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Research Article

The psychopathological roots of affective dependence: The origin and clinical evolution of the toxic bond

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Abstract

Background and aims: Starting from the concept of "affective addiction", then reworked and critiqued according to a clinical key, it was hypothesized that it is not a behavioral addiction, as erroneously determined by modern psychiatry, but is a symptom of a well-identified personality disorder. The purpose of this research is to test the correctness of this hypothesis.

Materials and methods: Clinical interview, based on narrative-anamnestic and documentary evidence and the basis of the Perrotta Human Emotions Model (PHEM) concerning their emotional and perceptual-reactive experience, and administration of the battery of psychometric tests published in international scientific journals by the author of this work: 1) Perrotta Integrative Clinical Interviews (PICI-2), to investigate functional and dysfunctional personality traits; 2) Perrotta Individual Sexual Matrix Questionnaire (PSM-Q), to investigate the individual sexual matrix; 3) Perrotta Affective Dependence Questionnaire (PAD-Q), to investigate the profiles of affective and relational dependence; 4) Perrotta Human Defense Mechanisms Questionnaire (PDM-Q), to investigate the defense mechanisms of the Ego.

Results: In a population sample of 206 subjects (103 m/f couples, in a stable relationship for at least 1 year and heterosexual), it was found that the totality exhibited at least 5 dysfunctional personality traits of the borderline, dependent, and masochistic types, with secondary traits of the neurotic, narcissistic covert, psychotic and histrionic types. Almost the totality of the sample also showed marked dysfunctionality of a sexual nature and activation of defense mechanisms typical of psychopathological processes.

Conclusions: The data obtained confirmed the study hypothesis, and it is, therefore, plausible to think that affective addiction is not a behavioral addiction but a manifested symptom of a broader framework of personality disorder and that it is established in subjects with the same dysfunctional personality traits. Such subjects, in close relational contact, hyperactivate themselves, according to a logic of pathological determinism. The maintenance of hyperactivation then facilitates the decompensation of the subject's psychopathological picture, reinforcing dysfunctionality and feeding the pathological circle that keeps one's personality structure alive, in a continuous feeding determined by the similar or same-natured traits present in the partner. This also explains why, once affective dependence is established, it is so complicated to succeed in breaking the chain of events that keeps the dysfunctional relationship alive, since overactivation prevents a correct, conscious, and rational assessment of the factors at play in relationships between elements and people. To summarize: the more the hyperactivation persists, the more it reinforces the psychopathological decompensation that keeps alive both the toxic relationship and the bond between the two individuals who, while tending toward destruction or self-destruction, fail to break the affective, sentimental, and sexual bond, maintaining over time an increasingly toxic dysfunctional attachment.

Contents of the manuscript

Introduction and background

In the literature, "Affectivity" is an aspect of psychic functions that define the spectrum of emotions (more primary, instinctive, immediate) and feelings (more reworked, reasoned, mediated by time and circumstances) positive and negative of man, in response to the environment in which he lives and the social relationships that surround him, characterized by a link between two or more individuals of intensity and/or intimacy. "Affections", meaning intense and intimate ties between two or more people who feel emotions and feelings, must, therefore, be distinguished from: a) "passions", understood as persistent, impetuous, and intense moments that cause well-being and pleasure, if experienced and nurtured over time; b) "impulses", understood as fleeting, instinctive and intense moments,

which provoke somatic (state of tension) and emotional (state of) excitement, if experienced and nourished in the moment; c) "emotions", understood as psychic states consisting of the sudden and instinctive reaction of the organism to perceptions or representations that disturb the homeostatic balance; d) "feelings", understood as states of mind that re-elaborate, reason and mediate over time the impulses, passions, and emotions, feeding the affective system of an individual towards objects, people, or animals. Many human actions, therefore, are erroneously attributed to the sphere of rationality, instead containing an affective determinant. Everything, event, and object has the affective coloring that manifests itself in the individual subject through states of mind variegated and grouped, schematically, within two opposite poles such as, for example, love-hate, joy-sadness. About their specific characteristics, such as intensity and duration, moods can be cataloged as emotions and feelings [1].

