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Research Article

The diagnosis of personality traits in "affective dependency": When the toxic bond is an expression of a personality disorder

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Abstract

Purpose: This research deals with the issue of dysfunctional personality traits in reference to affective dependency. In this research, the theme is aimed at the psychopathological investigation of personalities, according to the PICI-2 model and the PAD-Q, of all those subjects who with conscience and will complain of an emotional or sentimental relationship of a toxic or unhappy type with the partner.

Methods: Clinical interview and administration of the PICI-1 and PAD-Q.

Results: The use of the PAD-Q is functional to identify the dysfunctional personality traits that can explain the type of "affective dependency" of the patient; this indication must then always be compared with the data that emerged from the administration of the PICI-2 and the clinical interview, to ensure that the main disorder and the secondary ones are properly framed. The research on a population sample of 794 people demonstrated: 1) the affective dependency is to all effects a behavioral manifestation that cognitively represents a precise psychopathological trajectory grafted into a dysfunctional personality framework; 2) the erroneous placement of affective dependency among behavioral addictions is also confirmed here, as it is a psychopathological representation of a personality disorder to be identified and which pertains to one or more of these categories: a) affective-neurotic (anxious, maniacal, depressive or obsessive); b) dependent (dependent); c) histrionic (histrionic); d) masochist (masochist); e) borderline (bipolar and borderline); f) covert narcissist (covert narcissist); g) psychotic (psychopath, schizophrenic, schizoid, schizoaffective, schizotypic, dissociative).

Conclusions: The data emerging from the male population sample (336/794) finally show that only 12.5-20% have a clinically relevant diagnosis of "affective dependency" (these findings show that the toxicity of the affective-emotional-sentimental relationship is not attributed to a cause of affective dependence but rather to causes of another nature capable of interfering with the normal intimate relationship), while the female population (458/794) reports a clinically relevant value in 100% of the cases analyzed; however, it should be emphasized that this dependence dynamic represents a symptom of a specific personality disorder and therefore the dependency pattern becomes in the emotional relationship a real nourishing cause of the toxicity of the relationship, a sort of means to obtain a secondary benefit of nature dysfunctional -which feeds the psychopathology itself-, resistant even during psychotherapies possibly carried out by patients in the past.

Contents of the manuscript

Introduction and background

Starting from the concept of "affective dependency" [1] and from the research work of the writer during the drafting of the Perrotta Affective Dependency Questionnaire (PAD-Q) [2], this research intends to demonstrate that this specific nosography of behavioral dependence (indicated in the Diagnostic and Statistical Manual of Mental Disorders, DSM-V) [3] does not it can be reduced to a simple categorization in the list of addictions, although it has clinical and neurobiological aspects in common that could be misleading. In fact, the

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dependent manifestation is nothing more than a symptom that from time to time represents a specific element in various personality disorders, becoming the central focus of the dependent personality disorder. The analytical approach must, therefore, be multidimensional, precisely to better understand all the aspects of emotional dependence and how it "colors" the manifested disorder from time to time. From affective dependence to personality disorders, in relation to the dynamics of the human bond, to the implications determined by attachment theory, in a diagnostic transversal framework, to demonstrate the hypothesis through the use of Perrotta Integrative Clinical Interviews (PICI-2) [4-9] and PAD-Q, starting point at the base of the second questionnaire.

Another interesting in-depth note, at the basis of this work, concerns the use of the term "emotional" in almost all international publications on the subject of behavioural addiction to emotional ties. The writer here disputes the use of the above term, explaining why: although the English language uses the same term to indicate two or more concepts, the terms "affection" and "emotion" are intrinsically different, because the first refers to an intimate bond between two or more people made up of several emotions, while the second is a state of mind at the basis of human action; therefore using the binomial "affective dependency" with the term "emotional" is technically wrong for the following two reasons: a) bond dependency pertains to the affective profile and not to the field of emotions, which are indeed at the basis of human action but do not explain the essence of bonding and interdependence; b) semantically, the term "affect" is different from the term "emotion" and therefore the concepts expressed follow different interpretative tracks, although related to the more general theme of human emotional bonds. The best use is surely "*affective dependency*", precisely because it relates to the sphere of affects and not simply emotions. The same argument should be made for the incorrect use of "love addiction", as the term "love" is too generic and does not take into consideration all those hypotheses where it is more related to the sphere of affects and not of feelings, also taking into account that "Love" would imply a stable, lasting, lived and shared relationship, with clear and precise objectives. Also "love" is therefore an improper use and more used in journalism [10].

