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## Review Article

# “Perrotta Integrative Clinical Interview” (PICI) for adults and teenagers (1TA version) and children (1C version): new theoretical models and practical integrations between the clinical and psychodynamic approach

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## Abstract

Starting from the general concept of “personality”, this work dwells on the analysis of the different theories, to then expand the theme on practical, applicative, psychodynamic, and clinical profiles, proposing a revision of the classic and modern psychodynamic model, in an integrative key. Based on three specific corrective measures, we came to propose an “Integrative Psychodynamic Model” (IPM) able to better adapt to the more complete definition of “personality”; on the same theoretical basis, we proceeded, for clinical needs, to propose a new “Psychodiagnostic Investigation Model” (PIM), revising the whole implant of the DSM-V appropriately combined with the contents of the PDM-II, to determine the listing of the new psychopathological classes on a personological basis (twenty-seven) and with the listing, for each class, of the nine dysfunctional traits, according to four areas of the domain (neurotic, latent, psychotic, mixed or residual), leaving room also for the psychopathological conditions common to all twenty-seven personality disorders and any medical and socio-environmental conditions relevant to the diagnosis. On the basis of the new Psychodiagnosis Model (PIM), the first version of two clinical interviews has been created for the analysis of personality disorders (*Perrotta Integrative Clinical Interview* or PICI-1), for adults and adolescents (PICI-1TA) and children (PICI-1C), proposing a new nosographic classification that would take into account the structural, functional and strategic profiles of current knowledge in the psychodiagnostic field. The two new tools, in the form of clinical interviews, after administration to a sample of three hundred units (one hundred per type), are in the diagnostic phase identical to the results of the MMPI-II, integrated with the psychodynamic profiles of the PDM-II, with more indications on the profiles related to dysfunctional personality traits, to provide a broader overview necessary to build a personalized psychotherapeutic plan, targeted and adapted to the patient, taking into account both the nosographic and psychodynamic, functional, cognitive-behavioral and strategic profiles.

## Contents of the manuscript

### General introduction to the concept of “personality”

Giving an unambiguous definition of “personality” is very complicated. The term, as we know it today, has been established since the 1930s, particularly in the United States, by scholars including Allport and Murray, who raised the issue. Previously, to indicate similar concepts it was preferred to refer

to “character” (which, however, implied a greater emphasis on moral and social characteristics) or “temperament” (which in turn implied a greater emphasis on the relationship between psychological and biological characteristics). With this new term “personality” we wanted to particularly emphasize the passage from a nomothetic psychology (aimed at studying general laws valid for all men) to an idiographic psychology (aimed at studying the individual and the causes that make



each different from the others). The difficulties related to a general definition of personality are more than legitimate, as it is difficult to frame in a structured and unified way all the theories of personality that have been proposed so far [1].

Trying to sketch the main theories of personality in the most linear and detailed way, the main theories can be listed as follows: [2-11].

1. **Hippocrates' historical or biological theory:** Which defines four "personal types", based on the basic mood present in the body (melancholic, choleric, phlegmatic and sanguine), while Cicero defines it as the appearance and dignity of a human being or that part that is played in life. These concepts will then be taken up by Pavlov in his reflexological and behavioral theorization and by Sheldon with the intent to identify the links between biological and behavioral structures (starting from the soft, solid, or fragile physical constitution).
2. **Dynamic theory of S. Freud:** Sigmund Freud's theory of personality has undergone variations as it progressed in its theoretical development. According to Freud, the human personality is the product of the struggle between destructive impulses and the pursuit of pleasure. Without setting social limits aside as a regulatory authority. The construction of the personality is therefore a product: the result of the way that each person uses to manage their internal conflicts and demands from outside. The personality will indicate how each person acts socially and how they deal with their conflicts: internal and external.
3. **Jung's analytical theory:** Jung sees in the personality of the individual the product and the synthesis of his ancestral history. He emphasizes the racial origins of man. Man was already born with many predispositions transmitted by his ancestors and these guide him in his conduct. Thus there is a collective and racially preformed personality that is modified and elaborated by the experiences he receives.
4. **Eysenck's hierarchical theory:** Eysenck was the first to define the personality of the individual according to a general concept, labeling it as the stable and lasting organization of a person's character, temperament, intellect, and physique; an organization that determines his full adaptation to the environment.
5. **Allport's trait theory:** Resuming the concept of traits, Allport believed that each individual was a unique combination of "personality traits", and for this reason, it was impossible to identify two identical personalities. He hypothesized the first division into common traits and personal traits: the former are those that can be identifiable for a group of people or category (e.g., boxers defined as "aggressive"); the latter are specific to each individual, and cannot be defined in a single word.

