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ARTICLE

Love Addiction: From Attachment Theory to Affective Dependency. A Transactional Analysis Perspective and Treatment Protocol

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ABSTRACT
The authors briefly describe the etiopathogenetic origins of love addiction, including how they relate to the concepts of script protocol, symbiosis, and the stroke economy. They also consider the connection between attachment and love addiction and the various forms of love addiction. Finally, they propose a protocol for working with love addiction using transactional analysis.

KEYWORDS
Love addiction; attachment; ego states; games; strokes; miniscript; script; transactional analysis treatment

I have no Life but this
To lead it here
Nor any Death – but lest
Dispelled from there
Nor tie to Earths to come
Nor Action new
Except through this extent
The Realm of you.
Emily Dickinson

Definition of Love Addiction

The first definition of love addiction was offered in 1945 by psychoanalyst Otto Fenichel (1945/1951). He spoke for the first time about "love dependent" to refer to people who need love like some others need food or drugs. For Fenichel, those who are dependent on love need to be loved despite their own limited ability to love, so they continually seek to find greater love from their partner but obtain little or no results. Somehow, they choose a partner who is not suitable for them, and even though they are obviously not happy with that person, they are unable to leave them.

Love addiction is a clinical disturbance that has been considered recently in the psychology literature because it implies pathological dynamics that touch on relationships with a significant other (Gabbard, 1990; Lingiardi, 2005). This syndrome fits into the wider category of new addictions that includes all those forms of dependency (American Psychiatric Association, 2022) that do not involve chemical substances (e.g.,

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drug, alcohol, medication, etc.) but where the object of the dependency is represented by behavior or an activity that is an integral part of daily life. It concerns the relationship between two people bound together by a distorted intimate relationship, where the constant movement between the quest for the other and the impossibility of reaching the other is played out.

Love addiction is thus a pathological way of living in relationship, where the addicted person comes to negate their own needs and to renounce their own vital space so as not to lose their partner. They consider the other person to be their single source of gratification and a fundamental source of love and care.

This is a form of obsessive love that is symbiotic, fusional, and stagnant. It becomes like a drug for which all developmental prompts for change and all gratification are sacrificed. In fact, partners who are chosen often are not gratifying but rather are people with whom an unsatisfying, unhappy, and painful relationship is begun. The love addicted person experiences an absolute, obsessive need for reassurance and certainty and suffers a sort of loss of the self, a condition in which the other represents the only source of joy and possible gratification.

Thus, love addiction is a pathological form of love characterized by a constant absence of reciprocity within the couple relationship, where one of the two has the role of one-way giver of love and sees the bond with the other (which is often problematic or evasive) as their only reason for living. The continual quest for love has all the hallmarks of substance dependency and thus shares with it some fundamental aspects. These have been articulated by Giddens (1992) in terms of specific characteristics:

- *The high*: The addicted person tends to be fine only when in the presence of the loved one; it involves the sensation of pleasure felt by the addicted individual when their partner is indispensable to feeling good, something that cannot be felt in any other way.
- *The dose* (*tolerance*): The addicted person tends to increase their "doses" of the loved one's presence/proximity; their own autonomy decreases as well as relationships and contacts with others.
- *The abstinence*: The absence of the partner (e.g., for work) throws the dependent person into a state of alarm. Sometimes the need for the physical presence of the other is so strong that the addicted person feels they exist only when the partner is near them (loss of self). In fact, the partner is seen as the only source of gratification, and daily activities are forgotten, the only important thing being time spent together. The addicted individual aims for a fusional state with the loved one, which can compromise the love addicted person's critical capacities and experience of reality.

Other characteristics include:

- *Obsessive*: The love addicted person is obsessed by the idea of the partner and by fear of being abandoned. The partner becomes a "fixed idea" until it is no longer possible to think about anything else. This can lead to

neglecting daily life responsibilities such as those related to work, children, and so on.

- *Avoidance of change*: The love addicted person avoids change because that could lead to risks for their relationship. Considering that the risk is represented by abandonment, the individual gives up any other interests and personal growth (often also professional development), a "sacrifice" for the "good" of the other. The stagnation of the relationship produces the opposite effects to those that are expected because love, by definition, is a dynamic process that is nurtured by change and personal growth.
- *Lack of real intimacy*: The state of ongoing tension, anxiety about losing the partner, terror of abandonment, and possessiveness, paradoxically, prevent real intimacy and genuineness with the other.
- *Parasitical*: The love addicted individual, like a parasite that lives thanks to the "nurturing" of the host organism, depends on the other to feel alive. They give up expectations, interests, and needs and assume the other's needs and desires because they believe "if the host organism (the loved one) dies (abandons me), I'll die too."
- *Proof of absolute devotion from the loved one*: For the love addicted person, it is not enough to think about the other; they require constant proof of love. In time this attitude "stresses" the partner, who, in order to safeguard their own autonomy, might "neglect" the infinite needs for demonstration from the addicted one. The love addicted person then does not feel reassured and requests more and more proof of love, thus creating a vicious cycle.
- *Manipulative and hyperpossessive*: The love addicted person, in order to satisfy the need for emotional security, exacerbates their attitudes of possessiveness and control by trying to "spy on" not only the behavior of the loved one but also their partner's thoughts. The manipulation becomes a functional strategy to fulfill the need for security. In the extreme, this can lead to self-harming acts or suicide attempts carried out in order to control the partner.

In her book *Is It Love or Is It Addiction?* Brenda Schaeffer (2009, Part III) distinguished between three types of addictive love: love, romance, and sex addiction.

- *Love addiction* refers to an unhealthy dependency on the object of love. We look to another person to satisfy our hunger for security, sensation, power, identity, belonging, and meaning. It is an unconscious attempt to fix past and present pain, avoid what we fear, fill our loneliness, and gain control of our lives. Rather than a healthy bond, the love relationship becomes a subjugation.
- *Romance addiction* refers to when the object of love addiction is the romantic figure. This person can be a partner or exist only in the elaborate fantasy life of the individual. A romance addict is "in love" with the sensation of being "in love."
- *Sex addiction* is any obsessive-compulsive behavior or excessive sexual behavior that if left unattended causes distress or despair for the person and/or partner. It occurs when a person uses one or more sexual behaviors as a "fix" or a drug.

