying environmental factors contributing to emotional deprivation. These new descriptions of the criteria for EDD will help educators and trainers more clearly identify for therapists (as well as for their clients) the symptoms that are evidence of the
interior emotional difficulties experienced by these persons, rather than simply identifying behavior. These clarifications in the criteria of EDD can bring an improved precision to marriage and family therapists as well as other clinicians, educators, trainers and their clients in identifying this syndrome. This will lay a stronger foundation for effective prevention of the development of EDD, and its treatment in individual, marriage and family therapy.

Other Considerations

Other considerations within this study expand the content validation of EDD: open-ended questions regarding variables and factors that the panel associated with EDD, and challenges in diagnosing and treating such persons and training therapists to treat these persons and their families. Participants stated that they think EDD overlaps other disorders or conditions. Finally, participants discussed how they differentiate EDD from Avoidant Personality Disorder, Dependent Personality Disorder, or from insecure attachment.

Variables Associated With EDD

Therapist participants identified demographic characteristics related to persons with EDD: over half of the respondents noted that they associated the following variables with the presence of EDD in their adult clients. The majority of these included being children of divorce or a single parent and parents not being present to the child. In the literature reviewed by this researcher, no specific references were found regarding being a child of divorce or of a single parent as a factor in later adult psychological difficulties. Rather, the literature does regard childhood antecedents of neglect and/or abuse as sources for development of personality disorders (Bierer et al., 2003; Grover et al., 2007;
Rademaker et al., 2008). Laraia et al. (1994) associated lack of parental warmth and support with anxiety in women. Parental overprotection was associated with anxiety and depression in adults (Parker, 1983). Stansfeld, Head, Barley and Fonagy (2008) noted that childhood emotional and physical deprivation is associated with lower parental warmth.

Although not confirmed in the literature on childhood antecedents of abuse and/or neglect in adults, participants’ identification of these variables lends strength to this content analysis, inasmuch as these provide clarity for the etiology of EDD, and present a picture of how EDD may develop within particular contexts. Of course, all of these variables are meant to illustrate the lack of affirming love for the child, rather than simply a lack of an opportunity of attachment. Further research is needed to refine what participants mean by identifying these particular variables.

**Factors Associated with EDD**

Participants identified several factors that they associate with EDD. Almost universally, these therapists reported that denial of feelings by others contributes to the development of EDD. Other factors were also reported: lack of time to share, talk, and an overuse of technology. These factors point to Terruwe and Baars’ (1976) emphasis on the child’s need for affirming interactions with his or her parents. These factors are further evidence of neglect, or a lack of affirming relationships in childhood, and therefore strengthen the criteria for EDD.

While none of the studies reviewed by this researcher note issues specifically related to technology, there may certainly be studies on this factor related to attachment insecurity and personality disorders. The specific factors of lack of time to share and talk
somewhat were not found in the literature. While not being identical with the factors identified by the expert panel, some literature reports similar problems. For example, Stansfeld, Head, Barley, and Fonagy (2008) noted that childhood emotional and physical deprivation is associated with lower parental warmth. Briere and Jordan (2009) identify low self-esteem, lack of self-awareness, identity disturbances, anxiety, depression and anticipation of rejection or abandonment as specific cognitive and emotional consequences of neglect and abuse in childhood. Briere and Rickards (2007) associate childhood maltreatment with identity disturbances and interrelational problems.

This study therefore identifies particular issues within family dynamics pertinent to the development of EDD. The identification of factors by the panel of lack of time to share, talk, and an overuse of technology lends support to content validation of EDD.

Challenges in Treatment of EDD

Participants emphasized the importance of the therapeutic relationship in treating persons with EDD. The participants noted that the client’s dependency needs and self-affirmation constituted a unique challenge within the therapeutic relationship. When discussing whether they treat persons who present with symptoms of EDD differently than those who do not present in this way, these therapists emphasized that affirming or being affectively present to each client is “good therapy practice.” However, it was evident that the majority of the panel believe that being present to the client and allowing the person to share who he/she is best serves these persons, rather than use of cognitive-behavioral treatment, psycho-education, or skill-building. Instead, treatment focuses on the goodness of the client, “helping them experience their senses,” and being “present/attuned to (the) client’s entire emotional life and well-being.” This lends
credence to the fact that EDD is not fundamentally a cognitive or behavioral issue (although EDD affects both) – rather, it is a matter of the stunted growth of the emotions.

The panel noted that therapy with clients who present with EDD is not different from therapy of other clients, in the sense that they treat each client as an individual. However, these expert affirmation therapists emphasized the importance of being receptive to the client with EDD with more time, patience, gentleness, and focusing on the emotions of the client, affirming and validating these, as this enables confidence to grow as well as an appreciation of their own feelings and identity. All saw openness to the goodness in the client as primary in treatment of the client with Emotional Deprivation Disorder, helping them to find what is good about themselves, rather than focusing on problem solving. Several participants noted that sessions with such clients often are more informal, for example, just hearing about the client’s week, what they felt and did. Most of the participants discussed being more gentle with these clients, and all noted that the importance of being fully present to the person. One participant mentioned reparenting as an approach with clients with EDD. Another noted the importance of assisting these clients to experience their senses, and eventually how to guide their emotions with their reason and will. One participant discussed viewing clients being on a ‘continuum of affirmation,” and that it ‘depends where they are, I’ll move them towards cognitive elements relating to emotion and behavior.” This participant added, “EDD clients receive minimal addressing of their thought processes.”

Much of what the participants observed is consonant with the work of Terruwe and Baars (1976), and with that of this researcher. The contention that persons with EDD are on a ‘continuum of affirmation’ is a different way to express what Terruwe and Baars
described, that is, that the earlier in life the child did not receive unconditional love or affirmation, as an adult the person will experience greater severity of symptoms of EDD. Moreover, the contention of the panel that these clients have a greater need for an affirming, affective response from the therapist supports Terruwe and Baars’ contention that what persons with EDD need most is someone willing to be fully present emotionally and receptive to them. As noted by the panel, this is facilitated by attentive listening, being present with one’s feelings, and simply asking the client what they feel and think, rather than engaging in problem solving. The uncertainty and insecurity felt by these clients generally prohibits them from knowing their own feelings and opinions, and the inadequacy and inferiority often cause them to hesitate in being honest with others. This again lends confirmability to idea that EDD is a unique disorder that brings with it certain treatment challenges.

**Challenges in Training Therapists to Treat Emotional Deprivation Disorder**

Participants reported that affirmation therapists in training must be affirmed themselves and need mentoring regarding the meaning of therapeutic affirmation. Other challenges identified included that the mental health field favors cognitive–behavioral therapy, meaning that most therapeutic approaches often support ‘doing-oriented’ therapy versus an approach like affirmation therapy that favors ‘being-oriented’ treatment. While these are all helpful comments, none was made by a majority of the participants. It would be important to examine this question from other perspectives in future studies to see if this outcome could be improved. Additionally, clarification on the meaning of ‘being-oriented’ treatment would increase the understanding of appropriate interventions by therapists in training.
Challenges in Diagnosing EDD

The majority of respondents noted that distinguishing EDD from other co-morbid disorders could be challenging. They identified the following as sometimes replicating or overlapping other disorders: Personality disorders, Mood disorders, Attachment disorders, Obsessive-Compulsive disorder, Autism Spectrum disorders, schizoaffective symptoms or Schizophrenia, Social anxiety and Generalized anxiety. It is noteworthy that the participants reported such a range of disorders which need to be differentiated from EDD, yet personality disorders was the only category identified by the majority of the participants to replicate or overlap EDD. This seems to point even more clearly to the need for further studies supporting discriminant validity regarding EDD and other disorders.

Differences Between Emotional Deprivation Disorder and Other Disorders/Conditions

Considerations Regarding EDD and Personality Disorders

The panel was asked “It has been suggested that EDD is a primary diagnosis and at least three personality disorders, Avoidant, Dependent, and Borderline, are subtypes that fall under EDD. Would you agree with this? Why or Why not?” The majority of the participants agreed that they consider EDD as a primary diagnosis with three subtypes being Avoidant, Dependent and Borderline Personality Disorders. They agreed with the view of EDD being the ‘substrate,’ or underlying cause of these personality disorders, with the personality disorders being distinct manifestations of EDD. However, several of the participants found it difficult to assume that Borderline Personality Disorder would be
a substrate of EDD, due to their view that the “aggressiveness that typically accompanies BPD …is not adequately described by EDD.”

When discussing how they differentiate between Avoidant Personality Disorder and EDD, participants had a range of responses. One stated that he rarely makes a diagnosis of personality disorder, so never needs to make this distinction, and believes that Avoidant Personality Disorder is a consequence of emotional deprivation. Others saw EDD as the etiology for APD. Most saw them as very similar, but would treat them as someone who is emotionally deprived.

The participants also discussed how they differentiate EDD from Dependent Personality Disorder. The majority of the participants observed that Dependent Personality Disorder is more similar to EDD and that it exhibits more of the mood and behaviors that they notice in EDD. Half specifically noted that the underlying cause of this personality disorder is emotional deprivation, or lack of affirmation.