Research objectives, methods, limits and conflicts of interest

This research deals with the issue of dysfunctional personality traits in reference to affective dependency. In this research, the theme is aimed at the psychopathological investigation of personalities, according to the PICI-2 model and the PAD-Q, of all those subjects who with conscience and will complain of an emotional or sentimental relationship of a toxic or unhappy type with the partner.

The phases of the research were divided as follows:

1) Selection of the population sample.

2) Individual clinical interview.

3) Administration of the PICI-1 to each population group.

4) Data processing following administration.

5) Administration of the PAD-Q.

6) Data processing following administration, in relation to data obtained from clinical interviews and the administration of the PICI-1 and PAD-Q.

All participants were guaranteed anonymity and respects the ethical, moral and clinical content of the 1964 Declaration of Helsinki.

The main limitations of the research is one: The PICI-2 and PAD-Q are not yet standardised psychometric instruments but are proposed, despite the excellent results obtained and already published in international scientific journals [2,9].

This research has no financial backer and does not present any conflicts of interest.

Setting and participants

The requirements decided for the selection of the sample population [with a method of random sampling and recruitment via social networks, direct and indirect acquaintances and contacts with e-mail and interview via telematic platforms (whatsapp video, FB messanger, skype and zoom)], are:

1) *Age between 18 years and 77 years.*

2) *Residence or domicile on Italian territory for at least 5 year*, regardless of nationality and/or citizenship.

3) *Well-defined male or female gender*, regardless of sexual orientation. During the execution of the research, the need emerged to distinguish the selected population sample also with respect to their sexual orientation, dividing them into the following categories: heterosexuals (A), homosexuals (B), bisexuals (C). Transsexual populations are excluded from the selected sample because in a previous research they totaled extremely high pathological values, capable of significantly distorting the research data [11,12].

4) *Absence of psychopathological diagnosis.*

5) *Statement of an unstable, insecure, unhappy or toxic emotional-emotional relationship for at least 2 years*, with a stable partner and an active level of awareness of the persistent malaise for at least 6 months, or that you have ended a relationship that you consider "toxic or unhappy" for no more than 24 months.

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 Videocall Whatsapp, both for the clinical interview and for the administration.

The present research work was carried out from June 2020 to June 2021 (12 months).

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The selected population sample is 794 participants, divided into male and female, six groups by age and three by sexual orientation (Table 1).

Results

Following the selection of the chosen population sample (first phase), the clinical interview (second phase) and the assessment about PICI-2 [8,9] (third phase) and to the processing of the data (fourth phase), in order to obtain the clinical findings necessary and useful (Table 2).

The subsequent phases were carried out by submitting to the selected population sample the PAD-Q test, in order to obtain the clinical findings necessary and useful (Table 3).

The research on a population sample of 794 people demonstrated:

1) On the Clinical interview, the entire sample of the population selected (672/794, 84,6%) was represented with an emotional, affective or sentimental malaise that was well aware and attributable to the emotional relationship with the partner; however, this awareness was not accompanied by the need to interrupt the relationship or find solutions for solving problems, remaining focused exclusively on the level of complaints and attempted solutions.

2) On the PICI-2, the data are even more significant and expressive a precise psychopathological diagnosis of personality [11,13-37]. In particular:

a) In the *male population* (336/794), the selected sample was completely psychopathological (336/336, 100%), with at least 5 dysfunctional traits in at least 1 specific personality disorder (Table 4). The data that emerged show that, with respect to the selected sample, heterosexual young people between 18 and 47 years have a neurotic prevalence (anxious, depressive and obsessive), while both homosexual and bisexual young people, as well as the rest of the selected sample, have a clear borderline prevalence (bipolar, borderline, histrionic, narcissistic and antisocial). Psychotic

Table 1: General population sample.