Schaeffer (2009) explained how addictive ties go from the Child of the partner to the Child of the other in any addictive love type. Addictive lovers believe they need to be attached to someone in order to survive because the other has the magic power to make them whole. This is the reason why for them love often goes wrong. A pervasive feeling of something missing drives them into adult relationships unconsciously looking for the other to satisfy their unmet needs.

Attachment Theory and Love Addiction

Returning to the etiopathogenetic origins of the love-addicted disturbance, it is important to remember that authentic independence is born from the ability to depend on another. This definition (Lingiardi, 2005), in turn, raises the question about the relationship between attachment security, the ability to self-regulate affection, and mentalization. For Mikulincer and Shaver (2004), strong attachment facilitates the construction of the processes of nurturing and reassurance of the self that sustain the person when faced with stressful or threatening situations. Healthy dependency, the foundation and matrix of identity, is constructed, then, on the basis of the earliest bodily-affective exchanges between mother (or primary caretaker) and child.

The child, from birth, "knows" the mother through the senses of taste, touch, sound, smell, and sight. The sensorial experience comes about together with the bodily and visceral experience of pleasure and pain and with body-organized motor actions that involve the mouth, the hands, and the entire body. All these separate perceptive functions are subsymbolic and symbolic and converge in the image that the infant child creates of the caretaker. It allows the mother and child to establish an affective consonance that seems to play an important role in the further development of ways of relating that are more sophisticated and include the use of language.

This way of conceiving the formation of emotive schemes corresponds to the ideas of Beebe and Lachmann (1988) about the organization of the "representational worlds" (p. 306) of the infant in the first 6 months of life, before the development of symbolic abilities that lead to the development of generalized prototypical images that then become the basis for the symbolic forms of the representations of self and object. We can thus surmise that between our first organizational mental processes there are protonarrations of prerepresentations as relational knowledge like the self-with-the-other (Winnicott, 1984/1990).

It is clear that clinical reflection on dependency must be placed in a relational reality in which healthy object relations lead the person to contain, in dialectic tension, the regulation of their own self (Blatt & Blass, 1996).

The bond of attachment begins with the processes of emotive regulation and psychological harmonization. They are interpreted as the main mechanism in the formation of an attachment bond whose essential function is the creation of positive and vital affections.

The first experiences of object relations are registered in the unconscious and influence the development of the psychic systems that elaborate the unconscious information for the rest of the person's life. So the first relationship of the child with the mother acts as a mold for the structuring of circuits of the right hemisphere of

the brain (Panksepp, 1998; Schore, 2000; Tronick, 1989). This models permanently a person's ability to adapt or not adapt when entering all future emotionally important relationships.

According to Fonagy and Target (1997), one of the fundamental consequences of strong attachment is the development of reflective and mentalization functions. The reflective function refers to those mental operations that allow one to interpret their own behavior and that of others in terms of hypothetical states of mind, which is in relation to thoughts, affections, desires, needs, and intentions. In TA terms, the failure of the reflective function can be compared to the missed integration of the parent's self and, therefore, to the injunctions that the same parent sends to the child having to do with the structural pathology of the Parent (P1+) and (P1-) (Hargaden & Sills, 2002; Haykin, 1980; Moiso, 1985). Erskine (2009) affirmed that anxiously ambivalent attached individuals express affect and distress intensely in a hypervigilant, preoccupied manner. They tend to form dependent and clingy relationships with unreasonable emotional demands for security, reassurance, and consideration. They can be either passive or overwhelmed in intimate relationships. When significant others are experienced as inconsistent or unpredictably responsive, an excessive focus on clinging dependency and physical attachment may develop. The life script of such individuals involves an unconscious escalating or minimizing of awareness and expression of relational needs and feelings of attachment. These individuals may alternate between affective expressions of confused/passive and fearful/overwhelmed narratives. They often feel unhappy because of a lack of emotional acknowledgment and care from the other person, yet they remain uncomfortably dependent in the relationship, attached to the other without attunement but unable to part, desperate and anxious about a possible loss. They have an implicit fear of abandonment.

Through the parents' behavior in the first months of life, the child moves gradually from a reflective behavioral model to a mentalistic one. The lack of reflective function in the parent leads not only to an insecure attachment but also to less mentalization and regulation of affects because somatic perceptions are not symbolically elaborated and do not acquire any psychological meaning (Schore, 2003).

Mentalization is the ability to represent one's own mental states and those of others as possessing intentionality so as to render behavior predictable. It is a transgenerational acquisition: The child can think of themself as an intentional person to the degree that they have been thought of as an intentional being by the parent. Thus, the child responds not only to the behavior of others but also to their understanding of their feelings. Here, too, it is a context of strong attachment that provides the scenario in which the child can develop the ability to sense the states of the self.

From the point of view of transactional analysis (TA), we can compare mentalization to the change that people, through their relationship with their significant other and on the basis of their neuronal heritage, bring forth, choosing between new options to reach a redecision. Thus, mentalization in TA has to do with the construction of a welcoming and nurturing Parent (Clarkson & Gilbert, 1988). In TA we can work on mentalization by considering the ways patients, in the process of writing their script, have mentalized the mother and their relationship with the mother.

According to the theory of mind (Fonagy & Target, 1997; Meins, 1999), the first relationship between child and mother acts as a mold for the structuring of circuits

in the right brain, shaping permanently adaptive and maladaptive capacities of the individual to enter all the subsequent significant relationships from an emotional point of view. The evolutionary progression toward interpersonal awareness implies that the child, and therefore the patient, moves gradually from a preverbal subsymbolic model to a mentalistic one.

In the communicative exchange children have with the mother during the first months of life, this mentalizing relationship is in the service of the possibility of building both the child's and mother's mind and the dyadic relationship in the child's life script (Bollas, 1989/2018; Cornell, 1988). It appears clear that there is such a connection between attachment and dependence that only with the possibility of experiencing a healthy dependence can a nondefensive independence be built up to intersubjectivity.

Intersubjectivity refers to a need and a fundamental condition. By nature, our mind is constantly looking for other persons with whom to enter into resonance and share experiences. Stern (2004) introduced the concept of *intersubjective matrix* to describe how each person grows surrounded by interactions, affective states, desires, and thoughts of others who constantly interact with their own thoughts in an unceasing dialogue from which subjective mental life develops. Only those individuals who have overcome the conflicts of dependency and developed a sense of self that is integrated and cohesive are able to depend healthily on their own objects of love and to feel themselves enriched more than threatened in relationship. The theme of intersubjectivity is then of great importance because it is connected to the study of the evolution of the child's communicative skills and emotional management and, in a wider sense, to the development of their own self as recognized by another human being in a process of continual tension between self-affirmation and dependency.