The observations by the panel of expert therapists regarding differentiation between EDD and personality disorders confirm this researcher’s own experience as an affirmation therapist, that personality disorders are likely rooted in EDD, but manifest themselves in distinct ways. A personality disorder is defined by the DSM-5 (American Psychiatric Association, 2013) to be “an enduring pattern of inner experience and behavior that deviate markedly from the expectations of the individuals’ culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (p. 645). This is similar to the criteria of EDD, but is not identical: EDD is not defined by Terruwe and Baars (1976) as pervasive or inflexible, and they identified that its origin could be as early as infancy. In fact, these
authors note throughout their work that different temperaments may make different clinical impressions in persons with EDD. It is possible these could resemble different personality disorders.

Personality disorders are thought to have childhood antecedents (Bierer et al., 2003; Grover et al., 2007; Rademaker et al., 2008), as does Emotional Deprivation Disorder (Terruwe & Baars, 1976). Research has shown that there is a connection between childhood neglect and/or abuse and psychological difficulties in adulthood (Briere & Jordan, 2009; Parker et al., 2012). Parental overprotection is associated with anxiety and depression in adults (Parker, 1983). Briere and Jordan (2009) found that cognitive and emotional consequences of physical, sexual, and psychological abuse or neglect include low self-esteem, lack of self-awareness, identity disturbances, self-blame, hopelessness, anxiety, depression, and anticipation of rejection or abandonment. Some research (Briere & Rickards, 2007; Stansfeld et al., 2008) has identified major effects of childhood maltreatment: identity disturbances regarding sense of self, affect dysregulation and interrelational difficulties, as well as symptoms of anxiety, depression, posttraumatic stress, dysfunctional behavior, and dissociation. As a result, in adulthood both Avoidant and Dependent Personality Disorders are characterized by a negative problem-solving orientation (McMurran et al., 2007), due to a low sense of capability to resolve problems.

Meyer, Ajchenbrenner, and Bowles (2005) identify that children with a sensitive temperament, coupled with negative childhood experiences and a tendency to react to anticipated rejection may result in avoidant behaviors. The criteria for Avoidant Personality Disorder bears striking similarities to those of EDD, as both note the presence
of feelings of inadequacy and inferiority, hypersensitivity, fear of rejection, and unwillingness to get involved with people unless they are certain of being liked. However, a difference that APD does not address is that the person cannot establish rapport with other adults, although one might infer this from the criteria. Instead, DSM-5 (American Psychiatric Association, 2013) merely notes that the person with APD is unwilling to become involved with people, unless they are sure they will be liked and accepted. Terruwe and Baars (1976) observe that persons with EDD are unable to establish rapport with other adults, indicating a deficit in emotional growth.

Dependent Personality Disorder (DPD) (American Psychiatric Association, 2013) manifests itself in compliant and anxious behavior related to an extreme need to be taken care of (Appendix G). Disney (2013) reports that extreme forms of dependency can manifest as a personality disorder in adulthood, which then affect adult relationships. Disney’s review of the literature on DPD reveals that this disorder is often linked to overprotective and authoritarian parenting styles. In addition, this author notes fearful attachment style, lack of assertiveness and strong social anxiety are strong predictors of DPD in adulthood.

DPD also resembles Emotional Deprivation Disorder in cases where the person lacks self-confidence and believes herself incapable of functioning without the help of another person. These persons can certainly be very self-effacing in order to elicit help. Mikulincer and Shaver (2007) state that an insecure anxious attachment style is associated with Dependent Personality Disorder. However, an important distinction between Avoidant Personality Disorder and EDD is that criteria for the latter requires that the person is incapable of normal emotional rapport with other adults (Terruwe & Baars,
1976). While this may be the case in Dependent Personality Disorder, it is not explicitly stated. This is the inner experience of the person with EDD, who feels insecure, inadequate, uncertain and inferior precisely because of this inner emotional deficit. It is this deficit in itself that is significant, which in turn leads to other behaviors such as avoidance or dependence. Therefore, in distinguishing between DPD and EDD, one again observes that Terruwe and Baars offer a nuance towards identifying the inner emotional deficits and resulting turmoil which may be manifested differently, depending on the temperament and disposition of the person (i.e., more asthenic personalities being more avoidant or dependent, stronger personalities more self-centered, etc.).

This researcher agrees with the expert panel that it is helpful to view the syndrome of EDD as the ‘substrate’ of personality disorders, or to view personality disorders on a continuum of emotional deprivation. Her own experience as a therapist treating a person with DPD or APD in the same manner as someone with EDD has confirmed this conclusion. It has also been her professional experience that persons with EDD who exhibit characteristics of avoidance or dependency do make better progress in therapy, given appropriate treatment.

Although there is further need for clarification, the conclusions discussed by the panel strengthen this study, insofar as participants discussed both similarities and differences between EDD and both personality disorders, as well as a potential relationship between them. Future research may provide more clarity in differentiating EDD and personality disorders.
Considerations Regarding EDD and Insecure Attachment

Participants were asked how they differentiate between EDD and insecure attachment. Of the six therapists who provided comments, one stated that he considered someone with insecure attachment as someone deprived of affirmation. Another thought that emotional deprivation is the source of anxious, ambivalent or avoidant attachment behaviors, which are the result of not feeling safe, due to lack of unconditional love. Two participants stated that either they could not differentiate EDD from insecure attachment, or that they appear to be very similar. One participant noted that in her limited experience persons with attachment disorder seem disinterested in attachment, but that EDD clients “yearn for affirmation and attachment.” The sixth participant noted that there is a clear difference: “EDD affects the identity of the person on such a deep level that attachment theory does not adequately describe its chronicity.” The expert panel sees similarities between insecure attachment and EDD, but it is important to note that the majority considers EDD as the source of attachment difficulties. These results underlie the majority of the panel’s conclusion that EDD is the etiology for insecure attachment and that this condition simply expresses a particular form of EDD.

Bowlby’s (1988) work in attachment confirms that maltreatment in childhood may manifest itself in adulthood as negative working models of relationships. On the other hand, attachment researchers state that secure and attentive relationships facilitate the child’s ability to regulate emotion (Gross & Thompson, 2007), form a secure base (Bowlby, 1988) from which children can explore their environment because they feel safe (Ungar & De Luca, 2014) and provide an emotional foundation which persists into adulthood (Brisch, 2012). Bowlby (1988) advocated that parents’ willingness to set aside
their own interests in favor of giving time and attention to their children would produce “healthy, happy and self-reliant adolescents and young adults” (p. 2). These findings parallel those of Terruwe and Baars (1976), but these authors specifically identified the presence of unconditional love (affirmation) as the factor that engenders a sense of security, worth, certainty, and the ability to form and maintain adult relationships.

Bowlby (1988) and Ainsworth (1970) asserted that when children’s needs for attachment are met consistently and appropriately, such children become more independent which leads to the conclusion that adults who have been reared in this way will also be independent (Mikulincer & Shaver, 2007). Bowlby (1988) found that caregivers who are responsive and available provide a secure base for children to internalize a feeling of security. This ‘felt’ sense of security arises out of the attachment system (Feeney & Noller, 1996) which becomes part of an internal working model (Bowlby, 1969) of seeing others as trustworthy and available, and the self as worthy of love (Karakurt & Silver, 2014). Bowlby (1979, 1988) noted that attachment patterns begun in childhood continue across the lifespan (see also Stansfeld et al, 2008; Unger & De Luca, 2014); he and Ainsworth (1970) also believed that early relationship patterns in childhood directly affect how a person later enters into relationships with future partners as well as his or her own children.

The answers of the panel of experts in this study confirmed these conclusions, but they attributed this sense of security and feeling of worthiness to affirmation by the child’s parents. The panel would agree with Mikulincer and Shaver (2007) that “the broaden-and-build cycle of attachment security provides the foundation for mental health and is built from repeated experiences with loving, caring, and sensitive attachment
figures” (p. 369). The panel’s identification of the criteria for EDD underscores their observations that Terruwe and Baars’ (1976) own findings provide nuances not found in attachment literature.

In a study of how parental bonds affect self-efficacy, Mallinckrodt (1992) found that the more parents were recalled as warm and responsive by college students, the higher their levels of social self-efficacy. In fact, in their survey of the research on attachment, Mikulincer and Shaver (2007) found that “attachment-anxious people experience an unmanageable stream of negative thoughts and feelings that contribute to cognitive disorganization” (Mikulincer & Shaver, 2007, p. 371). These authors stated that both anxious and avoidant attachment styles are related to neurotic thinking and behavior. The authors stated “many insecure people identified by our measures do not seem to suffer from a diagnosable mental disorder” (Mikulincer & Shaver, 2007, p. 373). These conclusions seem to underscore the possibility that EDD may fill a gap in the literature, as Affirmation Theory directly identifies insecurity as one of the main symptoms of Emotional Deprivation Disorder.