6. **Cloninger's neurobiological theory:** The author formulated the "TCI" theory, i.e. a psychodynamic theory that defines personality substantially based on the functioning of four important neurotransmitters, and their receptors, that determine dominant behaviors and responses to the environment.
7. **Murray's theory of needs:** Then taken up again from Maslow's studies, who theorized the hierarchical pyramid of needs, Murray maintains that personality is a hypothetical psychic structure that governs the organism and constantly mediates with the environment, exercising its processes based on the motivations behind the unconscious needs of the individual (twelve, how to feed and reproduce) and conscious needs concerning the environment (twenty-seven, how to defend oneself, preserve, recognize, acquire, build, be autonomous, avoid and be successful), creating adaptive behavior patterns from time to time (always concerning one's own needs).
8. **Kernberg's structural psychoanalytic theory:** Kernberg defined his theoretical approach as the Psychology of the Ego and Object Relationships, in which the three psychoanalytical models of reference converge. Kernberg, starting from the limits found in Freud's drive theory, i.e. the inability to give adequate explanations to the complexity of human motivation, referring to Mahler's theory, focused on the separation-individuation process, and Jacobson's theory, with the definition of the representational world, i.e. images or past experiences from which cognitive maps of the external world are derived, formulated a new theory on personality disorders. Kernberg's work is based on the belief that the psychopathology of personality is determined by psychic structures resulting from emotional experiences with primary significant objects. Mental structures are relatively stable configurations of psychic processes resulting from different internalized objective relationships. The structural organization stabilizes the psychic apparatus, determining a mediation between etiological factors and the direct manifestations of illness and behavior.
9. **Zucherman's basic theory:** For Zuckerman, at the center of the personality there would be a basic trait, the sensation seeking, describable as a continuous need for new experiences and sensations, which determines the propensity to take physical and social risks: individual differences in the expression of this trait would correspond to the expression of a fundamental dimension of personality.

### The structural, dynamic, and functional relevance of the personality. Persistent traits and patterns [12].

Trying therefore to define the concept of "personality" in a unified way, the synthesis could be the following: <<the



organized and complex, stable and lasting whole, of the psychic characteristics and of the behavioral and relational modalities that define the person>>>. From this definition, however, it is necessary to distinguish the concept of “personality trait” which instead represents only a constant way of perceiving and relating to oneself and the environment concerning that specific modality (and consequently the personality is given by the sum of the traits of an individual that would be able to explain the observed behavior). The “trait”, in turn, is distinguished from “attitudes” (behavioral modes reinforced by the environment that predispose the subject to certain actions repeated over time) and from “habits” (behavioral integrations repeated over time because they are structured in a complex of actions aimed at satisfying an unconscious pleasure) [13-18].

The term “personality” must also be clearly distinguished from [13]

- 1) “character”, which indicates the characteristics of the person most in conformity with social values and standards: in fact, it is said “you have a good character”, “a bad character”, underlining the adherence to a shared social and ethical criterion;
- 2) “temperament”, which is the innate component of personality, although, at least in part, it can be modified in interaction with the environment. The temperament is, therefore, the biological substrate, the average level of activation of the organism;
- 3) “constitution”, which is the external and anatomical configuration of the person.