Generally, when we indicate alterations in the emotional-affective tone we refer to a whole series of morbid conditions, which have a dysfunctional tone as a common basis; just think of anxiety disorders, among which we find panic, phobias, separation anxiety (at the basis of many psychotic and personality disorders) and generalized anxiety, eating disorders, obsessive-compulsive disorder, post-traumatic stress disorders, somatic syndromes, mood disorders (such as depression, dysthymia, cyclothymia, and suicidal risk), behavioral and substance addictions, bipolar disorder, paraphilic disorder and also a large part of personality disorders. And it is precisely in personality disorders that dysfunctional affectivity becomes a real addiction, often confused even by technicians and therapists (and wrongly treated in psychotherapies) as a new "behavioral addiction" (the so-called "love addiction"), according to one's perception of reality, until it evolves into the largest form: the "personality addiction disorder". Although effective addiction, due to a lack of experimental data, is not included among the mental disorders diagnosed in the DSM-5 (the Diagnostic and Statistical Manual of Mental Disorders), it is erroneously classified among the "New Addiction", new behavioral addictions, including Internet addiction, pathological gambling, sex addiction, sports addiction, compulsive shopping, and work addiction [1,2-31].

All aspects that overwhelmingly recall signs and symptoms of psychopathological personality profiles. In clinical practice, one often encounters patients who are unable to break deeply destructive intimate relationships, which generate suffering and compromise their lives on various levels; this happens, in fact, in the most extreme form of addiction: the "dependent personality disorder". But it also happens to detect this symptom (or this behavioral mode) even in personality disorders such as histrionic, borderline, and narcissistic. In the hypothesis of borderline personality disorder, on the other hand, emotional dependence is necessary to continue to maintain the bond with the person on levels of high instability, first favoring a morbid attachment and then a clear separation, alternating these behaviors in synchronization; we can, therefore, say that in the borderline patient, attitudes of dependence are not equivalent to the need for dependence in the strict sense of the word but to maintain the bond with the person, even if between "ups and downs", thus favoring instability and excessive reactivity to facts or events that are completely harmless or potentially not risky for the stability of the couple or the emotional bond. Finally, in the hypothesis of narcissistic personality disorder, the patient implements modalities of affective dependence in the hypothesis of "covert" narcissism, i.e. the form that foresees low self-esteem and high sensitivity to criticism. It is no coincidence that all the predisposing factors, according to the etiopathogenetic model of "love addiction" (the presence of traumas of emotional abuse and emotional neglect, worried and fearful attachment styles, the presence of dissociative symptoms on a pathological level, the difficulty, clinically significant, in regulating emotions) further recall the psychological and environmental factors of the personality disorders mentioned above [1,32].

The primary objective of this study is to demonstrate that effective dependence cannot be considered a behavioral addiction disorder or confused with a dependent personality disorder but is a true symptom of a more articulated and complex psychopathological picture that falls into one of the categories found in the PAD-Q report [33,34], the questionnaire for investigating the possible presence of affective dependence. The secondary objective, on the other hand, concerns the confirmation of the organizational accuracy, both structural and functional profile, of the aforementioned questionnaire.

Materials and methods

Starting from the classic definition of "affective dependence", the present research extended the survey to the above hypothesis by examining 462 results found on Pubmed, selecting from January 1972 to July 2022 all experimental clinical trials and observational research. Having a clear definition and clinical context, the population sample was selected to which the following clinical instruments were administered: 1) Clinical interview, based on narrative-anamnestic and documentary evidence and the basis of the Perrotta Human Emotions Model (PHEM) concerning their emotional and perceptual-reactive experience; 2) Administration of the battery of psychometric tests published in international scientific journals by the author of this work: a) Perrotta Integrative Clinical Interviews (PICI-2), to investigate functional and dysfunctional personality traits; b) Perrotta Individual Sexual Matrix Questionnaire (PSM-Q), to investigate individual sexual matrix; c) Perrotta Affective Dependence Questionnaire (PAD-Q), to investigate affective and relational dependence profiles; d) Perrotta Human Defense Mechanisms Questionnaire (PDM-Q), to investigate ego defense mechanisms.

The phases of the research were divided as follows

1) Selection of the population sample, according to the parameters indicated in the following paragraph.

2) Clinical interview, with each population group.

3) Administration of the Perrotta Integrative Clinical Interviews (PICI-2), Perrotta Individual Sexual Matrix Questionnaire (PSM-Q), Perrotta Affective Dependence Questionnaire (PAD-Q) e Perrotta Human Defense Mechanisms Questionnaire (PDM-Q).

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4) Data processing following administration.

5) Comparison of data obtained.

Setting and participants

The requirements decided for the selection of the sample population are

1) Age between 18 years and 67 years, healthy and robust constitution, and in the absence of psychopathological symptoms or confirmed diagnoses.

2) Italian nationality, with Italian ancestors in the last two generations.

3) Candidate's subjective statement about his or her romantic relationship for at least 1 year, in heterosexual orientation, which is characterized by a dysfunctional, complicated, unhappy, or otherwise perceived as a toxic bond that needs to be broken.

