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## Affective Dependence: From Pathological Affectivity to Personality Disorders: Definitions, Clinical Contexts, Neurobiological Profiles and Clinical Treatments

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**REVIEW**

# Affective Dependence: from Pathological Affectivity to Personality Disorders

## Definitions, Clinical Contexts, Neurobiological Profiles, and Clinical Treatments

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**ABSTRACT**

Starting from the general concept of affectivity, the present work focuses on the clinical, neurobiological, and dysfunctional aspects of the morbid condition, when dysfunction gradually becomes first an affective addiction and then a symptom of a psychopathological personality picture, thus suggesting a multidimensional treatment. From affective dependence to personality disorders, about the dynamics of human bonding, to the implications determined by the attachment theory, trying to demonstrate that the clinical category of affective dependence cannot be considered simply a form of behavioral dependence, as erroneously done in the last decade, but as a symptom of a psychopathological manifestation of personality, in a framework of diagnostic transversality.

**KEYWORDS:** Affective Dependence, Pathological Affectivity, Personality Disorders, Borderline.

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**INTRODUCTION**

Affectivity" [1] 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) 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, erroneously attributed to the sphere of rationality, instead contain an affective determinant. Everything, event, and object has its 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 characters, such as intensity and duration, moods can be cataloged as emotions and feelings. [2]

In philosophy, Aristotle defined the sensitive qualities as affective, since each of them develops an affection for the senses. In the work "De Anima" he recalled that among the aims of his investigation there was certainly affectivity (or in a more general and complete sense affections), first of all, because they seemed to him to be proper to the soul, and secondly because it was necessary to list those in common with animals. Later the Stoics evaluated affectivity (and affections) negatively because they were irrational and threatening the rational aspect of the soul. St. Augustine and later the Scholastics again took the Aristotelian opinion on the neutrality of affections and therefore, from a moral point of view, judged them good or bad depending on the moderating influence of reason on

them. Spinoza, on the other hand, will state, concerning affectivity, that as soon as we form a clear and distinct idea of it, affectivity ceases to be affectivity; he will also argue that God, being free of confused ideas, is free of affectivity. Kant finally distinguished between the sensor elements and those of intellectual cognitive power, and in his work "Critique of Pure Reason" he will sustain: "All intuitions, as sensitive, rest on affectivity; concepts, instead, on functions".

In psychology, attention is paid to the structuring of affections, which goes from birth to maturity. Initially, they are oriented towards the most significant figures for existence in its most elementary stage, such as the mother and, to a lesser extent, the father, according to the theory of attachment [3]; as they evolve, the child can direct his affectivity towards other familiar figures and then towards external figures, on which he exercises his feelings with increasing autonomy. A correct and complete development of affectivity, as well as the elaboration of possible traumas or affective deficiencies that have hindered the process, are fundamental for the maturation of the individual, in particular concerning the development of self-esteem and sexuality in adolescence and adulthood. It is no coincidence that Panksepp investigated the neuronal bases of emotions and affectivity, demonstrating that at the basis of any form of psychic activity there is an ancestral core of emotional consciousness called "emotional proto-consciousness" activated by the deep brain areas of the so-called "reptilian brain". [4]

#### **DYSFUNCTIONAL AFFECTIVITY AND ITS CLINICAL RELEVANCE**

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 [5-6], among which we find panic, phobias, separation anxiety (at the basis of many psychotic and personality disorders) and generalized anxiety, eating disorders [7], obsessive-compulsive disorder [8], post-traumatic stress disorders [9], somatic syndromes [10], mood disorders (such as depression, dysthymia, cyclothymia, and suicidal risk) [11, 18], behavioral [12] and substance addictions [13], bipolar disorder [14], paraphilic disorder [17] and also a large part of personality disorders [15-16].