Mikulincer and Shaver (2007) cited multiple studies that have identified “low self-esteem, low self-efficacy expectancies, [and] perceptions of lack of social support” (Mikulincer & Shaver, 2007, p. 386) as factors that mediate the relation of attachment style and affective disorders. These researchers concluded “from an attachment perspective, disorders of interpersonal relatedness can be construed as constellations of insecure attachment strategies” (Mikulincer & Shaver, 2007, p. 398). In fact, Mikulincer and Shaver identified difficulties in relationships such as problems in being assertive, desiring reassurance, loneliness and inability to express emotions as factors that relate
attachment insecurities and affective disorders. Kaperleris and Paivio (2011) found that severe emotional maltreatment in childhood had long-term effects on self-esteem and self-identity as evidenced by insecure attachment, fear and lack of trust in others, difficulties in identifying and expressing emotions, feelings of worthlessness, unhappiness, and fear of abandonment. These findings support Terruwe and Baars’ (1976) observation that childhood antecedents of abuse and/or neglect (i.e., in Terruwe and Baars’ terms, lack of affirmation or unconditional love) can manifest in adulthood as difficulty in establishing rapport in interpersonal relationships (therefore loneliness), feelings of uncertainty and insecurity, and feelings of inferiority and inadequacy.

Bowlby (1988) and Terruwe and Baars (1976) differ regarding their description of the origins of their respective identified syndromes. Bowlby identifies lack of a secure base in his description of the origins of what he terms insecure attachment. Terruwe and Baars assert that EDD is “a retardation of the emotional life not due to repression” (1976, p. 9) which “results from the frustration or deprivation of the natural sensitive need for affirmation in the infant, baby, or growing child by the mother, father, or both…” (1976, p. vi). Terruwe and Baars’ observations are similar to Bowlby’s observations, but their work appears to have a basic difference with that of Bowlby around the notion of love and unconditional love.

It is evident that both theories offer much to the literature on adults who experienced childhood antecedents of abuse and/or neglect. The responses of the expert panel in this study confirm that the construct of EDD is crucial to the therapy provided such persons and their families. Therefore, the provisional content validity for EDD
established through this study is important to how clinicians approach diagnosis and intervention.

Many of the symptoms of insecure attachment or personality disorders are also manifested in EDD: anxiety, depression, identity disturbances, interrelational difficulties, low self-esteem, lack of self-awareness, and fear of rejection or abandonment. However, none of these other researchers fully identified the unique constellation of symptoms presented by Terruwe and Baars (1976). The grouping of specific themes and subthemes that the expert panel in this study identified, *Inability to establish rapport with adults*, (and its subtheme *disconnect from others*), *Undeveloped emotional life* (and its subthemes) and their descriptive criteria are not found together in the literature on attachment or personality disorders. This brings the researcher to conclude that EDD is unique when compared to the literature regarding psychological difficulties in adulthood that develop following childhood neglect and/or abuse. This researcher would also posit, along with other researchers, that children with more sensitive temperaments might be more prone to development of personality disorders or insecure attachment or properly EDD.

This researcher believes that Terruwe and Baars’ work (1976) adds to this literature by refining symptoms, offering specific descriptions of the interior difficulties experienced by persons who have Emotional Deprivation Disorder, and proposing a unique grouping of these symptoms to illustrate the internal experience of these persons. Furthermore, it is this researcher’s contention that even how Terruwe and Baars’ name this syndrome by identification of the etiology of these difficulties (i.e., emotional deprivation) assists clinicians to diagnose EDD.
Conclusions

The purpose of this Delphi study was to provide provisional content validation for Emotional Deprivation Disorder by surveying ten therapists familiar with this disorder. These therapists provided information over three rounds of questions through an online PsychData survey, through which they reached a consensus on the criteria for Emotional Deprivation Disorder and answered the first research question. This Delphi study lends support for provisional content validity for the criteria for Emotional Deprivation Disorder. The researcher considers this provisional inasmuch as qualitative research does not seek to determine certainty about the object of study, but rather seeks to elucidate evidence that confirms credibility (Eisner, 1991). Rather than seeking validity and reliability as found in quantitative research, in qualitative research one seeks confirmability. Lincoln and Guba (1985) used terms such as credibility, authenticity, and trustworthiness to describe the validity of qualitative research. As shown by Brady (2015) and Fletcher and Marchildon (2014), future research using the Delphi may add to the confirmability and trustworthiness of these results. This result shows that Emotional Deprivation Disorder fills a gap in the literature on adults with childhood antecedents of abuse and/or neglect.

Additionally, this study meets the benchmarks set out by Whittemore, Chase, and Mandle (2001), who identified four primary criteria related to validity in their analysis of the literature. They examine whether the research is a correct interpretation of the participants’ meaning, whether there are multiple views, whether there is a critical assessment of all parts of the research, and whether the researchers examine their own methods and biases.
The second purpose of this study was to determine what affirmation therapists see as the difference between EDD and other diagnoses such as insecure/anxious attachment patterns and Dependent Or Avoidant Personality Disorders. The therapists in this sample were able to provide information regarding their view that EDD is distinct from Avoidant Personality Disorder, Dependent Personality Disorder, and insecure attachment. Moreover, the participants reported their views that other diagnoses might overlap the criteria for EDD.

Conclusions drawn from this research are:

1. Emotional Deprivation Disorder has a unique set of criteria.
2. Emotional Deprivation Disorder can be mistaken for other diagnoses.
3. Emotional Deprivation Disorder may be the etiology of other syndromes or diagnoses such as personality disorders and insecure attachment.
4. Emotional Deprivation Disorder has identifiable demographic characteristics.
5. EDD has factors that may be commonly associated with this syndrome/disorder.
6. EDD requires a specific approach to treatment with regard to the therapeutic relationship.
7. Training therapists to treat EDD requires that the therapist be affirmed himself/herself.
8. Others outside the therapeutic alliance may help facilitate the healing process of persons with EDD by being emotionally mature and able to love unconditionally.
Implications

1. The results of this study lend provisional content validity to the syndrome of Emotional Deprivation Disorder. Having defined EDD along with characteristics and factors associated with it provides a foundation for identification of this as a unique syndrome.

2. The results of this study yield information that will help clinicians such as marriage and family therapists and other researchers to discriminate between EDD and other disorders and conditions using the themes and subthemes identified herein.

3. The results of this study lend support for future research on Emotional Deprivation Disorder, its treatment and associated challenges. Future research should include replication of this study and developing surveys that would help practitioners identify persons with EDD.

4. The panel of therapists added to the criteria of EDD by noting symptoms and environmental factors that Terruwe and Baars (1976) discussed throughout their work, but which they did not address specifically in the list of their criteria for EDD. Future research to support environmental factors for EDD is needed to clarify these factors.

Limitations

There is a limitation to this study. Although Delphi studies do not require a particular sample size, it is possible that the content validity would have been strengthened by having the original twelve therapists remain in the study. Of the initial sample, one therapist never followed through with her agreement to participate, and
another dropped out after the first round due to personal reasons. Their participation could have enriched the study by providing data not available from other participants.

**Recommendations**

The results of this study will be published as an article for journal submission, in order to inform clinicians such as marriage and family therapists of the identification of EDD. Application of the ideas of Terruwe and Baars (1976) would benefit many persons. Therefore, future studies on the treatment of EDD should follow this study in order to facilitate the emotional well-being of individuals, couples and families. The evidence provided here regarding this little known syndrome contributes new information on emotionally deprived persons to the field of marriage and family therapy, as well as other mental health fields.

Using case studies to obtain information by affirmation therapists may be another way of confirming content validity for Emotional Deprivation Disorder. This may also prevent participant fatigue in future studies.

Teaching therapists to treat EDD will be an important endeavor. Evidence of its criteria will lend credence to its identification as a unique syndrome.

This researcher plans to write articles and books on her own experience in treating EDD. Utilizing former clients’ experiences of therapy through use of client Delphi studies to gather consensus on how therapy was helpful might help underscore effectiveness of affirmation therapy in treatment of EDD, as well as bring greater clarity on the process of treatment for affirmation therapists.
Finally, new studies comparing insecure attachment and personality disorders with EDD would provide further discriminant validity. Therapists could benefit from being able to differentiate these conditions, as well as determining how they overlap.

Summary

The purpose of this Delphi study was to provide provisional content validation for Emotional Deprivation Disorder by asking a panel of affirmation therapists to answer two questions: (1) What criteria do experts in affirmation therapy use to identify Emotional Deprivation Disorder? and (2) What do affirmation therapists see as the difference between EDD and other diagnoses such as insecure attachment patterns and Dependent Or Avoidant Personality Disorders? A humanistic framework was used to focus the study on Terruwe and Baars’ (2002) belief that the balance of the human person’s physical, intellectual, volitional, spiritual and emotional dimensions is in the service of the individual person’s freedom and happiness, as well as helping develop the capacity to form mature bonds in adulthood.

This chapter reviewed the conclusion of the study and provided a discussion of the themes and subthemes that emerged from the data analysis, as well as variables and factors the panel associated with EDD. Panelists also discussed how they differentiate EDD from Avoidant and Dependent Personality Disorders and from insecure attachment. Also included were implications, limitations of the research, and recommendations for marriage and family therapists and for future research. This research yielded data that contributes to the marriage and family therapy literature and to mental health literature in general, and provides an introduction to a little known syndrome that can help therapists.
recognize and develop effective treatment for persons with Emotional Deprivation Disorder.
REFERENCES


adult attachment representations: A longitudinal adoption study with secure base scripts. *Attachment and Human Development, 17*, 241 - 256.