The selected setting, taking into account the protracted pandemic period (already in progress since the beginning of the present research), is the online platform via Skype and Video call Whatsapp, both for the clinical interview and for the administration.

The present research work was carried out from March 2021 to May 2022. All participants were guaranteed anonymity and the ethical requirements of the Declaration of Helsinki are met. Since the research is not financed by anyone, it is free of conflicts of interest. The selected population clinical sample, which meets the requirements, is 206 participants o 103 couples (with each other in a binary, heterosexual, monogamous, stable romantic relationship), divided into five groups Table 1.

Results and discussion

After the selection of the chosen population sample (first stage), we proceeded with the clinical interviews (second stage), from which the first significant data emerged.

1. Looking at the total population sample (206/206), we immediately notice the greater popularity of 38-47-year-olds (31.1%) compared to other groups. Finally, the interviews show that the geographical origin of origin (family) is well distributed in all areas, confirming that the phenomenon of affective dependence is cross-sectional and not affected by this characteristic. These preliminary results would suggest, however, that the phenomenon under investigation has a greater tendency to occur in the female group, the core group of young adults and adults, and missed in the mature age group: these findings suggest that at a younger age the phenomenon is markedly perceived in the female population, while as age advances it is the male population that feels the brunt of the relational dysfunctionality more strongly, with a higher index of endurance/resignation of the female partner.

2. Using, during the interview, strategic language [29,30] and Perrotta's Human Emotions Model (PHEM) [35], it was found that the entirety of the selected population sample exhibits a complete distress orientation, facilitating feelings such as guilt, shame, anger, fear, and disappointment, in the presence of past (childhood) and current (interpersonal and work) family trauma.

The third stage of the research focused on the administration of the battery of questionnaires and these revealed the following results

1. ***Administration of the Perrotta Integrative Clinical Interviews (PICI-2)* [36-41]:** Regarding the analysis of dysfunctional traits (PICI-2TA): the primary disorder that emerged with at least 5 traits, in the male population was borderline disorder (46/103 or 44.7%), dependent disorder (21/103 or 20.4%), and narcissistic covert disorder (11/103 or 10.7%); in the female population, on the other hand, the primary disorder that emerged with at least 5 traits was masochistic disorder (28/103 or 27.2%), borderline disorder (22/103 or 21.4%) and narcissistic covert disorder (16/103 or 15.5%). In 202/206 (98%), the following disorders emerged as comorbidities: ADHD (in the under-37 population), body dysmorphism, ICT disorder, sleep disorders, eating disorders, anxiety and mood disorders, paraphiliac disorders, and behavioral addictions (especially technology and internet addiction). The concrete risk of suicide emerged in 7/206 cases (3.4%), while the presumed risk or demand for attention emerged in 109/206 (53%) Table 2.

Another significant finding emerges from the correlation between the condition suffered and the heavy use of tattoos on the body [42]: 98/206 or 47.6% have tattoos on more than 15% of the body. On the other hand, in the analysis of functional traits (PICI-2FT), it was found that the classes most impaired because they tended to be dysfunctional (with values of 0 or 4) were those referring to self-control, sensitivity, action, Ego-Id comparison, emotionality, ego stability, safety, and relational functionality, again reiterating the marked dysfunctional tendency of the clinical population. The preference for administering the PICI-2 over other widely validated and used psychometric tests, such as the MMPI-2, was motivated by reasons of expediency: in fact, previous research has demonstrated the efficacy and efficiency, sometimes better indicated, of the PICI-2 over the MMPI-2, in terms of performance and completeness of diagnosis. The data obtained bring out a clear, evident, and marked dysfunctionality

Table 1: Population sample (numerousness).

Age	Male	Female	Total
18-27	20	20	40
28-37	27	27	54
38-47	32	32	64
48-57	18	18	36
58-67	6	6	12
Total	103 (50%)	103 (50%)	206 (100%)

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Table 2: Comparison table of couples by three principal psychopathological traits (PICI model). Legend: 1: Borderline; 2: Dependent; 3: Masochistic; 4: Narcissistic Covert; 5: Psychotic; 6: Neurotic; 7: Histrionic. The figure within the brackets represents the number of dysfunctional traits of the type under consideration.