Gender of the sample Population	Bunds of age	Sexual orientation and sample number	% single sample	% Total sample (794)
Male	18-27	A = 15/25	60%	1.89 %
		B = 8/25	32%	1.01 %
		C = 2/25	8%	0.25 %
Male	28-37	A = 32/54	59.3 %	4.03 %
		B = 18/54	33.3 %	2.27 %
		C = 4/54	7.4 %	0.5 %
Male	38-47	A = 77/103	74.8 %	9.7 %
		B = 24/103	23.3 %	3.02 %
		C = 2/103	1.9 %	0.25 %
Male	48-57	A = 67/84	79.7 %	8.44 %
		B = 15/84	17.9 %	1.89 %
		C = 2/84	2.4 %	0.25 %
Male	58-67	A = 43/50	86%	5.42 %
		B = 4/50	8%	0.5 %
		C = 3/50	6%	0.38 %
Male	68-77	A = 10/20	50%	1.26 %
		B = 8/20	40%	1.01 %
		C = 2/20	10%	0.25 %
Female	18-27	A = 46/73	63%	5.79 %
		B = 24/73	32.9 %	3.02 %
		C = 3/73	4.1 %	0.38 %
Female	28-37	A = 113/148	76.3 %	14.23 %
		B = 30/148	20.8 %	3.78 %
		C = 5/148	2.9 %	0.63 %
Female	38-47	A = 97/107	90.6 %	12.22 %
		B = 7/107	6.5 %	0.88 %
		C = 3/107	2.9 %	0.38 %
Female	48-57	A = 78/84	92.8 %	9.82 %
		B = 4/84	4.8 %	0.5 %
		C = 2/84	2.4 %	0.25 %
Female	58-67	A = 34/38	89.5 %	4.28 %
		B = 3/38	7.9 %	0.38 %
		C = 1/38	2.6 %	0.13 %
Female	68-77	A = 5/8	62.5 %	0.63 %
		B = 2/8	25%	0.25 %
		C = 1/8	12.5 %	0.13 %

Table 2: PICI-2 Population sample.

Gender of the sample Population	Bunds of age	Sexual orientation And sample number	% single sample	% total sample (794)	pathological values (at least 5 dysfunctional tracts)	
Male	18-27	A = 15/25	60%	1.89 %	15	100%
		B = 8/25	32%	1.01 %	8	100%
		C = 2/25	8%	0.25 %	2	100%
Male	28-37	A = 32/54	59.3 %	4.03 %	32	100%
		B = 18/54	33.3 %	2.27 %	18	100%
		C = 4/54	7.4 %	0.5 %	4	100%
Male	38-47	A = 77/103	74.8 %	9.7 %	77	100%
		B = 24/103	23.3 %	3.02 %	24	100%
		C = 2/103	1.9 %	0.25 %	2	100%
Male	48-57	A = 67/84	79.7 %	8.44 %	67	100%
		B = 15/84	17.9 %	1.89 %	15	100%
		C = 2/84	2.4 %	0.25 %	2	100%
Male	58-67	A = 43/50	86%	5.42 %	43	100%
		B = 4/50	8%	0.5 %	4	100%
		C = 3/50	6%	0.38 %	3	100%
Male	68-77	A = 10/20	50%	1.26 %	10	100%
		B = 8/20	40%	1.01 %	8	100%
		C = 2/20	10%	0.25 %	2	100%
Female	18-27	A = 46/73	63%	5.79 %	46	100%
		B = 24/73	32.9 %	3.02 %	24	100%
		C = 3/73	4.1 %	0.38 %	3	100%
Female	28-37	A = 113/148	76.3 %	14.23 %	113	100%
		B = 30/148	20.8 %	3.78 %	30	100%
		C = 5/148	2.9 %	0.63 %	5	100%
Female	38-47	A = 97/107	90.6 %	12.22 %	97	100%
		B = 7/107	6.5 %	0.88 %	7	100%
		C = 3/107	2.9 %	0.38 %	3	100%
Female	48-57	A = 78/84	92.8 %	9.82 %	78	100%
		B = 4/84	4.8 %	0.5 %	4	100%
		C = 2/84	2.4 %	0.25 %	2	100%
Female	58-67	A = 34/38	89.5 %	4.28 %	34	100%
		B = 3/38	7.9 %	0.38 %	3	100%
		C = 1/38	2.6 %	0.13 %	1	100%
Female	68-77	A = 5/8	62.5 %	0.63 %	5	100%
		B = 2/8	25%	0.25 %	2	100%
		C = 1/8	12.5 %	0.13 %	1	100%

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traits, on the other hand, are present in the number of three in almost all profiles, except in the male groups over the age of 58, where they become four and five (paranoid, delusional, dissociative, schizoaffective).

b) In the *female population* (458/794), the selected sample was completely psychopathological (458/458, 100%), with at least 5 dysfunctional traits in at least 1 specific personality disorder (Table 5). The data that emerged show that, compared to the selected sample, the total prevalence of personality disorders at the limit (bipolar, borderline, histrionic, narcissistic and antisocial). Psychotic traits, on the other hand, are present in the number of four in almost all profiles, except in female groups over the age of 48, where they become five and six (paranoid, delusional, dissociative and psychopathic).