In the development of pathological dependency, a predominant role is played by the attachment relationship with the mother in which she, instead of mirroring the child at the breast and reflecting onto the child herself, shows the state of her own soul, her own anxiety, or her own defense against the child. The baby at this point becomes overcome by the sense of anxiety and begins to activate levels of somatization as a sign of emotional avoidance and repudiation. These somatizations show how emotions, in excess or avoidance, make their way through the body if they are not regulated and processed. Body-brain-mind integration is jeopardized, and the relationship with the exterior world and the child's self-reflective ability are significantly reduced. As an adult, the person will activate primitive and intense defenses when faced with threats of fragmentation of self, which can lead to an enduring psychic tension that can only be apprehended through compulsive activities that alter self-awareness and keep the sense of personal vulnerability at bay.

Intrapsychic Processes of Dependency

A defect of the regulatory ability not only interferes with the child's natural exploratory urges but also tie the need for safety to concrete modalities that heavily interfere with symbolization processes (Fonagy & Target, 1997; Liotti, 2005; Siegel, 2020).

An individual may report episodes when they are overwhelmed by feelings and moments of intense and generalized excitement and are not able to distinguish

affective states or to transform them from physical sensations into emotional states. A defensive strategy that may help the person to bear such situations, which otherwise would be unbearable, is the process of dissociation, in which disconnected experiences of ego states are kept. As a consequence, we may observe in the individual:

1. Dissociation or a split in the representation of the self with the other
2. A lack of impulse control
3. Metacognitive deficit
4. Warning signs of love addiction

Dissociation

Dissociation refers to a defense mechanism whereby some elements of psychic processes remain disconnected or separate from the rest of the individual's psychological system. It is activated by the self with the aim of regulating affective states that are otherwise unmanageable. It deprives the person of the possibility of experiencing their own internal world, being able to access their own emotions, and regulating them respecting their own feelings and those of others with whom the person interacts.

Lack of Impulse Control

The fundamental characteristics are the inability to resist an impulse, an impelling desire, or the temptation to carry out an action. A growing sensation of tension and excitement exists before an action is undertaken, which is followed by pleasure, gratification, and relief when it is done.

Metacognition

Metacognition indicates a type of self-reflectiveness about one's cognitive phenomenon that can be activated thanks to the possibility of distancing the self, self-observing, and reflecting on one's own mental states. Metacognitive activity allows, among other things, the control of thoughts and thus knowing and directing learning processes.

Warning Signs of Love Addiction

As described by Schaeffer (2009, Part V), the warning signs of love addition can include: overadapting to what others want; boundary problems; sadomasochism; fear of letting go; fear of risk, change, and the unknown; stunted individual growth; difficulty experiencing intimacy; playing psychological games; giving to get something back; attempting to change others; need for the other to feel complete; wanting, wishing, waiting; demanding and expecting unconditional love; refusing or abusing commitment; looking to others for affirmation and worth; fear of abandonment; repetitive bad feelings; desire yet fear of closeness; attempting to fix feelings; and power plays.

Symptoms and manifestations of love addiction are seen at two levels: in relationship with the other and toward oneself. In relation to the other, the addicted person feels terror of abandonment and separation, fear of losing the person they love, extreme devotion, morbid jealousy, a total absence of boundaries with the partner, and the activation of a symbiotic and fusional relationship. Toward the self, the person shows an apparent lack of interest in the self and one's own life and becomes isolated, unable to tolerate loneliness, experiences fear of being oneself, guilt and anger, and alarm and panic when facing minimal opposition.

Transactional Analysis Framing of Love Addiction

Love addiction is based on the unchangeable idea of the other as an exclusive source of nourishment (interiorization of the other) and on the idea of the self as a needy object unable to think for oneself. It can be read as the failure of the dialectical model based on the two evolutionary thrusts that define the need for relationality and the need for autonomous identity.

The pathological outcomes of this tension lead to introjective pathologies or anaclitic pathologies. The first are dominated by avoidance, depression, and a sense of guilt and shame. They appear mainly in people with schizoid, schizotypical, narcissistic, antisocial, and avoidant personalities. The latter are dominated by concern for relationships with undermining aspects, depression with a sense of loss, and need for the other with confusional aspects. They mainly appear in histrionic, borderline, and dependent personalities.

From that we observe how love addiction is a transversal syndrome that is present in many personality traits and manifests in the relationship with the other, with resources and script limitations that have to do with the search for the other as unique regulators of the self (Lingiardi, 2005, p. 71). The affective interlocutor then takes the form of emotive containment and self-esteem.

Norwood (1985) usefully explained this kind of behavior. In her work, she examined families, thoughts, and behaviors of codependent women and found that when childhood experiences were particularly painful, the women were often unconsciously compelled to re-create similar situations as a way of trying to gain control over them. Freud (1938/1980) referred to this as *repetition compulsion*. In TA this process is referred to as living out one's script (Blackstone, 1987), a set of conclusions, beliefs, and decisions forming the child's frame of reference, a filter through which the child experiences life. Events are understood, explained, and justified accordingly. Although it is binding, the script itself represents a frame in a person's life. It is not equivalent to disease, contrary to the definition of affective dependency proposed by Norwood. This idea of understanding affective dependency through the concept of script refers to the use of diagnosis offered by Clarkson (1992, pp. 53–74). In particular, it is important to keep a humanistic/existential TA perspective in which every person is radically OK and to carefully avoid the risk of labeling or using the diagnosis itself in a restrictive or insensitive way.

The life script of a person with affective dependency often includes a preference for having type 2 symbiotic relationships (in which the symbiosis occurs between second-order ego states of two individuals; Schiff, 1975) with the parents, wherein

the child is the one taking care of the needs of a parent unable to care and take care of themselves by themselves. The Rescuer position of Parent and Adult ego states helps the child deny feelings of disappointment, despair, and anxiety, which would otherwise overwhelm them. This original symbiosis is repeated in adult relationships as soon as the person with affective dependency finds a candidate for the role of Victim to rescue and take care of. Rescuing is the manifestation of the survival adaptations and script decisions.