APPENDIX A

IRB Approval Letter
DATE: February 28, 2017

TO: Ms. Suzanne Baars
    Family Sciences

FROM: Institutional Review Board (IRB) - Denton

Re: Exemption for Using a Modified Delphi Study to Establish Content Validation of Emotional Deprivation Disorder (Protocol #: 19457)

The above referenced study has been reviewed by the TWU IRB (operating under FWA00000178) and was determined to be exempt from further review.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. Because a signed consent form is not required for exempt studies, the filing of signatures of participants with the TWU IRB is not necessary.

Although your protocol has been exempted from further IRB review and your protocol file has been closed, any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Karen Petty, Family Sciences
    Dr. Linda Ladd, Family Sciences
    Graduate School
APPENDIX B

Recruitment Letter
Recruitment Letter

March 14, 2017

4425 W. Airport Fwy, Suite 244
Irving, Texas 75062

Potential Participant name

Re: Using a Delphi Study to Establish Content Validation of Emotional Deprivation Disorder, a dissertation research study by Suzanne Baars.

Dear Potential Participant:

I am writing to let you know about an opportunity to participate in a research study about Emotional Deprivation Disorder. I am conducting this study for my dissertation at the Family Sciences department at Texas Woman’s University in Denton, Texas.

This study will provide information from therapists experienced in working with persons with Emotional Deprivation Disorder (EDD). Emotional Deprivation Disorder was identified by psychiatrists Terruwe and Baars (1976) as an adult syndrome arising from a lack of unconditional love; its primary symptoms include difficulty in developing emotional rapport with other adults, deep feelings of inferiority, inadequacy, uncertainty and insecurity. Affirmation therapy was designed to be a way of aiding the emotional life of these adults to develop and to decrease these symptoms.

This study will examine similarities and differences between Emotional Deprivation Disorder and insecure attachment patterns, Avoidant Personality Disorder and Dependent Personality Disorder. No studies to date have been done on the syndrome of Emotional Deprivation Disorder, making this study significant in determining whether it is distinct from the disorders with which it is being compared. You have been asked to participate in this study because you have been identified as a therapist who has experience with clients presenting with Emotional Deprivation Disorder.

We are contacting you for this study because you were identified on the referral site, Catholictherapists.com, as someone who works with this population of clients; you have previously participated in conferences on the subject of Emotional Deprivation Disorder; you are personally known to us as someone who works with this population of clients. Participation is voluntary and any participant may withdraw from the study at any time.

We will send you a follow-up email; however, agreement to be contacted or a request for further information does not obligate you to participate in any study. If you would like
additional information about this study, please call Suzanne Baars (principal investigator) at 214-441-3797, or Linda Ladd (faculty advisor) at 940-898-2694.

Thank you for considering being a participant in this opportunity to research Emotional Deprivation Disorder.

Please note that there is a potential risk of loss of confidentiality in all email, downloading, electronic meetings, and internet transactions.

Sincerely,

Suzanne Baars, M.A.
APPENDIX C

Consent to Participate In Research
Title: Using a Delphi Study to Establish Content Validation of Emotional Deprivation Disorder

Investigator: Suzanne Baars ........................................... Sbaars@twu.edu 214-441-3705

Advisor: Linda Ladd, Ph.D., Psy.D ................................. lladd@twu.edu 940-898-2694

Explanation and Purpose of the Research

You are being asked to participate in a research study for Ms. Baars’ dissertation at Texas Woman’s University.

The purpose of this research is to obtain information from therapists experienced in working with clients with Emotional Deprivation Disorder (EDD). Emotional Deprivation Disorder has been identified by psychiatrists Terruwe and Baars (2002) as an adult syndrome arising from a lack of unconditional love; its primary symptoms include difficulty in developing emotional rapport with other adults, deep feelings of inferiority, inadequacy, uncertainty and insecurity. Affirmation therapy was designed to be a way of aiding the emotional life of these adults to develop and to decrease these symptoms. This study will examine similarities and differences between Emotional Deprivation Disorder and insecure attachment patterns, Avoidant Personality Disorder and Dependent Personality Disorder. No studies to date have been done on the syndrome of Emotional Deprivation Disorder, making this study significant in determining whether it is distinct from the disorders with which it is being compared. You have been asked to participate in this study because you have been identified as a therapist who has experience with clients presenting with Emotional Deprivation Disorder.

Insecure attachment patterns, according to Mikulincer and Shaver (2008), describe a strategy of emotion regulation in persons who are insecure. These authors state that hyperactivating strategies amount to an “anxious,” “anxious-ambivalent,” or “anxious-resistant” pattern of attachment, which in adolescents and adults they call an anxious attachment style. Deactivating strategies increase the likelihood that persons will inhibit, suppress, or deactivate normal attachment behavior; this leads to an “avoidant” attachment pattern.

Avoidant Personality Disorder (APD) is “a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts” (DSM-5).

Dependent Personality Disorder (DPD) is “a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts” (DSM-5).
Description of Procedures

As a participant in this study you will be asked to answer three questionnaires which will be sent to you either by email or surface mail every one to two weeks, over a period of no more than six weeks. Once all informed consent forms are returned, you will receive an email to a link to PsychData, an online survey website, where you may complete all answers to the questions of the first round of the Delphi study on Emotional Deprivation Disorder. If you do not use internet or email you will be sent a copy of the questionnaire by U.S. mail or fax which you may complete and return by fax (see below). Each questionnaire may take between 45-60 minutes to answer in writing. Once your written responses are received, the researchers will consider all participants’ answers and construct the next questionnaire which will then be sent to you. This process will be followed at least twice after the researchers receive the first questionnaire from you. In order to be a participant in this study, you must be a therapist who has worked with clients with Emotional Deprivation Disorder.

Potential Risks

The researcher will ask you questions about your opinion about Emotional Deprivation Disorder and how it is similar or different from insecure attachment styles, Avoidant Personality Disorder and Dependent Personality Disorder. Potential risks to participation may include fatigue, loss of time, coercion, loss of confidentiality, and loss of anonymity. If you become tired you may take breaks as needed. To decrease the risk from loss of time, the researcher has attempted to make the process of participation as simple as possible. In addition, you are encouraged to be succinct in your responses. You may also stop answering questions at any time and withdraw from the study.

One of the risks in this study is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. This Delphi study depends on assurance of anonymity, to prevent you from experiencing any sense of coercion from other participants. Additionally, your questionnaire will be assigned a number to ensure anonymity during coding. No one but the researcher will know your real name. The answers to the questionnaires will be kept on a flash drive belonging to the principal researcher. Only the researcher, her advisor and another coder will read the written answers to the questionnaires. The master list of codes and names will be stored separately from all other data. The questionnaires will be disposed of within 1 year after the study is finished. The results of the study will be reported in scientific journals but your name or any other identifying information will not be included. There is a potential risk of loss of confidentiality in all email, downloading, electronic meetings and internet transactions.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.
Participation and Benefits

Participation in this research study is voluntary and participants may withdraw from the study at any time without penalty. There are no direct benefits from participation in this study; however, participation may provide you satisfaction in contributing to new research on Emotional Deprivation Disorder. If you would like to know the results of this study we will mail them to you.*

You will be sent a copy of this signed and dated consent form to keep. If you have any questions about the research study you should ask the researchers; their phone numbers are at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman’s University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

Please initial pages 1 and 2 at the bottom, and sign and date this page and fax it back to Suzanne Baars at 888-975-2092.

________________________________________
Signature Date

*If you would like to know the results of this study tell us where you want them to be sent:

Email: ________________________________
or
Address: ________________________________
________________________________________
APPENDIX D

Demographic Questions for Experienced Affirmation Therapists
Demographic Questions for Experienced Affirmation Therapists

1. Number of years in practice
2. Number of years doing Affirmation Therapy
3. License and/or certifications (if required in their state/country)
4. Gender
5. Age
6. Specialization
7. Types of clients you work with (age range; couples and/or families; individuals; types of disorders)
8. Other theoretical framework(s) you use
APPENDIX E

Emotional Deprivation Disorder. Diagnostic Criteria (Terruwe & Baars, 1976)
Emotional Deprivation Disorder Diagnostic Criteria  
(Terruwe & Baars, 1976)

The individual is over 21 years of age.

The person exhibits the following symptoms; these may be reported by the person or noted through clinical observation.

1. *Abnormal emotional rapport with other adults*, one that is very childlike or immature. Rapport with other adults is usually established only by a decision or an act of the will, rather than by feelings or emotional desire. He or she may state that internally they “feel like a child” and others may easily view them as childish when they show their feelings.