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 [19-20], until it evolves into the largest form: the "personality addiction disorder". Although affective 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. [21]

Reynaud himself, a decade ago, starting from the similarities found with substance addiction, proposed a diagnostic definition of "love addiction", based on the duration and frequency of perceived suffering, presenting

it as: a maladaptive or problematic model of the love relationship that leads to clinically significant deterioration or anguish, as manifested by three (or more) of the following criteria (which occur at any time, in the same 12-month period, for the first five criteria): 1) existence of abstinence syndrome due to the absence of the loved one, characterized by significant suffering and compulsive need of the other; 2) considerable amount of time spent in this relationship (in reality or in thought); 3) reduction of important social, professional or leisure activities; 4) persistent desire or unsuccessful efforts to reduce or control one's relationship; 5) search for the relationship, despite the existence of problems created by it; 6) existence of attachment difficulties, as manifested by one of the following: a) repeated exalted love relationships without any period of lasting attachment; b) repeated painful love relationships characterised by insecure attachment. [22] However, he too did not consider affective dependence as a symptom of a broader picture, but simply a dependence linked to the affective, sentimental and sexual sphere, reducing it in an excessively simplistic way.

It remains obvious that a certain level of interdependence with the partner is part of any love story that can be said to be such, especially in the phase of falling in love, characterized by a strong sense of intimacy and passion, where the sense of fusion is particularly strong, as well as euphoria, desire, tolerance, and emotional and physical addictions, precisely because of the effect of oxytocin in the blood. [23] Romantic love is a natural part of the biological imperative of human reproduction and corresponds to a specific pattern of physiological, psychological and behavioral characteristics, which includes: focused attention on the object of love, reorganization of priorities, increased energy and feelings of euphoria, mood swings, responses of the sympathetic nervous system such as sweating and heartbeat, high sexual desire and sexual possessiveness, obsessive thoughts about the other, desire for emotional union, affiliate gestures, purpose-oriented behaviors and intense motivation to achieve and maintain the bond. However, when the most dependent characteristics become rigid and pervasive and assume the connotation of absolute necessity, the risk is to fall into the most dysfunctional side of the love bond, the one related to pathological or dysfunctional affective dependence. The possibility of going beyond the phase of falling in love and loving the other depends precisely on the ability of the members of the couple to perceive and respect each other as separate individuals, i.e. to recognize the other in his diversity without losing sight of their individuality. When, on the other hand, the couple's bond obscures their needs and desires and chains us to the other by suffocating our individuality, we can speak of love addiction or emotional dependence. The transition to dysfunctional falling in love would take place through the transformation of desire into necessary need and pleasure into suffering. This would be accompanied by extreme obstinacy in the search for and maintenance of the relationship, despite the awareness of the negative consequences. Since compulsive desire (or craving), obsessive commitment, perseverance of problematic behaviors, and compromised control systems of these, characteristic elements of behavioral addictions, it is possible to assume that love addiction is due to a

dysfunctional stiffening of the natural characteristics of romantic love. [21, 29-33]

However, there is an important fact not to be taken for granted: falling in love and drug addiction have many similarities, as both lovers and drug addicts experience: a) intense euphoria when they see the partner, similar to the euphoria that characterizes the use of a drug; b) craving (which is a spasmodic and uncontrollable desire) for the partner or the drug; c) tendency to increasingly seek proximity with the partner (a phenomenon similar to tolerance a mechanism that pushes drug addicts to progressively increase the amount of drug habitually taken to obtain the desired effect). When a relationship ends, people in love have withdrawal symptoms that are similar to those found in drug addicts' withdrawal syndrome (depression, anxiety, insomnia or hypersomnia, irritability, loss of appetite or binge drinking) which, just like in drug addiction, lead to relapse; e.g. in emotional addiction, having a relapse means looking for the partner again despite having been unfaithful and/or violent. The similarities between falling in love and drug addiction are also confirmed by neuroimaging studies (which visualize brain activity in vivo). These studies show that falling in love activates certain brain regions of the mesolimbic pathway which is rich in dopamine (a substance that is released in our brain every time we do something pleasant such as eating, having sex, looking after offspring). The pleasure we try to take serves to motivate us to repeat these behaviors and therefore to guarantee the survival of the individual and the species. As numerous empirical evidence shows, these same regions are activated both in substance addiction. Just as happens in substance addiction, in emotional dependence too, with time everything inexorably revolves around the partner; often the dependent person closes himself off or deliberately avoids others in an attempt to protect himself from criticism or feared abandonment. Usually, both interests and hobbies are progressively abandoned and the focus of existence becomes the partner; also the work performance decreases because the person has his mind constantly occupied by his emotional problems and spends a lot of time brooding to try to solve them. In extreme cases, e.g. even when the partner is physically violent, dependent patients tend to justify it, isolate themselves, lie, or do not ask for help to protect them; unfortunately, they often fail to leave even when their physical safety is at risk. Generally, patients with emotional dependence are aware of the devastating effects that their partner has in their life, but just like drug addicts, they are unable to abstain from the relationship. [24] It is probably for these reasons that confusion is often created, bringing back to the sphere of action of behavioral addictions a symptom (affective dependence) which, although with clinical and neurobiological similarities, should have other considerations.