N. couple	Primary traits (equal to or greater than 5/9)		Secondary traits (less than 5/9)	
	M	F	M	F
1	1(5)	3(5)	4(4)	1(4)
2	2(7)	3(6)	4(3)	2(4)
3	2(5)	5(5)	5(3)	2(4)
4	1(5)	5(6)	3(4)	1(3)
5	7(7)	1(5)	1(4)	7(4)
6	2(5)	3(5)	3(4)	2(3)
7	5(5)	1(6)	1(4)	5(4)
8	1(7)	4(5)	4(4)	1(3)
9	2(6)	5(5)	5(3)	2(4)
10	1(5)	3(5)	4(4)	1(3)
11	5(5)	2(5)	2(3)	5(4)
12	7(5)	1(5)	1(4)	7(4)
13	1(6)	3(5)	2(4)	1(3)
14	4(7)	6(5)	5(3)	4(4)
15	7(5)	1(6)	3(4)	7(3)
16	4(5)	7(5)	7(4)	4(4)
17	1(5)	3(6)	2(3)	1(3)
18	5(5)	1(6)	1(4)	5(4)
19	6(7)	3(6)	3(3)	6(4)
20	5(8)	3(5)	3(3)	5(3)
21	1(6)	3(5)	7(4)	1(4)
22	2(6)	7(5)	7(3)	2(4)
23	5(5)	1(5)	3(4)	5(3)
24	4(5)	6(5)	7(4)	4(4)
25	7(7)	1(7)	1(3)	7(3)
26	1(6)	3(5)	6(4)	1(3)
27	2(5)	4(6)	4(3)	2(3)
28	2(7)	7(5)	7(4)	2(3)
29	1(5)	4(6)	6(3)	1(3)
30	7(6)	6(5)	6(4)	7(4)
31	2(6)	7(7)	7(4)	2(3)
32	1(5)	3(5)	3(3)	1(4)
33	5(5)	7(5)	7(4)	5(4)
34	6(5)	1(5)	1(4)	6(3)
35	4(6)	7(5)	7(3)	4(4)
36	2(5)	3(5)	3(4)	2(4)
37	1(5)	3(6)	2(4)	1(3)
38	1(5)	2(6)	4(3)	1(3)
39	1(6)	2(5)	4(4)	1(4)
40	1(5)	4(5)	4(3)	1(4)
41	3(5)	7(6)	7(4)	3(3)
42	1(6)	7(5)	6(3)	1(4)
43	4(7)	1(6)	1(4)	5(4)
44	2(5)	7(6)	7(3)	2(4)
45	1(7)	3(5)	6(4)	1(4)
46	3(5)	7(5)	7(4)	3(3)
47	5(6)	1(5)	1(4)	5(3)
48	2(5)	4(5)	4(3)	2(3)
49	1(6)	3(7)	4(4)	1(3)
50	1(5)	4(5)	4(4)	1(3)
51	3(6)	1(5)	1(4)	3(3)
52	2(7)	4(6)	4(4)	2(4)
53	1(6)	3(7)	4 (3)	1(3)
54	7(5)	1(6)	1(4)	7(3)
55	1(5)	6(6)	5(4)	1(4)
56	4(6)	1(5)	1(3)	3(3)
57	1(5)	3(5)	6(4)	1(4)
58	3(6)	1(7)	1(4)	3(3)
59	5(5)	1(6)	1(4)	5(4)
60	4(5)	2(5)	2(4)	4(3)
61	1(6)	6(6)	6(3)	1(4)
62	1(5)	3(5)	4(4)	1(3)
63	3(6)	4(7)	4(4)	3(4)
64	2(6)	1(5)	1(3)	2(3)
65	1(5)	6(6)	6(4)	1(4)
66	1(5)	3(5)	3(4)	1(3)
67	3(5)	1(6)	1(3)	4(4)
68	2(5)	3(5)	4(3)	2(3)
69	1(6)	4(6)	4(3)	1(4)
70	2(5)	4(7)	4(4)	2(3)
71	4(6)	7(5)	7(4)	4(4)
72	1(5)	6(5)	2(4)	7(3)
73	4(6)	2(7)	2(4)	4(4)
74	4(5)	1(6)	1(3)	4(4)
75	1(6)	4(5)	4(4)	1(4)
76	1(7)	2(6)	3(4)	1(3)
77	1(6)	3(5)	3(3)	7(4)
78	2(5)	4(7)	4(4)	2(3)
79	1(6)	3(5)	2(4)	1(3)
80	2(6)	3(7)	3(3)	7(3)
81	1(6)	3(5)	3(4)	1(4)
82	4(5)	2(7)	2(3)	6(4)
83	1(5)	7(6)	7(4)	1(4)
84	2(7)	1(5)	6(4)	2(4)
85	1(5)	6(6)	6(3)	3(3)
86	2(6)	3(5)	2(4)	2(4)
87	1(5)	7(6)	7(3)	1(4)
88	6(5)	2(5)	2(4)	6(4)
89	1(7)	6(5)	6(3)	1(3)
90	3(7)	1(5)	6(4)	3(4)
91	1(6)	3(5)	2(4)	1(4)
92	1(5)	4(5)	4(3)	1(4)
93	2(6)	6(6)	6(4)	2(4)
94	6(5)	3(7)	3(3)	6(4)
95	1(6)	6(5)	6(4)	1(3)
96	1(5)	3(5)	4(3)	1(4)
97	1(5)	4(7)	4(4)	1(4)
98	2(5)	1(6)	1(3)	2(3)
99	1(6)	4(5)	4(4)	1(4)
100	1(7)	2(6)	2(3)	1(3)
101	1(6)	3(5)	2(4)	4(4)
102	1(5)	1(6)	4(3)	1(3)
103	1(6)	3(5)	2(4)	4(3)