   - *Difficulty making friends* with others, while usually desiring friendships
   - *Superficial friendships and discomfort or fearfulness* in social situations – he or she is *incapable* of adult emotional connection in relationships
   - *Incapable of emotional surrender* to a spouse
   - *Egocentrism*
   - *Loneliness* – even if he or she is regularly interacting with others
   - *Oversensitive* to the opinions of others and *easily hurt* by criticism or slights of others

2. *Deep feelings of uncertainty and insecurity*

   - *Difficulty saying no to others* due to fear of disapproval or rejection
   - Needs frequent *reassurance*
   - *Fears disagreeing* with others because of the desire to be liked by others
   - *Difficulty making decisions*

3. *Deep feelings of inferiority and inadequacy*

   - *Feels self-conscious*
   - *Feels no one could possibly love them*
   - *Feels like a failure or stupid* even though he or she may be very intelligent
   - *Feels insignificant or worthless; lacks an identity* (may say they don’t know who they are)
   - May *compare themselves* unfavorably with others

Other symptoms which may or may not be present:

   - May complain of *fatigue*
   - May have difficulty with *organization* – cannot bring order into his or her environment (chaotic)
   - May constantly *anticipate* something bad happening
- May experience guilt feelings
- May have a need to collect and hoard useless things
- A change in circumstance (job, home, family, etc.) may be overwhelming and may cause emotional disintegration
- May have undeveloped or underdeveloped senses: vision, touch, taste, smell
APPENDIX F

DSM-5 Criteria for Avoidant Personality Disorder (301.82)
DSM-5 Criteria for Avoidant Personality Disorder (301.82 (F60.6))

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) or the following:

1. Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.
2. Is unwilling to get involved with people unless certain of being liked.
3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.
4. Is preoccupied with being criticized or rejected in social situations.
5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
6. Views self as socially inept, personally unappealing, or inferior to others.
7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.
APPENDIX G

DSM-5 Criteria for Dependent Personality Disorder (301.6)
DSM-5 Criteria for Dependent Personality Disorder (301.6 (F60.7))

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of his or her life.
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval. (Note: Do not include realistic fears of retribution.)
4. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
7. Urgently seeks another relationship as a source of care and support when a close relationship ends.
8. Is unrealistically preoccupied with fears of being left to take care of himself or herself.
APPENDIX H

Criteria for Insecure Attachment
Criteria for Insecure Attachment

Mikulincer and Shaver (2008) describe a strategy of emotion regulation in persons who are insecure:

Hyperactivating strategies derive from previous experiences in which inattentive, self-preoccupied, or anxious attachment figures were perceived as more likely to respond favorably if the normative strategies of calling, crying, contacting, and clinging were up-regulated to the point of demanding a response. Because such behavior, when addressed to a less than fully sensitive and responsive caregiver, is sometimes effective in relieving distress and sometimes not, according to an unpredictable partial reinforcement schedule, it is highly resistant to extinction. When consolidated over months and years, hyperactivating strategies and their effects on subjective experience and observable behavior amount to an “anxious,” “anxious-ambivalent,” or “anxious-resistant” pattern of attachment, which in adolescents and adults we call an anxious attachment style.

Deactivating strategies derive from previous experiences in which emotionally cool, distant, rejecting, or hostile caregivers reacted to normative cries for help and support by withdrawing, disapproving, or reacting with anger. This kind of behavior, if common and persistent, makes it likely that a child will inhibit, suppress, or deactivate normal attachment behavior; this leads to an “avoidant” attachment pattern… (p. 505-506)
APPENDIX I

Round One Questions
Round One Questions

1. What criteria do you use to diagnose Emotional Deprivation Disorder?

2. Are there variables you associate with EDD? E.g., socioeconomic status, gender, ethnicity, clients coming from single-parent family? Clients who have siblings (two or more)? Clients who are an only child? Abuse? Neglect? Other factors?

3. Do you see factors which are commonly associated with Emotional Deprivation Disorder (EDD) (e.g., little attention paid to the feelings of family members; use of television or other devices as a child; families not having a designated place and time to eat a meal together regularly, where there is opportunity for discussion and enjoyment of each other’s company, etc.)?

4. What do you think are some of the unique challenges in diagnosing Emotional Deprivation Disorder (EDD)?

5. In your experience, what are some of the unique challenges in treating Emotional Deprivation Disorder (EDD)?

6. In your opinion, what are the challenges in training therapists to treat Emotional Deprivation Disorder (EDD)?

7. Do you think Emotional Deprivation Disorder replicates or overlaps any other diagnostic category (e.g. DSM-5)? If so, which ones?
APPENDIX J

Round Two Questions
APPENDIX J

Round Two Questions

1. Regarding the criteria of Emotional Deprivation Disorder, the responses of the participants appeared to fall into two themes, each with several sub-themes. Would you agree with the names of these themes? Would you agree with the names of the sub-themes? Do you agree with the criteria listed under each theme and sub-theme?

   Theme 1: Poor relational connections with others

   a. Sub-theme: Disconnect from others
   - Disconnection from others' feelings
   - Difficulty or inability to establish rapport with other adults
   - Difficulty establishing rapport
   - Inability to form meaningful relationships
   - Difficulty maintaining relationships
   - Not spontaneous in relationships unless feels accepted of his/her childlike behavior/comments

2. Regarding the criteria for Emotional Deprivation Disorder, would you agree with the name of this sub-theme? Do you agree with the criteria listed under this sub-theme?

   Theme 1: Poor relational connections with others

   b. Sub-theme: Dependent on others
   - Dependent
   - Excessive fear of hurting other's feelings
   - Client engages in pleasing behaviors in order to win the favor or friendship of others
   - Excessive dependency on others
   - Relating to others who confirm lack of self-worth
   - Abnormal emotional rapport
   - Fear of loss of the other's love
   - Relating to others who confirm lack of self-worth

3. Regarding the criteria for Emotional Deprivation Disorder, would you agree with the name of this theme, Undeveloped emotional life? Would you agree with the name of this sub-theme? Do you agree with the criteria listed under this sub-theme?

   Theme 2. Undeveloped emotional life
Sub-theme a. Childish feelings

- Depression, anxiety that indicate a specific pattern of functioning over time
- Possible anxiety and depression
- Expressed feelings of depression
- Sadness that may lead to depression
- Lack of trust of his/her own emotions
- Over sensitive
- Easily offended
- Disconnect from own feelings
- Feeling like a child (in an adult body)
- Poor understanding of the emotions
- Inability to name and/or express emotions
- Poor understanding or expression of emotion
- Operating only on fear and anger
- Poor development of the senses
- Stage of psychological development
- Fear of being themselves
- Feel like a child in an adult world
- Fear of being embarrassed
- Immature emotional life
- Poor sense of self
- Lack of self-worth

4. Regarding the criteria for Emotional Deprivation Disorder, do you agree with the name of this sub-theme? Do you agree with the criteria listed under this sub-theme?

Theme 2. Undeveloped emotional life

Sub-theme b. Feelings of inadequacy and inferiority

- Inadequate
- Shame laden
- Social anxiety
- Low self-worth
- Fear of being exposed as immature or inadequate
- Presence of existential fear in the client
- The presence of existential fear
- Fear of not being accepted/discounted
- Feelings of inferiority and inadequacy
- Expressed feelings of inferiority
- Feeling unloved
- Feeling not worthy of being loved
- Lack of assertiveness
- Non-assertive in expressing own feelings
- Poor assertiveness

5. Regarding the criteria for Emotional Deprivation Disorder, do you agree with the name of this sub-theme? Do you agree with the criteria listed under this sub-theme?

Theme 2: Undeveloped emotional life

Sub-theme c. Feelings of uncertainty and insecurity

- Insecure
- Cannot fully feel their emotions and use these to help them
- Shut down emotionally
- Inability to articulate own likes and dislikes
- Feelings of uncertainty and insecurity
- Feelings of lack of self-confidence
- Lack of certitude
- Inability to make decisions

6. Regarding the criteria for Emotional Deprivation Disorder, do you agree with the name of this sub-theme? Do you agree with the criteria listed under this sub-theme?

Theme 2: Undeveloped emotional life

Sub-theme d. Self-affirming behaviors

- Operating only on logic
- Temperament may make them more aggressive in expressing emotion
- Self-affirming behaviors that attempt to hide client's insecurities
- Self-defeating attempts to feel worthwhile: keeping busy/productive/helpful

7. All of the participants emphasized the importance of the therapeutic relationship in successfully treating EDD. Do you treat the person with EDD differently than a client who does not have symptoms of EDD? If so, how so?

8. Some participants noted that having people outside the therapeutic alliance who would be affirming companions or mentors might help facilitate the healing process of the person with EDD. What would these affirming companions or mentors need in order to facilitate the healing process?
APPENDIX K

Round Three Questions
APPENDIX K

Round Three Questions

1. Do you ever have to differentiate between EDD and Avoidant Personality Disorder? If yes, please explain using the criteria below. (see Appendix D for EDD criteria and Appendix E for APD criteria)

2. Do you ever have to differentiate between EDD and Dependent Personality Disorder? If yes, please explain using the criteria below. (see Appendix D for EDD criteria and Appendix F for DPD criteria)

3. Do you ever have to differentiate between EDD and insecure attachment? If yes, please explain using the criteria below. (see Appendix D for EDD criteria and Appendix G for criteria for insecure attachment)
APPENDIX L

Round Three Answers
APPENDIX L

Round Three Answers

Is EDD a primary diagnosis, with personality disorders as subtypes? Why or why not?