The change process of script through redecision involves radical but usually gradual changes so that a series of redecisions replaces some early decisions that were appropriate during childhood but are no longer useful. In therapy, individuals with affective dependency question their early beliefs, changing or discarding them as needed. They no longer discount their own importance and no longer see the other as "damaged" and "to be rescued." In this way they can learn how to rely safely on partners while retaining their own autonomy. They can finally nurture reciprocity.

Cornell (1988), strengthening the concept of the dignity of people and their ability to change and integrating TA and developmental theories, viewed script formation as the process by which the person tries to make sense of familial and social environments, to find meaning in life, and to predict and manage the problems of life in the hope of making dreams and desires come true. When a person experiences severe self-failures or hostile environments, they will likely enact more rigid and dysfunctional aspects of the script. Nevertheless, important decisions can be made at any point in life in the service of the person's psychological development.

Among the norms of the personal and family histories of those with a problem of affective dependency we find:

- Families in which the emotional needs of the person have been overlooked, especially during their early years of development
- A family history marked by lack of authentic affection that tends to be compensated for through the person's identification with a partner, with the effort to save that person actually coinciding with the interior effort to save themselves
- Absence in childhood of the possibility of experiencing a sense of security. This later generates, in the context of codependency, a need to obsessively control the relationship and the partner and is hidden behind an apparent tendency to help the other.

Manifestations of Love Addiction According to a TA Perspective

Passive-Dependent Type: "I Love You Because I Need You"

Love-addicted people described as a passive-dependent type tend to stay together with their partner even if the relationship makes them unhappy. Even if they no longer have any feeling of love, they are scared to let their partner leave or to leave their partner themselves, even if they are being mistreated. In some cases they prefer to be left.

Relationship: Child-Parent (dependence), need to please the significant other
Existential position: "I'm not OK, You're OK" (Berne, 1961; Ernst, 1971)
Games: Poor Me, Stupid (Berne, 1964)

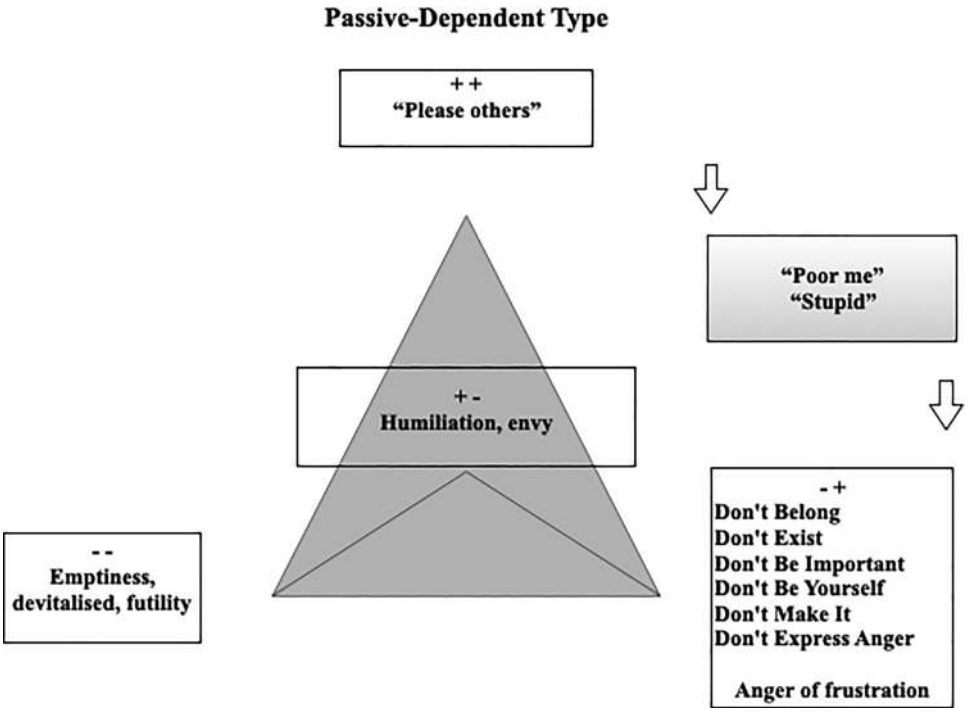

Figure 1. Passive-Dependent Type Miniscript.

Drama triangle: Victim (Karpman, 1968)
Prevalent emotion: anxiety over possibility of abandonment
Illusion: "You will save me"; Adult contaminated by Child
Miniscript: see Figure 1 (Kahler, 1974)

Codependent Type: "I Love You Because You Need Me"

The most common type of love addiction is the codependent type. These people have low self-esteem and behave, think, and show their emotions in a foreseeable and stereotyped way. Their basic insecurity and low self-esteem, typical of their personality, push them to hold their partners obstinately and desperately to themselves. In their fantasies, their partner can give them what they did not receive as children. When they fear abandonment, they put in place controlling behaviors on their partners (e.g., obsessive jealousy) or they act in codependent ways, becoming tolerant, permissive, even allowing abusive or mistreating behaviors from their partner. They will do anything to take care of their partners in the hope that they will not be abandoned and that someday their caring will be reciprocated or acknowledged.

Relationship: Parent-Child (symbiotic invitation); total care of the other
Existential Position: "I'm OK, You're not OK" (Berne, 1961; Ernst, 1971)
Games: Poor Me, Wooden Leg (Berne, 1964)
Drama triangle: Rescuer (Karpman, 1968)
Prevalent emotion: Hope. The codependent is convinced that they can give meaning to their existence through caring for the other.

