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Research Article

Perrotta Affective Dependence Questionnaire (PAD-Q): Clinical framing of the affective-sentimental relational maladaptive model

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Abstract

Starting from the concept of “affective dependence”, this work has shown that this nosography cannot be reduced to a categorization in the list of behavioral dependencies, even if it has in common clinical and neurobiological aspects that could be misleading. In fact, 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 dependent personality disorder. The analytical approach must, therefore, be multidimensional, precisely to better understand all aspects of affective dependence and how it colors the manifested disorder from time to time. From affective dependence to personality disorders, in relation to the dynamics of human bonding, to the implications determined by attachment theory, in a framework of diagnostic transversality, to the best possible therapy, always integrated between psychopharmacology and psychotherapy. The Perrotta Affective Dependence Questionnaire (PAD-Q), with 35 items, on a 0-5 scale, aims to study the phenomenon of “affective dependence”, defining it instead as a maladaptive model of the affective-sentimental relationship of a couple, which involves the establishment or persistence of a clinically significant bond, lasting at least six months and characterized by a functional impairment of the relational area, the emotional area and the somatic area.

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General introduction: the «affective dependence»

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 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 [1].

Reynaud, a decade ago, 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 [2]. 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.

Millon also identified the five subtypes of dependent personality disorder: [3]:

Subtype	Description	Personality Traits
Disquieted dependent	Including <i>avoidant</i> features	Restlessly perturbed; disconcerted and fretful; feels dread and foreboding; apprehensively vulnerable to abandonment; lonely unless near supportive figures.
Selfless dependent	Including <i>masochistic</i> 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.
Immature dependent	Variant of "pure" pattern	Unsophisticated, half-grown, unversed, childlike; undeveloped, inexperienced, gullible, and unformed; incapable of assuming adult responsibilities.
Accommodating dependent	Including <i>histrionic</i> features	Gracious, neighborly, eager, benevolent, compliant, obliging, agreeable; denies disturbing feelings; adopts submissive and inferior role well.
Ineffectual dependent	Including <i>schizoid</i> features	Unproductive, gainless, incompetent, meritless; seeks untroubled life; refuses to deal with difficulties; untroubled by shortcomings.

In clinical practice, we frequently encounter patients who are unable to break off deeply destructive intimate relationships that cause them suffering and compromise their lives on various levels; this condition is classified as "affective dependence" [4-7] However, this behavioral expression is common to many personality disorders, such as dependent disorder [8],

histrionic disorder [9], borderline disorder [10] and narcissistic disorder [11]. Indeed: in the dependent disorder, the main feature is precisely that of the toxic and destructive bond that reinforces one's personality tendency, as in a vicious circle; in the histrionic disorder, the affective dependence is functional to its tendency to dramatize, to try to capture the impression or attention of others, to continue to feed potentially useful situations to maintain its real or fictitious bond with the third party; in the hypothesis of borderline disorder, affective dependence is necessary to continue to maintain the bond with the person on levels of high instability, favoring first a morbid attachment and then a clear separation, alternating these behaviors in synchrony; finally, in narcissistic disorder, the patient implements modes of affective dependence in the hypothesis of "covert" narcissism, that is, the form that provides low self-esteem and high sensitivity to criticism [12-18].

Perrotta Affective Dependence Questionnaire (PAD-Q)

Starting from the concept of "affective dependence" and its international nosographic framework, the *Perrotta Affective Dependence Questionnaire (PAD-Q)* aims to study the phenomenon of "affective dependence", defining it as a maladaptive model of the affective-sentimental relationship of a couple, which involves the establishment or persistence of a clinically significant bond, lasting at least six months and characterized by a functional impairment of the relational area, the emotional area and the somatic area.

In particular, the passive subject of the relationship, suffering from emotional dependence, experiences the following symptomatological picture:

- a) "relational area": relational dependence/codependence, assumption of other people's responsibility with significant delegation, excessive justification of the partner's injurious, offensive or disparaging conduct, dynamics of psychophysical submission or subordinate relationship, excessive need for reassurance, attention or relational certainty, unfounded fear of abandonment.
- b) "somatic area": malaise emotional, relational, affective, sentimental and physical, excessive tolerance in relation to episodes harmful, abusive or disparaging of the partner, masochistic dynamics.
- c) "emotional area": inability to manage anxiety, low tolerance to frustration, emotional instability, need for control, unmotivated fears, low self-esteem, verbal and/or physical denigration, obsessive and/or delusional episodes.