Yes. These three personality disorders describe different aspects or outcomes of the process of emotional deprivation. While these PD diagnoses are not dependent on explaining their development as consequences of non or dis-affirming developmental experiences, I think that each one reflects and results from underlying emotional deprivation.

Yes. I believe that an Avoidant, dependent or borderline PD may also have EDD and that EDD may be the underlying cause. Especially when there is a trauma.

I disagree. The EDD person will function in work environments and be willing to take part in activities however demonstrates an immature childlike rapport with others. Unlike the Avoidant and Dependent EDD person makes willful choices to be involved or not to be with others attempting to be accepted and loved. They are not at all characteristic of a Borderline personality d/o as they do not have a defused sense of self. They know that they are insecure and have difficulty making decisions but know who they are. No swings from neurosis to psychosis as in the Borderline.

I strongly agree with Avoidant Personality Disorder and Dependent personality Disorder as being sub types of EDD. Until now, I have not seen BPD as a sub-type of EDD. However, I am thinking that BPD could be a subtype of EDD but with a fear repression component.

Yes, fully agree. I would state EDD is the substrate or underlying cause of the 3 PD's. EDD is the root cause and 'building block' of the 3 PD's. Moreover, one can say that the 3 PD's are more the behavioral and mood/affect manifestations of EDD. Of course, we must take into account, all being uniquely individual, one's biologic predisposition or temperament in how EDD will manifest itself for each individual. An argument can be made that at a birds-eye view, EDD corresponds well with the Attachment Disorders (Bowlby/Ainsworth etc.) and Bessel van der Kolk's Developmental Trauma Disorders to some variant degree.

I agree. The listed personality disorders are characterized based on a prevailing symptom. EDD, however is defined by causality. The listed personality disorders are merely symptoms of EDD.

I would agree with that in general. The lack of affirmation leaves an individual with significant fear of the adult world that can lead to avoidance, dependence and in extreme cases of deprivation and abuse, borderline features or a full blown borderline personality disorder.
Is EDD a primary diagnosis, with personality disorders as subtypes? Why or why not?

Patient suffering from borderline personality disorder or are generally not as bold and descriptive as those with EDD. Avoidant and dependent traits and disorders would be much more common among patients with EDD.

I agree that avoidant and dependent could be subtypes of EDD and/or more chronic versions of EDD. It would be difficult to assume that BPD is a subtype of EDD without qualifying the traumatic event that caused BPD. In other words, if BPD resulted from the trauma of neglect then it could be a subtype. If BPD resulted from a trauma to the body such as physical abuse and/or sexual abuse, the aggressiveness that typically accompanies BPD as a result of this aforementioned trauma is not adequately described by EDD.

Yes; all rest on the essential and foundational void which is the result of EDD.
How participants differentiate between EDD and Avoidant Personality Disorder

In a practical sense, in my clinical work I rarely make a diagnosis of "personality disorder," so I never need to make this distinction. I view the historical process of being un-/under-dis-affirmed (i.e. emotionally deprived) and its consequences - including a diagnosable avoidant personality disorder - as what I'm treating.

The EDD person is not sure of their emotions or may fear them, especially anger emotion. Their need and quest is to be accepted and loved and they seek guidance for their emotions and decisions. There is not pervasive pattern as indicative of an Avoidant Personality Disorder. EDD is not a personality disorder at all rather it is a result of a deprivation of affirming parents or other caregivers in their developmental years that would have affirmed them in an emotional, intellectual and spiritual way.

I think avoidant personality disorder has the strongest association with EDD. When I have an avoidant personality client I immediately place them somewhere on the continuum for EDD. I believe the DSM criteria are just a bit more descriptive of EDD than has been included in the writings of Baars and Terruwe.

EDD criteria 2 and 3 are similar to APD criteria; what is unique to EDD is "willed vs felt" rapport with others. Unwilling to get involved as in APD is different than "willing" to get involved but not emotionally felt, for example. Willed relationship lacks emotionality (no concupiscible emotions of love, desire or joy) but still involved in a relationship nonetheless and therefore set apart from APD.

In most cases avoidant personality disorders seem to me to be an outgrowth of emotional deprivation, however, a significant trauma may lead to symptoms of avoidant personality disorder as well, with or without emotional deprivation.

Many people with EDD are in positions of significant responsibility and authority, requiring real talent. But they are often depressed and frightened and use willpower to cover over their fearful emotions. The patients that I have dealt with who have dependent personality disorder are less likely to be in the limelight.

These 2 need to be differentiated. There are symptoms of EDD that are not adequately captured by APD. Firstly, EDD can be present as early as childhood and adolescence. Secondly, EDD has a positive response to treatment while APD seems more chronic.
How participants differentiate between EDD and Dependent Personality Disorder

In a practical sense, in my clinical work I rarely make a diagnosis of "personality disorder," so I never need to make this distinction. I view the historical process of being un-/under--/dis-affirmed (i.e. emotionally deprived) and its consequences - including a diagnosable dependent personality disorder - as what I'm treating.

The person with EDD will develop rapport with others willfully being with others in spite of their existential fears of being seen as childlike or indecisive. The EDD can appear like a Dependent Personality D/O in some instances; however, their behaviors are not pervasive and excessive in a need to take care of etc. Their existential fear may keep them from closeness with some and keep them close to others with whom they sense safety and acceptance in relationships.

Dependent Personality fits with the patterns of behavior that I see in EDD. I have not seen a dependent personality who is not also severely lacking in affirmation. I see dependent personalities as exhibiting an immaturity that is childlike. I would DX a dependent personality as EDD. I cannot differentiate the two.

Other than willed vs. felt rapport in EDD, DPD gets into more detail and stresses lack of self-determination, initiative, assertiveness and relies on others to give them a sense of well-being based on others. Again, DPD seems to exhibit more the behavioral and mood-congruent manifestations/overt behaviors of EDD.

I do see Dependent Personality disorder as very similar to Emotional deprivation disorder and in general, a result of the emotional deprivation. However, in some cases a significant trauma may also induce symptoms of dependent personality disorder as well, with or without emotional deprivation.

Many people with EDD are in positions of significant responsibility and authority, requiring real talent. But they are often depressed and frightened and use willpower to cover over their fearful emotions. The patients that I have dealt with who have dependent personality disorder are less likely to be in the limelight.

DPD could be a response to EDD. While they are related, DPD as a response to EDD, is a more chronic situation where the coping mechanism has affected the personality structure.

Yes; but I have found that dependent personality disorder is the more obvious syndrome associated with EDD; the others camouflage it better.

No

No
How participants differentiate between EDD and insecure attachment

In a practical sense, in my clinical work I rarely need to make this distinction. I view someone who has "insecure" or "avoidant" attachment difficulties as someone who has been un-/under-/dis-affirmed (i.e. emotionally deprived). I view such problematic attachment as a consequence of emotional deprivation.

If the EDD Pt. demonstrates anxious, ambivalent, or avoidant attachment behaviors it is important to interview the person or persons with whom the behavior exists. One will find the other(s) in the Pt's live is (are) non-affirming individuals. Due to the EDD the Pt. will not be secure in those relationships feeling inadequate of not fulfilling the expectations of the other to be someone they cannot be because of their immature emotion/intellectual conditions. The deprivation is not always a result of outright abuses in childhood it is more that of not being safe to be whom they are in every stage of development for example having only been accepted conditionally not unconditionally with loving guidance.

I can't differentiate EDD from insecure attachment. They seem to be the same to me. I am thinking that EDD and insecure attachment are the same, with avoidant personality and dependent personality being sub-types. BPD may be included as a subtype but with high anxiety over powering, or fear repression.

EDD and Anxious Attachment seem very similar to me. However, Levine and Heller get into great detail of how an anxious attachment person's fear of rejection/abandonment get's activated by the partner, similar to what's described above. As I recall, those with EDD will respond in similar fashion but don't recall in Baars/Terruwe how an anxious person's activation system gets set off/tripped up by the alleged avoidant or secure partner. I'm not familiar with Mikulincer & Shaver so I can't say much else on this.

In my limited experience with attachment disorder, the presentation is usually different from that of the EDD client. Most EDD clients are yearning for affirmation and attachment, although in severe cases may be guarded and cautious and seem to reject affirmation that is offered until they test the therapist to see if they remain consistent and can be trusted. The client with attachment disorder seems disinterested in attachment and unable to respond to genuine affirmation that is available to them. This may be because their deprivation is more pervasive and includes even sensory deprivation at very young ages, as in cases of children in orphanages that do not receive any affection or any touch beyond general changing and feeding.

Insecure attachment can be used as a diagnostic criteria for EDD but does not fully explain EDD. Therefore, differentiation is necessary. EDD affects the identity of the person on such a deep level that attachment theory does not adequately describe its chronicity.