#### **AFFECTIVE DEPENDENCE**

People who suffer from "emotional dependence" often feel inadequate and unworthy of love and constantly live in terror of being abandoned by their partner. The fear of abandonment leads to the attempt to control the other with complacent behavior of extreme sacrifice, availability, and care, in the hope of making the relationship stable and lasting. The very tendency to build a relationship of non-

meaning, but in which the other and his needs are central, leads to leaving room for egocentric and anaffective personalities, which end up confirming in those who suffer from emotional dependence the fear of not being able to be worthy of love. Low self-esteem pushes the person who suffers from emotional dependence to read the scarce availability of the other not as information about the other ("he is an egocentric narcissus"), but as information about himself ("he does not love me because I am not good"). The result is an increase in sacrificial and a continuous blame for the unsatisfactory performance of the relationship; the other is chased exactly as gamblers do who "chase the loss" and can't stop playing. Sometimes, because of a wrong done by the partner, anger can momentarily push the affective addict to stop and end the relationship, but inevitably, the symptoms of withdrawal (depression and inability to feel pleasure, anxiety, feeling of emptiness, etc.) push to forgive the partner and justify it, thus entering the vicious circle of a toxic relationship. [25] 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 histrionic personality disorder, the emotional dependence that the patient shows is functional concerning his tendency to dramatize, to try to capture the impression or attention of others, to continue to feed situations potentially useful to maintain his real or fictitious link with the third party. 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) [26] further recall the psychological and environmental factors of the personality disorders mentioned above.

#### **DEPENDENT PERSONALITY DISORDER**

If, however, in histrionic, borderline and narcissistic personality disorders, emotional dependence is an

expression of the emotional dysregulation and emotional dysfunction bond that these patients can create punctually in every relationship or sentimental bond, in the dependent personality disorder (the most extreme, rigid and consolidated form of emotional dependence) it becomes the central pillar, where everything else revolves around. In the past, this disorder was also called asthenic personality disorder precisely because it is characterized by a pervasive psychological dependence on other people from whom protection or approval is sought. This disorder is a long-term condition in which people depend on others to meet their emotional and physical needs, with only a minority reaching normal levels of independence. It is also characterized by excessive fear and anxiety. It begins in early adulthood and is present in a variety of contexts and is associated with inadequate functioning. In some cases, there is a continuous need to develop and/or maintain social relationships with certain reference persons, as well as the need to make oneself indispensable for those closest to one's heart, to avoid possible abandonment. Even a small sign of estrangement can be perceived as such and therefore the person strives to become indispensable for the other, or dependent on it in such a way that this danger can be averted, sometimes experiencing obsessive-compulsive phases of searching for certainties, security and comfort from other people (normally family and/or friends in general), in a form comparable to depression and often linked to collateral triggers such as childhood trauma or existential problems. People suffering from this disorder have a typical perception of themselves that leads them to low self-esteem. Usually, people with this disorder feel inadequate compared to others, as if they have something less that makes them feel inferior; they feel wrong. This makes them insecure and has low self-esteem and this affects the way they relate to people and the role others play in their lives. These patients usually feel the need for a reference person, from whom they feel protected and guided, who can be a parent, a close family member, a friend, a partner (if they have one), or a more experienced colleague, at work; it is not by chance that a skill that these people usually have well developed is the ability to understand in advance the needs of the person they love, to anticipate them over time. In this way they hope to instill in the mind of the person concerned the idea that they are essential for his or her happiness and well-being; this will safeguard them from any negative thoughts that the other person may have about them. However, at certain times in their lives, they may find themselves without a partner or relationships that are important to them and this is very destructive. Their existence becomes empty and useless; moods like emptiness, feelings of uselessness, depression, and sadness take over. Described in this way, these subjects would seem to have no will and no interests of their own, when in reality they are not automatons without personal purposes guided only by the will of others. They also have, like everyone else, personal interests and purposes and can recognize if these do not match those of the person they love, but are so in need of the approval of their partner that they are unable to carry out the behaviors necessary to achieve their personal goals if these do not match the will of others. It is therefore the relationships that guide their choices, even if the expectations of others are not in tune with their own. However, this provokes a sense of frustration, anger, and compulsion on an