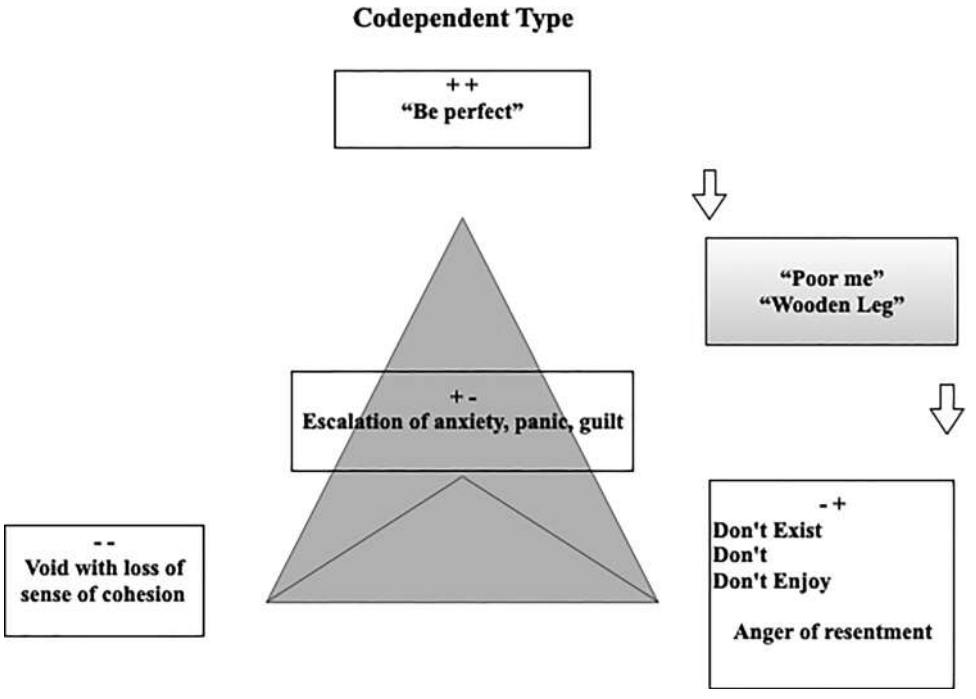

Figure 2. Codependent Type Miniscript.

Illusion: "I will save you"; Adult contaminated by Parent
Miniscript: see Figure 2 (Kahler, 1974)

Aggressive-Dependent Type: "I Hate You Because You Are Like Me"

In the aggressive-dependent type, people use domination or seduction to control their partners. They tend to be despots and not flexible about anything that can interfere with their well-being. They seem to have no need for anything or anyone and hide their fragility and low self-esteem with grandiose behavior, as is typical of narcissists. They apparently show no dependency but are detached and indifferent to relationships, but if they are left alone they explode in violent behavior and impede in every possible way their partner from leaving them.

Relationship: Child-Child (fear of dependence on the relationship); provocation and discounting aimed at the other and the self
Existential position: "I'm not OK, You're not OK" (Berne, 1961; Ernst, 1971)
Games: If It Weren't for You, Uproar, Courtroom, Now I've Got You, You Son of a Bitch (Berne, 1964)
Drama triangle: Persecutor (Karpman, 1968)
Prevalent emotion: discounting others and themselves
Illusion: "You will never be able to take care of me, and I shall never be able to take care of you"; excluding Child
Miniscript: see Figure 3 (Kahler, 1974)

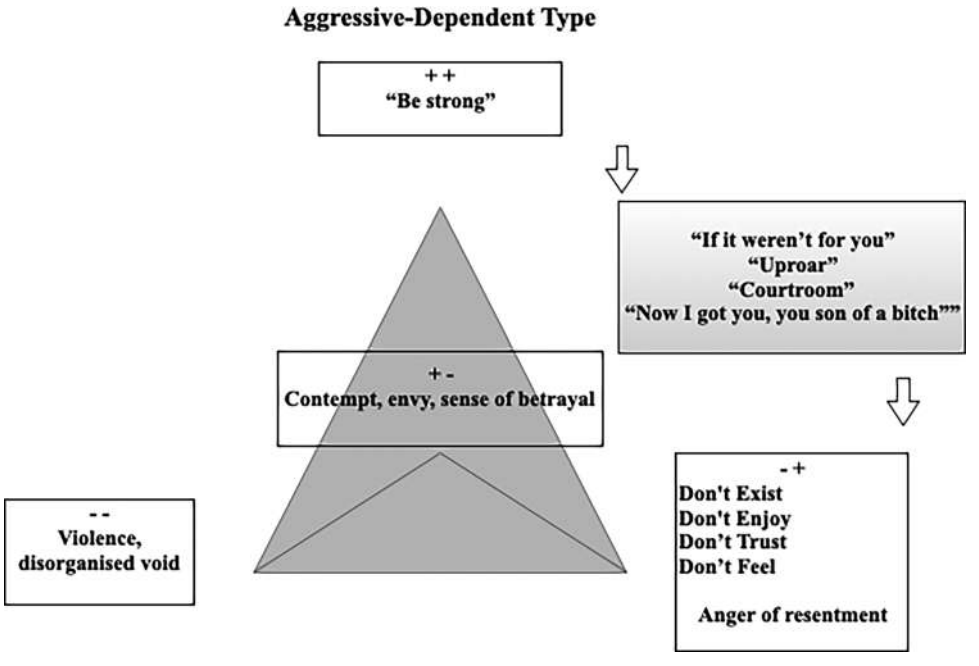

Figure 3. Aggressive-Dependent Type Miniscript.

Counterdependent Type: "I Don't Need You"

The counterdependent (or ambivalent) type is generally affected by an avoidant personality disturbance. Apparently they show no difficulty nor do they suffer particularly if their partner abandons them. Instead, they show difficulty in deepening their relationship and letting themselves become intimate because they are terrorized. They have a desperate need to be loved but fear becoming too bound up with another person.

Relationship: Child-Parent (affectively unavailable, avoiding intimacy). Representation of oneself as a person vulnerable to loneliness and prematurely made autonomous, representation of the other as scarcely reliable.

Existential position: "I'm OK, You're not OK"/"I'm not OK, You're not OK" (Berne, 1961; Ernst, 1971)

Games: Why Don't You, Yes But; Now I've Got You, You Son of a Bitch (Berne, 1964)

Drama triangle: Persecutor/Victim (Karpman, 1968)

Prevalent emotion: void, shame, lack of empathy

Illusion: "You'll never know who I am and what my needs are"; Adult contaminated by Child, Tough Kid (Lederer, 1996, 1997)

Miniscript: see Figure 4 (Kahler, 1974)

Treatment of Love Addiction Using Transactional Analysis

Paradoxically, the opposite of dependence is not independence but mature dependence. An authentic independence leans on the ability to depend, so we will look at the concept of dependence not in terms of a dependence-independence polarity but from a continuum of healthy dependence versus pathological dependence