3) On the PAD-Q, the data are even more significant and expressive than a precise psychopathological cataloging of personality traits. In particular:

Table 3: PAD-Q Population sample.

Gender of the sample Population	Bunds of age	Sexual orientation And sample number	% single sample	% Total sample (794)	Pathological values (> 90/175)	
Male	18-27	A = 15/25	60%	1.89 %	3	20%
		B = 8/25	32%	1.01 %	6	75%
		C = 2/25	8%	0.25 %	2	100%
Male	28-37	A = 32/54	59.3 %	4.03 %	4	12.5%
		B = 18/54	33.3 %	2.27 %	13	72.2%
		C = 4/54	7.4 %	0.5 %	4	100%
Male	38-47	A = 77/103	74.8 %	9.7 %	16	20.8%
		B = 24/103	23.3 %	3.02 %	20	83.3%
		C = 2/103	1.9 %	0.25 %	2	100%
Male	48-57	A = 67/84	79.7 %	8.44 %	11	16.4%
		B = 15/84	17.9 %	1.89 %	12	80%
		C = 2/84	2.4 %	0.25 %	2	100%
Male	58-67	A = 43/50	86%	5.42 %	6	14%
		B = 4/50	8%	0.5 %	3	75%
		C = 3/50	6%	0.38 %	3	100%
Male	68-77	A = 10/20	50%	1.26 %	3	30%
		B = 8/20	40%	1.01 %	6	75%
		C = 2/20	10%	0.25 %	2	100%
Female	18-27	A = 46/73	63%	5.79 %	46	100%
		B = 24/73	32.9 %	3.02 %	24	100%
		C = 3/73	4.1 %	0.38 %	3	100%
Female	28-37	A = 113/148	76.3 %	14.23 %	113	100%
		B = 30/148	20.8 %	3.78 %	30	100%
		C = 5/148	2.9 %	0.63 %	5	100%
Female	38-47	A = 97/107	90.6 %	12.22 %	97	100%
		B = 7/107	6.5 %	0.88 %	7	100%
		C = 3/107	2.9 %	0.38 %	3	100%
Female	48-57	A = 78/84	92.8 %	9.82 %	78	100%
		B = 4/84	4.8 %	0.5 %	4	100%
		C = 2/84	2.4 %	0.25 %	2	100%
Female	58-67	A = 34/38	89.5 %	4.28 %	34	100%
		B = 3/38	7.9 %	0.38 %	3	100%
		C = 1/38	2.6 %	0.13 %	1	100%
Female	68-77	A = 5/8	62.5 %	0.63 %	5	100%
		B = 2/8	25%	0.25 %	2	100%
		C = 1/8	12.5 %	0.13 %	1	100%

Table 4: PICI-2 for cluster (male) Population sample.

Bunds of age	Sexual orientation and Sample number	% Single sample	% Total sample (794)	The cluster (a/b/c) with the highest score
18-27	A = 15/25	60%	1.89 %	A
	B = 8/25	32%	1.01 %	B
	C = 2/25	8%	0.25 %	Bc
28-37	A = 32/54	59.3 %	4.03 %	A
	B = 18/54	33.3 %	2.27 %	B
	C = 4/54	7.4 %	0.5 %	B
38-47	A = 77/103	74.8 %	9.7 %	A
	B = 24/103	23.3 %	3.02 %	B
	C = 2/103	1.9 %	0.25 %	B
48-57	A = 67/84	79.7 %	8.44 %	B
	B = 15/84	17.9 %	1.89 %	B
	C = 2/84	2.4 %	0.25 %	B
58-67	A = 43/50	86%	5.42 %	B/C
	B = 4/50	8%	0.5 %	C
	C = 3/50	6%	0.38 %	C
68-77	A = 10/20	50%	1.26 %	B/C
	B = 8/20	40%	1.01 %	C
	C = 2/20	10%	0.25 %	C