The personality can still be defined as: <<an organization of ways of being, of knowing and acting (feelings, thoughts, behaviors), characterized by unity, coherence, continuity, stability, and planning to the relationships of the individual with the external environment. The personality has some biologically determined characters but it is an active construction, in progress, which is accomplished during the development through continuous interaction between the person and his external environment of reference. The psychology of personality aims to investigate the roots and the shared and unique expressions in the way of presenting oneself (self-representation), feeling (feeling emotions), and acting (carrying out behaviors) of the various individuals. The objective of personality psychology is to understand the unique and coherent elements of human conduct as well as to evaluate individual differences>> [19].

The “*personality structure*” [13,15] is, therefore, and ultimately, the set of profound and stable, largely unconscious, personal-psychological characteristics of a person that are expressed in every aspect of his psychic and behavioral life, making it predictable in daily life. This structure also makes each unique and unrepeatable. It consists of two parts: a plastic and modifiable, in continuous interaction with the external environment that influences it to make it adherent and appropriate to the contingent situations, and another

fixed, rigid, durable, and stable one that includes the biological structure and learning firmly acquired and permanent. Going back for a moment to Eysenck’s definition, for him, the personality structure is made up of three fundamental dimensions (which should be balanced with each other, to prevent the individual from encountering potentially pathological conditions):

- a) intelligence (or cognitive dimension),
- b) temperament (or relational dimension),
- c) character (or affective-emotional dimension).

Within the personality structure then we distinguish [13,15].

a) “**Personality traits**”: The tendency to process information, to express emotions and affections, to react and act in relatively stable ways in different contexts. They are genetically constitutive elements of the personality, traits understood as the ultimate causes of conduct;

b) “**Psychological types**”: These are constellations of traits.

When the totality of the emotional and behavioral traits typical of a person deviates from the culturally expected and accepted limits or when one is faced with rigid and non-adaptive personalities that cause social or environmental dysfunctions or marked subjective discomfort, a “Personality Disorder”, understood as a deviation of personality and behavior from “normal” cultural peculiarities, is configured. The therapeutic path, in this sense, aims at promoting the development of each person according to his or her potential, correcting dysfunctional manifestations, and improving the interaction of the individual both concerning the external world (relational sphere) and concerning himself or herself (intrapsychic sphere) [15].

The “*personality dynamic*” [13,15,20], on the other hand, concerns the functioning of the personality, both as a self-referential system (capable of reflecting on itself to achieve the objectives and respect the norms) and as a self-regulating system (it consists in implementing strategies that ensure the possibility of adapting to the environment and modifying it by the satisfaction of one’s needs). How the person interacts with the environment and builds his or her own identity therefore also depends on the motivations and causes that motivate an individual, concerning his or her needs and requirements. The various personality functions can be distinguished according to how dysfunctional and serious they are. We can think of them as if they were placed on a line (in a continuum) that defines the degree of compromise. They range from healthy or relatively healthy personality functions to those that are disturbed. This continuum has thus been subdivided into 4 levels of personality organization (healthy, neurotic, borderline, psychotic) and the evaluation is based on the analysis of the individual’s ability to distinguish between reality and fantasy (examination of reality) [21], to control impulses, judgment, mentalization or reflexive



function, to use the ego defense mechanisms [22], the balance of psychic instances among themselves and about the external environment, the strength of the Ego, internalized relational objects, the image of the Self, self-esteem, attachment styles [23] and the ability to relate to oneself (concerning emotions) and to others (concerning affections and feelings) [24].