Affective addiction, not being a well-identified psychopathological label in the international nosographic framework, except in the general framework of behavioral addictions, in this context is identified as a maladaptive behavioral model that describes a series of personality traits afferent to several nosographically recognized psychopathological disorders. In particular, according to this excellent, the patient who will present to the proposed



questionnaire the following total overall scores will receive the following diagnoses:

- 1) Behavior in the normal range: 0 - 35.
- 2) Dysfunctional behavior: 36 - 50.
- 3) Dysfunctional attitude: 51 - 65.
- 4) Dysfunctional Inclination: 66 - 80.
- 5) Dysfunctional predisposition: 81 - 95.
- 6) Clinically relevant condition:
 - a. moderate level: 96 - 115,
 - b. significant level: 116 - 135,
 - c. severe level: 136 - 155.
 - d. very severe level: 156 - 175.

On the basis of the summation of the individual categories it is possible to identify the pathological subtypes, provided that the overall total score is equal to or greater than 96/175. The subtype that obtains the highest score represents the most representative type of the patient:

- a) **Type I: Affective neurotic:** the person with the highest cumulative score in the type I items (items 10, 11, 13, 19, 22) describes him/herself with a tendency to frequently use neurotic defence mechanisms to obtain secondary benefits, preoccupation when having to meet the partner's expectations, brooding and disturbing fantasies related to the relationship, catastrophic ideas and negative and pessimistic ideations.
- b) **Type II: Dependent:** the person with the highest cumulative score in the type II items (items 2, 3, 8, 25, 26) describes him/herself with a tendency to lose contact with his/her own emotions by putting his/her partner's needs and expectations first, seeking approval and reassurance from his/her partner, generalised anxiety, unfounded fear that his/her partner might prefer another person and the use of cognitive distortions and self-deception to justify his/her behaviour.
- c) **Type III: Histrionic:** the person with the highest cumulative score in the type III items (items 15, 17, 18, 21, 24) describes him/herself as having a tendency to fear stability in relationships (even though he/she seems to be looking for it very hard), theatricality in the manifestation of his/her emotions, dramatic and excessive reactions, looking for complex emotional situations or with complicated people and the use of complaining.
- d) **Type IV: Masochistic:** the person with the highest cumulative score in the type IV items (items 1, 7, 14, 29, 30) describes him/herself with a tendency to excessively tolerate and justify his/her partner's behaviour, even if

disrespectful or inadequate, excessive attention in the relationship and towards the romantic relationship with relative excessive emotional investment, putting his/her own rights and needs first and delegitimising actions in favour of the partner.

- e) **Type V: Borderline:** the person with the highest cumulative score in the type V items (items 5, 6, 9, 12, 28) describes him/herself with a tendency to feel empty or bored, an impelling need for an affective, sentimental or sexual relationship even with people one has only just met, fear of abandonment and loneliness, use of idealisation/devaluation in the relationship.
- f) **Type VI: Covert Narcissist:** the person with the highest cumulative score in the type VI items (items 4, 16, 20, 23, 27) describes him/herself as having a tendency to prefer complicated, troubled or dramatic relationships even if he/she declares him/herself to be unhappy, an unfounded fear that the partner does not love him/her enough, a need to conquer people who initially show little interest or disinterest, passive-aggressive manipulation of the relationship and difficulty in maintaining distance and boundaries with the partner.
- g) **Type VII: Psychotic:** the person with the highest cumulative score in the type VII items (items 31, 32, 33, 34, 35) describes him/herself as having a solitary tendency, a preference for closure, a very controlled emotionality, frequent masturbatory activity with limited sexual intercourse in pairs, obsessions, delusions and an excessive concentration on the partner's pleasure as a priority to the detriment of his/her own body and needs.

The completion of the questionnaire must be done by the therapist, after the drafting of the previous history [19-23] and clinical interview and serves to better define the general framework based on the symptoms reported and possibly found, which can range from neurotic to borderline and psychotic [24-52].

The above psychopathological types do not recall any international nosographics of mental disorders equally named but simply recall, by personality traits, such disorders, which to be diagnosed in their complexity need further psychometric investigations; complexity that can also be studied through the newly proposed PICI-1 model [53-56].

Following the clinical interview, the therapist initials the responses of each item, entering a value from 0 to 5 where 5 equals "absolutely agree" and 0 equals "not at all agree." Once the answers have been initialed, the therapist proceeds to the summation of the results, obtaining any relevant values, initialing the groups of items of the psychopathological subtypes only if the final summation gives a result equal to or greater than 96/175.

The complete questionnaire is attached to this research.



Conclusion

The Perrotta Affective Dependence Questionnaire (PAD-Q), with 35 items, on a 0–5 scale, aims to study the phenomenon of “affective dependence”, defining it instead as a maladaptive model of the affective–sentimental relationship of a couple, which involves the establishment or persistence of a clinically significant bond, lasting at least six months and characterized by a functional impairment of the relational area, the emotional area and the somatic area. In this sense, the questionnaire proposes an investigation more closely related to personality traits, thus favoring a more complex and articulated approach, aimed at clinical treatment, in a framework of diagnostic transversality, to the best possible therapy, always integrated between psychopharmacology and psychotherapy [57,58], departing from the simple nosographic classification of behavioral addiction.

(Appendix)

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