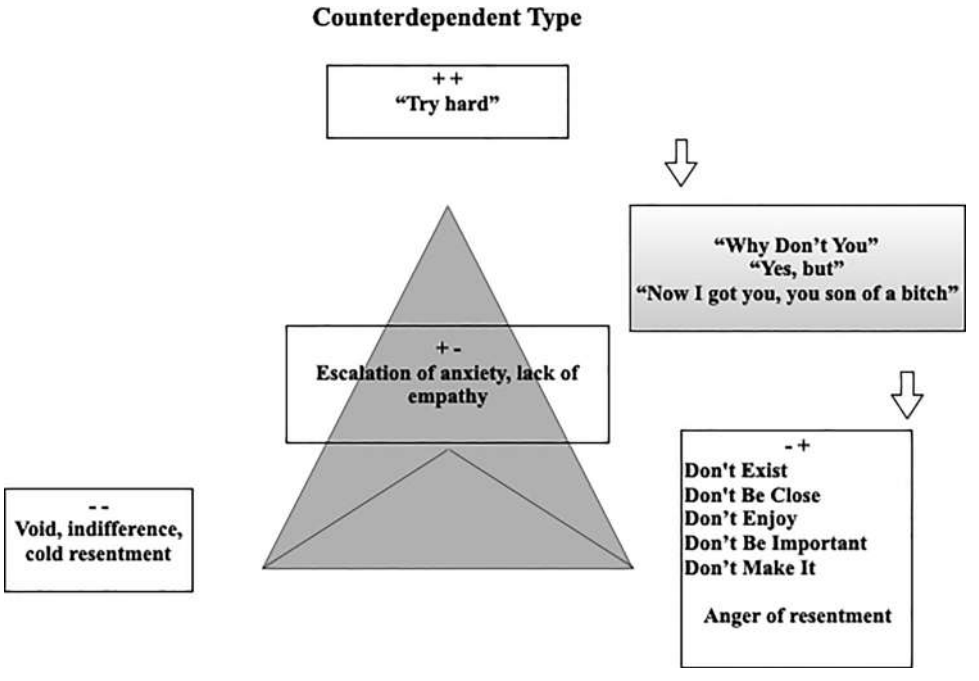

Figure 4. Counterdependent Type Miniscript.

(Liverano et al., 2009). Our starting hypothesis is that both the quality and the style of attachment can influence the vulnerability of dependence.

If the child experiences the child-parent figure relationship as unsatisfactory, they will be influenced in their reactions to themselves and to develop self-limiting behaviors, that is, decisions. In fact, there is an innate need to receive stimuli from the environment. This hunger for stimulus, structure, and recognition (Berne, 1961) influences in a central way the various vicissitudes of child-parent interactions. Attachment is, therefore, a primary need.

Berne stated that one of the reasons for social relationships is strokes, contact, and recognition of oneself and the other. He described two more reasons: the biological and the psychological. Berne stated that strokes, as motivations for the human being, not only encourage biological homeostasis but balance the psychic and somatic, thereby creating a variety of social relationships. Thus, human beings have multiple reasons for seeking strokes: social, recognition, psychological, biological, genetic, and anthropological-cultural.

The need for recognition leads the child to live in a vital manner various interactions with parental figures, whose responses are decisive in the acquisition of the positions the child takes with respect to self and reality. From the concept of hunger for recognition, we can move on to considering individual destiny. Berne (1961, 1972) conceived of it as the dynamic effect of two psychological positions: autonomy and the psychological script.

We think of the concept of dependence when Tudor and Summers (2014) described autonomy as the disposition of the human organism to realize the vital force to which Berne (1957/1968, pp. 78–97) alluded when speaking of physis: the biological and social basis to become autonomous. Tudor tied autonomy (i.e., healthy attachment)

to homonomy. Referring to Angyal's (1941) work, Tudor considered a person to be autonomous (i.e., self-governing) and homonomous in the sense that they aspire to be in harmony with the world and the complexity of its elements. Autonomy and homonomy describe the person in the experience of relationships.

In the coconstruction of a healthy attachment relationship (Summers & Tudor, 2000) it is important to give value to the concepts of the *stroke economy* (Steiner, 1971) and *empathic transactions* (Tudor, 2003, p. 117). The definition of the "Integrating Adult" given by Tudor accented the concept of integration and thus the process by which the neopsyche, as an innate function, organizes and integrates archaic and fixated material. This promotes the growth of awareness. Therapy is, first, the creation of new possibilities of (neo) psychic relationships, put into place, tried and tested in the therapeutic setting. Second, therapy has to do with the pain of the past trauma; in this, it is above all a phenomenological and existential process (Liverano & Piermartini, 2010).

Tudor and Worrall (2006) developed the concept of the Adult self as a vibrant personality able to elaborate and integrate feelings, behaviors, and thoughts and to adopt appropriate behavior in the here and now of every phase of life. This state of the self, concentrated uniquely on the present, knows how to act autonomously (with awareness, spontaneity, and intimacy). Even script theory evolves. Scripts are seen as narrative constructions and as memories; they are cocreated in the present and projected into the past, thus underlining the importance of contact and exchange with the other in the construction and maintenance of the sense of self, seeing the script as a print left by this ongoing process of negotiation, a print identifying the subject, a characteristic of their histories (Ligabue, 2004, p. 33).

Aims in the TA Treatment of Love Addiction

In TA we can define affective dependency as a process of disconnection (partial exclusion) from the ego states that corresponds to cognitive and emotional processes that are irrational and not systematic and become evident when the person is exposed to a strong emotional stimulus. The person is not able to recognize and identify their own emotions because they were not helped to develop a sense of self. So they are induced to accept traumatically part of the self of the violent or abusing caregiver. At an idea/affective level, they have difficulties in portraying what the other thinks or feels.

We are talking here about the consequences of a disorganized type of attachment in which there is a lack of adaptive capacity, internal security, and balanced regulation in the representation of the self and the self with the other. This type of attachment also involves the presence of dissociative dynamics because of the reduced efficiency of the integrative functions of memory and consciousness. If a child is not given the possibility of mirroring themself in the parental figure, a gap is created in the child's psychological self because they are forced to internalize the representation of the parent's mental state as a negative nuclear part within their own self.

This determines, at the level of structural analysis, two levels of pathology that affect the Adult ego state:

- A double contamination of the Adult whereby it moves outside of awareness and shows, on the one hand, aspects of the abusive Parent and, on the other, the angry and/or passive-pleasing Child

- A partial exclusion of Adult that leaves open space for the abusive Parent and the angry and/or passive-pleasing Child, which as described earlier manifests itself symptomatically through dissociation

Thus, the aim of treatment is for the patient to come into contact with their own internal experiences through the therapeutic relationship. The therapist must then welcome empathically the dependence of the patient and accompany them along the way of painful interior awareness with the goal of reknitting the tragic experience of one's own love injuries through a rediscovered love of the self that speaks of autonomy (Berne, 1966).