emotional level, which in turn makes them believe that the relationship is unstable. This is interpreted as a precursor sign of abandonment (the thing they fear the most), so their priority returns to satisfy their partner's desires, thus recreating a state of tranquility in them. Sometimes an internal rebellion against dependence on others occurs in the patient, generating a passive-aggressive personality; in it, the subject tends to obstruct without openly opposing (for fear of losing his position or the benevolence of others) things that he does not like, appears incapable or passive, but secretly aims to avoid responsibility, control and/or punish others; these subjects accept, often with complaints, to perform tasks they do not want to perform and then compromise them, often sabotaging them and, over time, become increasingly hostile and angry with the outside world. It is difficult clinically to identify in most cases the behavior with which this condition manifests itself in the subject under examination: there may be cases of submissive/depressive behavior as obsessive/aggressive and in particularly complex cases intersected with other parallel disorders both behaviors may occur, following each other suddenly. Moreover, these people are not able to be alone and, in case they meet again, they perceive their existence and themselves as useless and empty and everything for them loses attraction, thus falling into a depressive state. [1]

It is also useful to analyze the psychological characteristics of individuals with personality disorder in terms of their vision of themselves and others, intermediate and deep beliefs, perceived threats, coping strategies and main emotions: [21]

- a) "vision of self": they consider themselves needy, weak, powerless and incompetent;
- b) "vision of others": they see others as people who can take care of them in an idealized way. They think they are nurturing, supportive and competent;
- c) "intermediate and profound beliefs": "I need others (especially a strong figure) to survive", "I cannot live without him/her", "I can never be happy unless I am loved", "I can only move on if I have someone competent next to me", "if they abandon me, I will die", "if they don't love me, I will always be unhappy", "I mustn't offend those who take care of me", "stay close to me", "cultivate intimate relationships as much as possible", "be helpful to others", "I am completely powerless", "I am completely alone";
- d) "perceived threats": the main threat is rejection and abandonment because they do not feel able to face life on their own;
- e) "coping strategies": means cultivating a supportive/dependent relationship. They will do this by often subordinating themselves to a figure they perceive as strong and trying to appease or please this person;
- f) "main emotions": the main emotion is anxiety, concern about a possible end of the dependent relationship. They periodically experience high anxiety when they perceive that the relationship could be cracked or worn out. If the figure they depend on breaks down, they may sink into depression. On the other hand, they experience gratification or euphoria when their dependent desires are fulfilled.

Theodore Millon also identified, according to his studies, the five subtypes of dependent personality disorder (table1): [28]



**Table 1:** Subtypes of dependent personality disorder.

Subtype	Description	Personality Traits
<b>Disquieted dependent</b>	Including <u>avoidant</u> features	Restlessly perturbed; disconcerted and fretful; feels dread and foreboding; apprehensively vulnerable to abandonment; lonely unless near supportive figures.
<b>Selfless dependent</b>	Including <u>masochistic</u> features	Merges with and immersed into another; is engulfed, enshrouded, absorbed, incorporated, willingly giving up own identity; becomes one with or an extension of another.
<b>Immature dependent</b>	Variant of "pure" pattern	Unsophisticated, half-grown, unversed, childlike; undeveloped, inexperienced, gullible, and unformed; incapable of assuming adult responsibilities.
<b>Accommodating dependent</b>	Including <u>histrionic</u> features	Gracious, neighborly, eager, benevolent, compliant, obliging, agreeable; denies disturbing feelings; adopts submissive and inferior role well.
<b>Ineffectual dependent</b>	Including <u>schizoid</u> features	Unproductive, gainless, incompetent, meritless; seeks untroubled life; refuses to deal with difficulties; untroubled by shortcomings.