Table 5: *PICI-2 for cluster (female) Population sample.*

Bunds of age	Sexual orientation and Sample number	% Single sample	% Total sample (794)	The cluster (a/b/c) with the highest score
18-27	A = 46/73	63%	5.79 %	B
	B = 24/73	32.9 %	3.02 %	B
	C = 3/73	4.1 %	0.38 %	B
28-37	A = 113/148	76.3 %	14.23 %	B
	B = 30/148	20.8 %	3.78 %	B
	C = 5/148	2.9 %	0.63 %	B
38-47	A = 97/107	90.6 %	12.22 %	B
	B = 7/107	6.5 %	0.88 %	B
	C = 3/107	2.9 %	0.38 %	B
48-57	A = 78/84	92.8 %	9.82 %	B
	B = 4/84	4.8 %	0.5 %	B
	C = 2/84	2.4 %	0.25 %	B
58-67	A = 34/38	89.5 %	4.28 %	B/C
	B = 3/38	7.9 %	0.38 %	C
	C = 1/38	2.6 %	0.13 %	C
68-77	A = 5/8	62.5 %	0.63 %	B/C
	B = 2/8	25%	0.25 %	C
	C = 1/8	12.5 %	0.13 %	C

a) In the *male population* (336/794), the selected sample reported a clinically relevant value (> 95/175) equal to 20%, based on the age group, to settle at 30% in the 68-77 age range alone. These findings, in line with what emerged from the clinical interview, show that the toxicity of the emotional-sentimental relationship is not attributed to a cause of emotional dependence but rather to causes of another nature capable of interfering with the normal intimate relationship.

b) In the *female population* (458/794), the selected sample reported a clinically relevant value (> 95/175) in 100% of the cases analyzed. These findings, in line with what emerged from the clinical interview, show that the toxicity of the emotional-sentimental relationship is attributed to a cause of emotional dependence capable of interfering with the normal intimate relationship;

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however, it should be emphasized that this dependence dynamic represents a symptom of a specific personality disorder and therefore the dependency pattern becomes in the emotional relationship a real nourishing cause of the toxicity of the relationship, a sort of means to obtain a secondary benefit of nature dysfunctional (which feeds the psychopathology itself), resistant even during psychotherapies possibly carried out by patients in the past [38-46].

Conclusions

Based on these data, the following conclusions emerge clearly:

1. The use of the PAD-Q is functional to identify the dysfunctional personality traits that can explain the type of "affective dependency" of the patient; this indication must then always be compared with the data that emerged from the administration of the PICI-2 and the clinical interview, to ensure that the main disorder and the secondary ones are properly framed. In fact, the PAD-Q alone manages to frame the patient in the psychopathological macro-area with respect to the main dysfunctional traits but fails to frame him in its total set of traits.

2. The "affective dependency" is to all effects a behavioral manifestation that cognitively represents a precise psychopathological trajectory grafted into a dysfunctional personality framework. The erroneous placement of affective dependency among behavioral addictions is also confirmed here, as it is a psychopathological representation of a personality disorder to be identified and which pertains to one or more of these categories: a) affective-neurotic (anxious, maniacal, depressive or obsessive); b) dependent (dependent); c) histrionic (histrionic); d) masochist (masochist); e) borderline (bipolar and borderline); f) covert narcissist (covert narcissist); g) psychotic (psychopath, schizophrenic, schizoid, schizoaffective, schizotypic, dissociative).

3. The data emerging from the selected male population sample (794) demonstrate a strong neurotic tendency in the heterosexual male sample between 18 and 47 years, while the rest of the heterosexual, and all the homosexual and bisexual population has marked dysfunctional traits afferent to cluster B (bipolar, borderline, histrionic, narcissistic and antisocial). Psychotic traits, on the other hand, are present in the number of three in almost all profiles, except in the male groups over the age of 58, where they become four and five (paranoid, delusional, dissociative, schizoaffective). The female population sample, on the other hand, presents exclusively borderline traits, with a greater psychotic tendency after the age of 47. The data emerging from the male population sample (794) finally show that only 20% have a clinically relevant diagnosis of "affective dependency" (these findings, in line with what emerged from the clinical interview, show that the toxicity of the emotional-sentimental relationship is not attributed to a cause of affective dependency but rather to causes of another nature capable of interfering with the normal intimate relationship), while the female population reports a clinically relevant value in 100% of the cases analyzed (these findings, in line with what emerged from the clinical interview, show that the toxicity of the emotional-sentimental relationship is attributed to a cause of affective dependency capable of interfering with the normal intimate relationship; however, it should be emphasized that this dependence dynamic represents a symptom of a specific personality disorder and therefore the dependency pattern becomes in the emotional relationship a real nourishing cause of the toxicity of the relationship, a sort of means to obtain a secondary benefit of nature dysfunctional -which feeds the psychopathology itself-, resistant even during psychotherapies possibly carried out by patients in the past.

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