The following offers more details about what needs to occur in this kind of TA therapy.

Analysis of Ego States

P_2 (the Parent) contains internalizations of the terrifying experience of relationship with the significant other (violent, abusing, or absent).

A_2 (the Adult) is less developed and often partially excluded to make bearable what was experienced as violent and unbearable. At an intrapsychic and interpersonal level, it expresses with the projection of the persecutory element outward.

C_2 (the Child) is omnipotent, megalomaniac, and hypercontrolling: "I'm sure I'm right."

C_1 (the Child) with experience of void and freeze with the need of "being with" (C_{1+}, C_{1-}, which are aspects of the Child fixated at an earlier stage of development as a response to an unmet need for relationship with the caregiver; during this stage the part object introjects of the infantile ego are observable in the form of good and bad introjects; Haykin, 1980)

Structural Pathology

Double contamination P/A and C/A

Functional Analysis (see Figure 5)

Dusay's (1972) egogram:

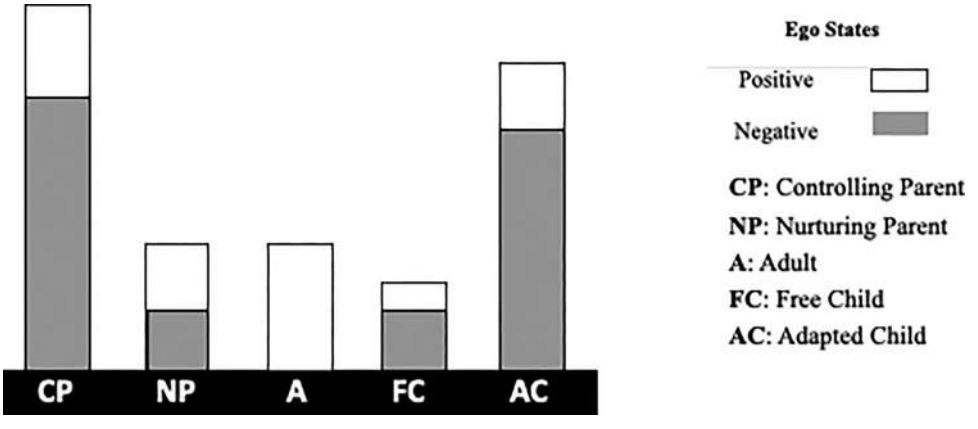

Figure 5. Egogram for Love-Addicted Individual (following Dusay, 1972).

Critical Parent is active toward the self and other.
Nurturing Parent is less present to self.
Adult is less energized.
Free Child is less energized.
Adapted Child is very adapted to the environment.

Drivers

"Be strong" – "Please" – "Be perfect" – "Try hard"

Injunctions

Injunctions are in the area of existence, intimacy, and relationships.

Script Beliefs and Script Decisions

"I'm not worth love."
"I won't be close to anyone!/I'll be close because I need the other."

Life Position

"I'm OK, You're not OK" (paranoid) – "I'm not OK, You're OK (depressive) – "I'm not OK, You're not OK" (schizoid)

Passive Behaviors

Agitation, incapacitation, hyperadaptation

Discounting

Alternate discounting of the self and the other

Racket

Anger, confusion, impotence, fear, void, lack of meaning of life

Thus, in therapy, we elaborate the fundamental elements of fear of the new, abandonment, and separation.

Goal 1

The person is helped to manage obsession in relationship, behavior of control of the other, and the crisis of "abstinence" provoked by the absence of the partner (contract of social control):

- Express what is felt/thought coherently with what is being done
- Differentiate real experiences from racket ones

Goal 2

Understanding the origins of the discomfort through the exploration of the patient's individual and family history with a view to increasing awareness about the mechanisms and events that caused the discomfort:

- Show stability and coherence in maintaining the relationship with the self and with the other, differentiating one's own experiences from those of others.

Goal 3

The person is helped to take charge of their own life, their own spaces, their own relational network; to face the fear of loneliness; and to support the development of self-esteem (contract of autonomy):

- Express a wide range of affects, modulated in relation to the context of the communication with the other
- Use fantasy and find creative solutions in the relationship
- Accept one's own body
- Empathize easily with the experiences of others
- Express different representations of one's parental figures
- Express the need/desire to "be with"

In the experience of rebonding between past and future, the patient shows:

- Recognition of representation of the self and the other here and now as compared to the there and then at the level of affection
- Recognition and separation in the here and now of the script "thorns" with which they were blocked from satisfying their own attachment needs in the there and then

Goal 4

The person strengthens the skills acquired and monitors any failings. It is advisable to integrate individual therapy with group treatment, which is a useful instrument of encounter in which to share and elaborate one's own sufferings. Widening awareness with respect to one's own interior dialogue allows the patient to move forward in relationship to self and other and to maintain a sense of continuity with one's own identity, leaving the person to be guided by their own intuitive-affective resources.

Clinical Case: Aggressive-Dependent Type: "I Hate You Because You Are Like Me"

Treating a patient suffering from affective dependency, whatever their personality disorder is and regardless of the therapy framework, there are some specific and constant aspects. We are talking about the therapeutic alliance and the

development of the therapeutic relationship, which are a significant part of the treatment. Berne (1963) argued that the hunger for recognition is the main motivation for a relational behavior, which is seen as a push toward the search for intimate relationships with a striving for intimacy underlying the most intense and important operations.

We can say that the focus of the problem is actually the quality of object relationships, which makes relationality difficult because it is considered deceptive and a forerunner of future desertion. Thus, therapy work requires focus and patience. At the beginning, the relationship with these patients—who have good comprehensive functioning—is easy. They seem collaborative and present.

From a developmental point of view, the inability to elaborate healthy autonomy during psychological development is related to an experience of manipulation the person experienced during their first relational attachment. This condition of manipulation is an internalized manner related to the mental representation of the self and outer world, and henceforth it causes persecution regarding every aspect of dependency.

The therapist's task is to return an empathic answer and to work via acknowledgment and listening. The discounting and idealization the patient manifests express the suffering caused by their low self-esteem. It is therefore necessary to bring them back to a reparative affective experience in order to re-create an image they can use to reevaluate their value and sense of self.