Therefore, in accordance with the diagnostic criteria established by the DSM-V (Diagnostic and Statistical Manual of Mental Disorders, Fifth Ed. ), for a diagnosis of "dependent personality disorder", patients must have a persistent and excessive need to be taken care of, with consequent submission and tendency to cling, highlighting for diagnostic confirmation  $\geq 5$  of the following points: 1) difficulty in making daily decisions without an excessive amount of advice and reassurance from other people; 2) need to get others to be responsible for the most important aspects of their lives; 3) difficulty in expressing disagreement with others because they fear loss of support or approval; 4) difficulty in personally undertaking projects because they are unsure of their judgment and/or skills (not because they lack motivation or energy); 5) inclination to strive (e.g., doing unpleasant tasks) to gain the support of others; 6) feelings of discomfort or helplessness when they are alone because they fear they cannot take care of themselves; 7) urgent need to establish a new relationship with someone who will provide assistance and support when a close relationship ends; 8) unrealistic concern with fear of being left to take care of themselves. Also, the symptoms must begin in early adulthood. [27]

In contrast to the differential diagnosis, several other personality disorders are characterized by hypersensitivity to rejection. However, they can be distinguished from the dependent personality disorder based on the following characteristics:

- a) "Borderline personality disorder": patients with this disorder are too scared to undergo the same type of control as patients with personality disorder. Patients with borderline personality disorder, unlike those with a personality disorder, waver between submission and angry hostility.
- b) "Avoiding personality disorder": patients with this disorder are too scared to undergo the same type of control as patients with personality disorder. Patients with avoidable personality disorder isolate themselves until they are sure to be accepted without criticism; on the contrary, those with personality disorder try to find and maintain relationships with others.
- c) "Histrionic personality disorder": Patients with this disorder seek attention rather than reassurance (as those with personality disorder do), but are more uninhibited.

They are more conspicuous and actively seeking attention; those with personality disorders are shy and shy.

d) "Schizotypal personality disorder": The subject's paranoia (not delusional or paranoid) or fear is accentuated in the dependent disorder if he or she remains alone. Often the subject may also seem to like or accept a certain level of relative loneliness (perhaps preferring the company of a few), because he fears the judgment of others, but in reality - with elements of split personality (the subject would sometimes want autonomy but fears it) - if it is total or great it makes him feel enormously uncomfortable, making him feel abandoned and helpless. The employee can willingly accept the company if he feels protected by the reference figures.

There is, however, a possible comorbidity with obsessive-compulsive disorder (due to the presence of alexithymia in the dependent disorder, i.e. difficulty in identifying emotions and distinguishing them from physical sensations, with the inability to describe them to others) but also with psychosomatic disorders in which consciously or unconsciously the subject appears weak to attract the attention and help he feels he needs, such as (without falling into true hysteria more typical of severe histrionic disorder) in conversion disorder, hypochondria, and somatoform disorder. [27]

## TREATMENT

A clear understanding of the systematic error that is made in framing emotional dependency simply within the framework of behavioral dependency (and not within the broader framework of a symptom of a disfunctional personality structure) is especially crucial for therapeutic purposes, as there is much difference in treating an addiction to a personality disorder. And if up to now, too many therapies focused on the dependent symptom have failed, it is precisely for this reason. The treatment of emotional dependence is primarily structured on the achievement of short and long-term goals, such as dealing with and resolving the patient's current suffering in terms of symptoms and behavioral dysfunctions and dealing with early experiences of abandonment, physical and emotional neglect, maltreatment or abuse [36], which generally underlie the belief that they are worth nothing and not worthy of being loved that characterize patients suffering from emotional dependence (understood as behavioral

dependence); the general treatment instead of personality disorders, including addiction, focuses on the structure and functional mode of action. In the latter case, an integrated approach to solve or at least better manage the pathological consequences appears evident: cognitive-behavioral psychotherapy, strategic or psychodynamic, which focus on the exploration of the fear of independence and the difficulties of self-assertion (the strategic model appears particularly useful precisely because of its natural ability to adapt to the patient, reasoning on the most suitable functions and strategies) [37] and the use of an integrative psychopharmacological therapy only if strictly necessary.

## CONCLUSION

Starting from the general concept of affectivity, this work has shown that emotional dependence cannot be reduced to a categorization in the list of behavioral addictions, even if it has in common clinical and neurobiological aspects that could be misleading. In reality, the 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 aspects of emotional dependence and how it colors the manifested disorder from time to time. From affective dependence to personality disorders, concerning the dynamics of the human bond, to the implications determined by the attachment theory, in a framework of diagnostic transversality, to the best possible therapy, always integrated between psychopharmacology and psychotherapy.

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## COMPETING INTERESTS

The author declares no competing interests with this case.

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