of traits in the totality of the sample studied and notes that within each m/f couple there are common traits of the same psychopathological type, albeit to varying degrees, confirming that in the personality pictures of the individual members of the couple there is the presence of the same pathological traits that are somehow hyperactivated in the presence or constancy of direct, continuous and stable relationship with the partner.

2. ***Administration of the Perrotta Individual Sexual Matrix Questionnaire (PSM-Q)* [43,44]:** PSM questionnaires showed that 177/206 (85,9%) claimed to have experienced severe psychological or physical abuse at a young age, intra-parental relational imbalance, or otherwise a sexual upbringing that was not open and lacked free communication. Concerning dysfunctional psychophysical sexual conditions, 201/206 (97,6%) declared themselves to be sexually dissatisfied because

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they suffer from a sexual pathology or because they do not find complete fulfillment of their urges, fantasies, and paraphilias; circumstances that emerged later and were confirmed by questionnaire C and questionnaire D, as well as by the test on dysfunctional sexual behavior (in the latter case, with scores all above 30/50). On the other hand, questionnaires A and B on sexual relational style showed in 188/206 (91.3%) a polygamous tendency that was nevertheless dysfunctional, sublimated into monogamy but tending toward omission and cheating (the latter with scores above 28/50 and 38/75). These data show that almost the entire sample population exhibits severe forms of pathological affective dependence concerning the reference partner, while only for 5/206 (2.4%) there does not appear to be this relationship probably because the subjects have been in the relationship for a relatively short time (they are all relationships under 2 years in duration) and because their personality pictures, when screened by PICI, detect a markedly severe psychopathological nature, with at least 6-7 basic pathological traits and therefore their relationship is in itself already marred by this condition.

3. ***Administration of the Perrotta Affective Dependence Questionnaire (PAD-Q)* [33,34]:** The administration of the questionnaire confirmed the finding that emerged indirectly during the administration of the PICI-2, specifying the weights involved: 89/95 (93.7%) for the male sample and 107/110 (97.3%) for the female sample had a pathological score higher than 95/175 (54.3%), for an overall total score of 196/205 (95.6%), with a greater accentuation of types V (borderline), II (dependent) and IV (masochistic) in that descending order, demonstrating on the one hand that the condition of affective dependence is equally marked and indicative of PICI values and at the same time relevant in the totality of the sample, which has secondary traits of types VI (narcissistic covert), VII (psychotic), I (neurotic) and III (histrionic).

4. ***Administration of the Perrotta Human Defense Mechanisms Questionnaire (PDM-Q)* [45,46]:** The administration of the questionnaire reported the following data: in 203/205 (99%) values of 4 and 5 were found on the mechanisms of isolation, denial, regression, reactive formation, denial, projection, removal, withdrawal, instinct, repression and idealization, confirming the widespread psychopathological tendency of the framework of ego function.

Conclusions

In conclusion, data obtained from the administration of the clinical interview and questionnaires brings out the confirmation of the study hypothesis. It is plausible to think that affective dependence is established in subjects with the same dysfunctional personality traits and that in close relational contact these become hyperactivated in turn, according to a logic of recognition and pathological determinism. The maintenance of hyperactivation then facilitates the decompensation of the subject's psychopathological picture, reinforcing dysfunctionality and feeding the pathological circle that keeps one's personality structure alive, in continuous feeding determined by the similar traits or traits of the same nature present in the partner. This also explains why, once emotional dependence is established, it is so complicated to succeed in breaking the chain of events that keeps the dysfunctional relationship alive, since hyperactivation prevents the correct and rational evaluation of the factors at play and the relationships between elements and people; the more the hyperactivation persists, the more the psychopathological decompensation is reinforced that keeps alive both the toxic relationship and the bond between the two individuals who, while tending toward destruction or self-destruction, are unable to interrupt the affective, sentimental and sexual bond, maintaining over time a dysfunctional and increasingly toxic attachment.

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