In the following clinical case, we will show how the first phases of the therapeutic alliance look like a dance wherein the two dancers, through slow movement, gradually develop the movements creating the full dance sequence. This is our understanding of the therapeutic alliance: a set of dance moves leading to the comprehension of the patient's and the therapist's experiences in that specific therapeutic relationship.

Giovanni was 42 years old when he decided to begin therapy because of dissatisfaction caused by his marriage. He feared his wife would cheat on him, and he was in the grip of violent jealousy. He had been married for about 20 years to a woman he met at work; she was one of his employees. She had always indulged him, becoming passive and considering herself like Cinderella. When she decided to go to therapy for her personal life choices, Giovanni became angry. He was afraid of losing her. He hated his wife's therapist and ended up suspecting therapy would contribute to pushing his wife away from him.

Giovanni believed that he had lost his mirroring object, and he felt lost and empty. This was paranoid thinking with the risk that he would develop a depressive disorder. What the therapist understood and reflected back to Giovanni in the first sessions was the huge suffering of a man—apparently a confident and strict manager—facing an eventual challenge in his relationship with his wife, a woman he said he deeply loved. The therapist left Giovanni's anger in the background at first because she believed he needed to feel welcomed, heard, and even validated for his feelings.

Gradually, Giovanni opened up to the relationship. He began trusting the therapist, even if she was a woman like the important women of his life (mother, wife, and daughter) who had betrayed him because they did not appreciate and mirror him as he wished. In this phase of the therapy, the idealizing transference (Kohut, 1977)

toward the therapist began. Giovanni saw her as he needed to see her in order to be reassured and to find the strength to carry on with therapy. In this phase of the alliance, the therapist's countertransference was twofold: She felt alternately part of his deep suffering because of his difficult marital relationship and frustrated and angry when she got in touch with Giovanni's challenging and oppositional aspects. Therefore, she encouraged the construction of a relationship that swung between great distance and dangerous closeness: monologues that pushed her away and the pursuit of an almost fusional closeness through exhausting calls for particular and exclusive attention (e.g., changes in the day and/or time of sessions).

The therapist always tried to keep firm control, which showed from the beginning that the basis of therapy was collaboration, not collusion. She acknowledged her mistakes in the relationship (e.g., when taking back an image he did not find suitable for himself) and thereby provided an example of the permission to be wrong without losing dignity as a human being. The therapist also used a precise and soft confrontation to prevent Giovanni from seeing it as an attack.

This led to the building of a bond, an interest from Giovanni to be in a relationship with his therapist, accepting the risk implied in relying on the other and accepting his vulnerability, his feelings, and everything the therapeutic relationship could reflect about the bonds of his real life. At the same time, he kept swinging toward manic speech about his importance and strength and their relevance in his daily relationships with others and his wife. In this phase of the alliance, the therapist did not feed Giovanni's assumptions, but she remained steady on her positions, gently encouraging him to prove himself in reality: "Why do you keep expecting from your wife something she cannot give you?"

With this intervention, the therapist wanted to push Giovanni to make choices and encouraged him to get rid of the self-pity that led him to strong aggressive attacks toward his wife, reminding him of the consequences those choices could have for him and how they were his responsibility. Little by little, Giovanni's defensive behavior turned into a willingness to face his painful reality, especially his inability to accept himself and others, with all their limits, as human beings.

In this advanced phase of the therapy, old and painful memories emerged of Giovanni being misunderstood, humiliated, seen by his parents as an angry person and the glory-bearer of the family. Gradually, he became more willing to face and work on the missed reflection and the emotional and physical neglect from his parents, accepting his becoming unfaithful toward them, which had been impossible for him at the beginning of therapy when his family was "just wonderful."

Gradually, Giovanni learned to be with his feelings of pain, hate, despair, panic, and dismay. With the help of the therapist's interpretation, he tracked down the origins of those feelings and revisited old experiences of lack of protection related to being treated as unmanageable. He began giving up the hope of being appreciated by his parents and began focusing mainly on his resources, interests, and gifts, including his kindness. He stopped praising (and therefore envying) those who had, in his opinion, qualities he lacked.

After some paradoxical interventions, where the therapist suggested that he leave his wife (who was seen as detached and unfaithful), Giovanni slowly adopted a new position with his wife whereby he shifted between detachment and withdrawal, on

the one hand, and the deepest love, on the other. He succeeded in his first attempts at dialogue, expressing his feelings and difficulties to his wife. It was a great success for him to give up his self-image as a strong and impassive man. Accepting the change, his responsibility for seeing his wife as ideal, and nurturing mutuality as an important goal in a relationship were Giovanni's achievements during years of therapy.

In conclusion, considering the work with such patients and referring to TA concepts and authors, we agree with Cornell (2008) in stressing Berne's understanding of personal responsibility, intrapsychic conflict, interpersonal manipulations, and construction of a life script. For this reason, we believe the task of the therapist is to welcome the patient empathically into the relationship in order to build an alliance, helping them thinking about the ways, reasons, and assumptions they base their relationships on in order to choose to change their way of relating with others. In other words, the therapist helps the patient develop independent functioning in a facilitative setting.

The final goal in the therapeutic relationship is not only to offer a corrective relationship for the original experience but also to change the patient's way of thinking and experiencing through the real relationship with the therapist, whose Adult sides with the observing Adult of the patient.

Conclusions

Love addiction is clearly a complex theme and one that is worthy of attention and study in order to further understanding and identification of strategies and methods of working usefully with it. Transactional analysis as a theoretical and practical approach appears to offer opportunities for this to happen, including in a dialogue with other theoretical approaches. In this way, it is possible to fix one of the cores of the dependent personality: the lack of agency, that is, the ability to carry on an action plan coming from inside, even in cases of lacking relational support or difficulties.

To make that happen, it is essential to teach patients how to regulate their feelings and use them in the context of personal relationships. Then it is necessary to make them aware of the affective-cognitive processes underlying the dissociation mechanism used as a defense against overwhelming feelings. Lastly, the therapeutic work must aim at integrating and processing traumatic memories, which surface implicitly in the dysfunctional dependent behavior. The outcome of the resolution of love addiction appears to be the ability to be interdependent in a constructive and healthy way, obtaining and developing intimacy, authenticity, and spontaneity, which are the basic goals of TA.

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