No
No
I don’t know
Perhaps I should make such a distinction, but in all honesty, I do not.
APPENDIX M

Emotional Deprivation Disorder Criteria, Themes 1 through 3 with Subthemes
APPENDIX M

Emotional Deprivation Disorder Criteria, Themes 1 through 3 with Subthemes

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Criteria</th>
<th># of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1. Poor relational connections with others</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disconnect from others</td>
<td>Inability to establish rapport with other adults</td>
<td>(3)</td>
</tr>
<tr>
<td></td>
<td>Difficulty in maintaining relationships.</td>
<td>(2)</td>
</tr>
<tr>
<td></td>
<td>Not spontaneous in relationships unless feels accepted of his/her childlike behavior/comments</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Disconnection from others’ feelings.</td>
<td>(1)</td>
</tr>
<tr>
<td>Dependent on others</td>
<td>Dependent.</td>
<td>(2)</td>
</tr>
<tr>
<td></td>
<td>Excessive fear of hurting other’s feelings.</td>
<td>(2)</td>
</tr>
<tr>
<td></td>
<td>Client engages in pleasing behaviors in order to win the favor or friendship of others.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Relating to others who confirm lack of self-worth</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Theme 2. Undeveloped emotional life</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childish feelings</td>
<td>Depression</td>
<td>(4)</td>
</tr>
<tr>
<td></td>
<td>Poor understanding and/or expression of the emotions</td>
<td>(4)</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>(2)</td>
</tr>
<tr>
<td></td>
<td>Lack of trust of his/her own emotions.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Over sensitive.</td>
<td>(2)</td>
</tr>
<tr>
<td></td>
<td>Disconnect from own feelings.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Feeling like a child (in an adult body).</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Operating only on fear and anger.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Poor development of the senses.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Stage of psychological development.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Fear of being themselves.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Feel like a child in an adult world.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Fear of being embarrassed.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Poor sense of self.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Lack of self-worth</td>
<td>(1)</td>
</tr>
<tr>
<td>Feelings of inadequacy and inferiority</td>
<td>Feelings of inferiority and inadequacy.</td>
<td>(5)</td>
</tr>
<tr>
<td></td>
<td>Fear of being exposed as immature or inadequate.</td>
<td>(3)</td>
</tr>
<tr>
<td></td>
<td>Lack of assertiveness.</td>
<td>(3)</td>
</tr>
<tr>
<td></td>
<td>Social anxiety.</td>
<td>(2)</td>
</tr>
<tr>
<td></td>
<td>Feeling unloved/not worthy of being loved</td>
<td>(2)</td>
</tr>
</tbody>
</table>
**APPENDIX M**

**Emotional Deprivation Disorder Criteria, Themes 1 through 3 with Subthemes**

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Criteria</th>
<th># of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame laden.</td>
<td></td>
<td>(1)</td>
</tr>
<tr>
<td>Poor eye contact.</td>
<td></td>
<td>(1)</td>
</tr>
<tr>
<td>Feelings of uncertainty and insecurity</td>
<td>Feelings of uncertainty and insecurity/ inability to make decisions</td>
<td>(3)</td>
</tr>
<tr>
<td></td>
<td>Cannot fully feel their emotions and use these to help them</td>
<td>(2)</td>
</tr>
<tr>
<td>Insecure.</td>
<td></td>
<td>(1)</td>
</tr>
<tr>
<td>Inability to articulate own likes and dislikes.</td>
<td></td>
<td>(1)</td>
</tr>
<tr>
<td>Feelings of lack of self-confidence.</td>
<td></td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Self-affirming behaviors</strong></td>
<td>Operating only on logic.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Temperament may make them more aggressive in expressing emotion.</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Self-affirming behaviors that attempt to hide client’s insecurities</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Self-defeating attempts to feel worthwhile: keeping busy/productive/helpful</td>
<td>(1)</td>
</tr>
</tbody>
</table>

**Theme 3. History of abuse or neglect in childhood**

<table>
<thead>
<tr>
<th>History of abuse or neglect</th>
<th>Family neglect or abuse</th>
<th>(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>History of denial of own lovability</td>
<td>(1)</td>
</tr>
</tbody>
</table>
APPENDIX N

Round One, Question 2 Parental variables (complete)
APPENDIX N

Round One, Question 2 Parental variables (complete)

- 1/11 Death of parents
- 1/11 Religion based on fear
- 1/11 parents with history of trauma
- 1/11 Parents overly stressed – marital discord
- 1/11 Client is spoiled
- 1/11 Lack of affective touch
- 1/11 Too much responsibility too early
- 1/11 Both parents working
- 1/11 Family system with denial of emotion
- 1/11 Rules against sharing emotions
- 1/11 Denial of needs of individual child
APPENDIX O

Variables Associated with Emotional Deprivation Disorder
APPENDIX O

Variables Associated with Emotional Deprivation Disorder

(Issues that received less than half of the responses)

<table>
<thead>
<tr>
<th>Category</th>
<th>Issues that received less than half of the responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental issues and rules</td>
<td>3/11 issues: Addiction, Laissez-faire family system, Poor compromised attachments, Child of parent with EDD 2/11 issues: Mentally ill parent 1/11 issues: Death of parents, Religion based on fear, Parents with history of trauma, Parents overly stressed – marital, Authoritarian parents, Clients spoiled, Lack of affective touch, Too much responsibility too early, Both parents working, Family system with denial of emotion, Rules against sharing emotions, Denial of needs of individual child</td>
</tr>
<tr>
<td>Neglect, abuse, and trauma</td>
<td>3/11 issues: Trauma, Emotional abuse 2/11 issues: Physical abuse, Sexual abuse, Emotional abuse in family 1/11 issues: Abandoned child, Lack of stable upbringing, Death or debilitating illness of spouse or another child, Wealthy parents who focused more on their business or pleasures</td>
</tr>
<tr>
<td>Socioeconomic Status</td>
<td>3/11 EDD affects every socioeconomic status 1/11 issues: Poverty-stricken, Economic instability for child’s family</td>
</tr>
<tr>
<td>Sibling/no sibling</td>
<td>4/11 Only child 2/11 Multiple siblings 1/11 issues: Number of siblings/being the only child not predictive of EDD, One child favored over another</td>
</tr>
<tr>
<td>Gender</td>
<td>Not seen as a factor</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>4/11 Ethnicity (I.e., EDD affects every ethnic group – makes no difference) 2/11 Ethnicity can be an influence if the culture is less physically demonstrative/stoic 1/11 Race, when poverty-stricken, single parent overwhelmed and stress due to financial burdens</td>
</tr>
</tbody>
</table>
APPENDIX P

Factors Commonly Associated with Emotional Deprivation Disorder
## APPENDIX P

*Factors Commonly Associated with Emotional Deprivation Disorder*

<table>
<thead>
<tr>
<th>Factor</th>
<th>List of factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/11 Denial of feelings</td>
<td>4/11 Parents not aware of or comfortable with their own emotions&lt;br&gt;2/11 issues: Denial of feelings by family members, Shaming for feelings, Not asking a child what he or she feels, Parents overreacting to family members’ feelings, No affective relationships between the child and caregiver&lt;br&gt;1/11 Compensatory emotional life – i.e., acting as if strong, over-reaching will power, insistence on one’s rights, overconfidence in the possibilities of self-destiny and achievement</td>
</tr>
<tr>
<td>6/11 Lack of time to share/talk</td>
<td>3/11 issues: No time given for sharing thoughts and feelings, Little family recreational time&lt;br&gt;2/11 Isolation within family&lt;br&gt;1/11 Families not having a designated place and time to eat a meal together regularly</td>
</tr>
<tr>
<td>5/11 Overuse of technology</td>
<td>5/11 Overuse of devices such as TV/cellphones &amp; computers</td>
</tr>
<tr>
<td>3/11 Utilitarian ends</td>
<td>3/11 “Pace of life often so busy that to sit still and have quiet time or gentle exchanges is rare”</td>
</tr>
<tr>
<td>4/11 Parents’ attitudes towards child</td>
<td>1/11 issues: Parents who have rigid attitudes and exert control, Excessive emphasis on rule following, “No recognition of the child’s individuality or difference from siblings”, Dysfunctional rules: don’t talk/don’t feel/don’t trust/don’t rock the boat</td>
</tr>
</tbody>
</table>
APPENDIX Q

Suggestions from Expert Therapists for Mentoring People with EDD
APPENDIX Q

Suggestions from Expert Therapists for Mentoring People with EDD

To be emotionally mature, to have been genuinely affirmed.

I agree that would be most helpful. These affirming companions must be adequately affirmed themselves, understand the boundaries of the relationship and be able to address themselves unselfishly to the client to facilitate an environment where they can grow their emotions at their own pace. They must also be willing to commit to the client for long term. This would best be accomplished by middle aged and older people whose lives are stable and settled. Younger people with young children may not have the time and energy to devote to clients and may begin to feel overwhelmed by their neediness. Having some kind of evaluation tool to screen such companions and training to help them understand true affirmation would be an important component to success with such a program.

Emotional maturity and the ability to love unconditionally

Training and an understanding of their own emotions, senses and how to use them with reason and free will. The ability to affirm others the way Conrad Baars speaks of this.

Being present to the EDD person requires patience and a long commitment and ability to accept changes in the patient as the pt. begins in time to express emotions that were previously feared and inhibited by fears of being embarrassed and ashamed. The slow growth of the emotional life must be supported in an affirming and emotionally safe environment. Conditions of the pt. and the genesis of the illness and the cure must be fully understood by the supportive family or mentors. These support persons need to be able to accept the Pt. in every stage of the continuance of his/her emotional and intellectual development with validation of emotional expressions while providing guidance for the Pt. whose task includes learning the ways to guide and express those emotions on the pathway to their full maturation in the light of informed reason. The helper has to be availability to affirm these efforts and expressions of Pt's emotions by the helper's affective, facial, and then verbal presence.

a developed and integrated emotional life to the point that they could recognize the unique goodness of the client and revel that to the client.

The "affirming companions" would need to be well affirmed themselves. They would need to have their own support system as they deal with the emotional triggers they would experience. They should be trained similarly to the level of non licensed substance abuse counselors.
They would need emotional maturity and have a motherly or fatherly presence, role. I also believe that they need much time to be present to the client. If someone is too busy or rushed they will simply re-injure the client.

Follow the principles outlined in BORN ONLY ONCE

As much as humanly possible for outside companions/mentors be relatively mature emotionally, to will the good and wellness of the other for his/her own sake and respecting their religious/moral beliefs; where outside folk embrace where the client is at in their respective stage of change; stage of treatment all the while supporting/encouraging change wherever/whenever the client is open and receptive to that change. However, the outside resources must not provide therapy per se but be mentors/supports for the client. It is advised these mentors/companions consult with therapist and client with appropriate releases so as to provide a comprehensive treatment plan with therapist and outside resources/mentors/companions.
APPENDIX R

Participants’ Therapeutic Relationships with Clients who have

Emotional Deprivation Disorder
In one sense no. All clients deserve our best genuinely affirming behaviors. But, persons with EDD may need more time and patience - also gentleness.

Yes. Once it is clear that a client has EDD, and as long as there is no concomitant psychopathology, I will be more open to share about some aspects of my own life that may be helpful to the client. In addition, a session with an EDD client may seem more informal as I allow the client simply to be and share who they are. The focus of therapy is to help them find what's good about themselves, therefore we won't focus on problems per se. In some instances I may spend time with the client "living the affirming life", e.g. taking a walk in a park or on the beach to experience beauty and allow their hearts to engage and experience their emotions.

I would not use Cognitive Behavioral Therapy, although I would help the patient correct negative thinking. But my approach would be emotion-led and I would always be receptive the goodness, beauty and truth of the patient, no matter how difficult they might be.

I think affirming others in the sense that Conrad Baars spoke of is good therapy practice that can be used with most clients. Maybe not narcissistic personality disorders but for the most part, most people respond well to authentic affirming and often lack this in their life. One thing I have done that I don't do with others who are not experiencing EDD is helping them experience their senses and allowing these senses to help them. At the same time, I as a therapist often help most clients learn how to use their emotions with reason and free will (in secular setting I use the words "logic or thinking" instead of reason and "choices" instead of free will).

The most important component in treating EDD is the full presence of the therapist to the pt. with a heartfelt caring. Therapist has to bring this to every session along with the acknowledgment and validation of emotional expressions of pt. meeting Pt where s/he is and re-parenting them with the unconditioned loving regard of a loving parent for his/her child within the moral order as the Pt grows his/her emotional, intellectual and spiritual life. Patients who present as affirmed may be better treated with cognitive/behavioral, gestalts, group modalities whereas the EDD Pt. necessitates an affirmation therapy; i.e. being present not just doing things.

No, because affirmation is simply love seen from a psychological point of view. And not all those with EDD have the same temperament or personality. Each client is treated as an individual. Love is only individual.
APPENDIX R

Participants’ Therapeutic Relationships with Clients who have EDD

I see most clients on a continuum of affirmation. Depending upon where they fall on the continuum will determine how much I move them toward the cognitive elements relating to emotion and behavior. My EDD clients receive minimal addressing of their thought processes. When I address thoughts with an EDD client, I quickly move back into affirming them where they are at that moment. EDD clients are quite defensive if their thoughts are challenged even minimally.

I am more gentle with a person with EDD. I sometimes see them more often than I would a typical client. Our conversations rarely focused on psycho-education, skills, or diagnosis. The conversations are simply about how their week was, how they felt, what they did etc.

Yes. To fill in what was lacking, time-attention-listening-affirmation-patience--- this brings needed confidence and appreciation of feelings and one’s own identity.

No, treat the EDD or non-EDD client with equal respect/dignity and be present/attuned to client’s entire emotional life and well-being.
APPENDIX S

Answers from Expert therapists for Theme 2, Subtheme A: *Childish feelings*
APPENDIX S

Answers from Expert therapists for Theme 2, Subtheme A: *Childish feelings*

a. "Undeveloped" could be “under developed” or "immaturely underdeveloped."
Otherwise, Yes, Yes, Yes (some of these, e.g. "lack of self-worth" overlap the next sub-theme).

b. "Undeveloped emotional life" is brilliant, brief description of part of the suffering of such patients. I agree with all the criteria listed under the theme.

c. "Stage of psychological development” and Immature emotional life might be better stated as "immature emotional developmental stage that does not match chronological age." "Fear of being themselves' doesn't seem clear to me because they don’t know themselves well enough to even fear being themselves.

d. I agree with the theme and sub theme. Perhaps under criteria adding

Expresses emotions in an immature way." i.e. when angry, "throws tantrums" etc.

e. Theme 2: Underdeveloped and unexplored emotional life.

f. Difficulty with emotional self-regulation. Agree with above.

g. Yes, I agree. These criteria describe well the plight of the unaffirmed.

h. Yes... Childish feelings.... I don't like the name of this sub theme at all. But the criteria I agree with are: Possible anxiety and depression. Lack of trust in his/her emotions. Over sensitive/easily offended, Disconnect from own feelings. Poor understanding of emotions. Inability to name and/or express emotions, operating only on fear and anger (but I think it should be and/or anger).
I have seen folks operating only on fear or only on anger, Poor development of senses, fear of being themselves..... I think also just fear of being and instead believes self esteem is tied into doing. Immature emotional life or maybe another way of saying... inability to use emotions to help oneself and others. Tends to react on fear and/or anger rather than taking a step back and using reason to help. Poor sense of self and lack of self worth.
APPENDIX T

Answers from Expert therapists for Theme 2, Subtheme B:

*Feelings of inadequacy and inferiority*
APPENDIX T

Answers from Expert therapists for Theme 2, Subtheme B:

Feelings of inadequacy and inferiority

a. Not sure what this means: "The presence of existential fear." Also, "assertiveness also relates to: "relational connection" Theme. Yes, Yes. Yes

b. Again, the fear is a result of the underdevelopment.

c. Theme and sub theme seem correct. Remove: "Presence of existential fear in the client" Leave: “The presence of existential fear " "Fear of not being accepted/discounted" I would remove "discounted". The EDD client doesn’t believe their thought and feelings have validity. I would remove "Lack of assertiveness - Non-assertive in expressing own feelings - Poor assertiveness" I would simply state "non assertive.". Remove: "Expressed feelings of inferiority"

d. I agree with the sub theme. What about adding inability to establish boundaries for fear of being rejected? I am not sure if this would fit better under category 6.

e. See above for better title: undeveloped and unexplored emotional life

f. Substance use to mask feelings of inferiority Agree with above; question what is meant by "presence of existential fear in the client"
APPENDIX U

Answers from Expert therapists for Theme 2, Subtheme C:

*Feelings of uncertainty and insecurity*
APPENDIX U

Answers from Expert therapists for Theme 2, Subtheme C:

*Feelings of uncertainty and insecurity*

a. Being "shut down emotionally" gets into the phenomenon of repression and suppression. We have to be careful not to confuse the subjective with the objective. One may feel shut down, but what is actually taking place? Is it a lack of development, or, rather, an act of repression?

b. I agree with the theme and sub theme "Cannot fully feel their emotions and use these to help them" I would remove In favor of : "does not identify emotions in self or others" Note: In differential diagnosis, I wonder if some of those persons being diagnosed with high functioning autism are actually EDD persons.

c. I agree with the theme and sub-theme. Perhaps under criteria adding changing mind often.
APPENDIX V

Answers from Expert Therapists for Theme 2, Subtheme D:

*Self-affirming behaviors*
APPENDIX V

Answers from Expert Therapists for Theme 2, Subtheme D:

*Self-affirming behaviors*

a. I would call this "pseudo" self-affirming behaviors. Self-affirmation may be authentic. Yes, Yes, Yes

b. Yes, I would add that they attempt to extort affirmation from others by their self-affirming behaviors that only alienate others and further their despair

c. Such patients are often so overwhelmed with fear that their cognitive abilities are clouded and impeded.

d. I agree with the sub theme and criteria. Possible addition. Focus on doing rather than just being.

e. I would say the first two criteria do not apply to self-affirmation. The second two criteria use the same term "self-affirming" as the sub-theme. One can’t define or limit a term using the same term.

f. bravado energetic externalization "acting" basing one's behavior on the style and values of an idealized hero

g. Substance use to give an air of pseudo-confidence and/or hide insecurities.