- 1) **“Healthy” level of organization of the personality:** Individuals with a healthy personality score very good or good scores in the above areas. They can have different styles but are flexible and adapt to the challenges of the environment.
- 2) **“Neurotic” level of personality organization:** Neurotic subjects tend to highlight some specific emotional issues around which discomfort is organized: for example, loss or rejection or self-punishment in people with a depressive personality.
- 3) **Borderline level of personality organization:** People with borderline personality organization are not able to regulate their affections adequately and that is why they are often overwhelmed by them. This means that they experience extremely weak and disproportionate emotional conditions, bouncing from conditions of depression to intense anxiety, to moments of uncontrollable anger.
- 4) **“Psychotic” level of organization of personality:** Normally, when we talk about psychosis, we refer to a fracture in the relationship with reality, characterized by delusions and hallucinations. We speak instead of organizing personalities on a psychotic level for those subjects who manifest in a lasting way characteristics such as a concrete, bizarre and imaginative thought, whose generalizations go beyond what can be justified by the evidence, inappropriate social behavior, a serious and pervasive anxiety of annihilation.

The structural and functional definition of “personality disorders”, which are maladaptive models of long-term thinking and behavior, that differ significantly from the social norms and expectations of one’s environment, appears clearer and more immediate now; if not diagnosed and adequately treated they cause interpersonal problems, inadequate coping skills, and lifelong suffering, since the personality structure develops early and tends to remain stable over time. Often the behavior is egosyntonic, i.e. it is coherent and functional concerning the self-image, and therefore it is perceived by the patient as appropriate, contributing to rigidity and pervasiveness in several areas of life.

### Towards an integrative model

In general, personality disorders are diagnosed in more than half of psychiatric patients, making them the most frequent in psychiatric diagnoses. Personality disorders are generally recognizable in adolescence, early adulthood, or sometimes even childhood, and can affect two or more of the following areas: the way you think about yourself and others; how you

respond emotionally; how you relate to other people; how you control your behavior [25].

Taking into consideration the “DSM-V (Diagnostic Statistical Manual)” [16], this instrument speaks of “mental disorder” as a syndrome that groups together clinically significant and individual disorders by criteria of Cognition (A), Regulation of emotions (B) and Behavior (C). They correspond to a specific dysfunction in the psychological, biological and developmental processes underlying mental functioning. These conditions lead to discomfort and social, occupational or other disability. The culturally expected response to an event, socially deviant behavior and conflicts between individual and society, are not (per se) mental illnesses. Mental disorders are distributed as follows, beyond dysfunctional conditions of cognitive [26,27], neurodegenerative [28-30] and developmental [31-33] processes:

- a) Neurotic area (anxiety [34], doc [35,36], panic [37], tic [38], traumatic events [39,40], somatic [41,42] and type C personality disorders);
- b) Borderline area (bipolar [43], depressive [44,45], nutrition [46], addictions [47-49], paraphilias and sexual identity disorders [50,51], suicide risk [52], personality disorders type B [53]);
- c) Psychotic area (schizophrenia, psychotics [54], dissociative [55-57], personality disorders type A).

It also lists eleven indicators of possible diagnostic criteria: shared neurological substrates, family traits, genetic risk factors, specific environmental risk factors, biological markers, temperament background, abnormalities in emotional or cognitive processes, the similarity of symptoms, disease course, high comorbidity, shared response to treatment, whether cognitive-behavioral, psychodynamic, humanistic or strategic [58]. With reference, in particular, to personality disorders, the DSM-V groups them into three clusters, based on descriptive similarities:

- 1) **“Cluster A”.** It is characterized by eccentric behavior, distrust, and a tendency to isolation; it includes the following three personality types:
  - a) **“Paranoid personality”:** characterized by distrust and suspicion towards others, to whom it tends to attribute bad intentions; it fears to be damaged or deceived, even in the face of lack of concrete evidence.
  - b) **“Schizoid personality”:** characterized by withdrawal and introversion into social relationships, emotional detachment, and coldness; the proximity of others and intimacy are lived with annoyance and fear but are also indifferent to the opinions of others towards them.
  - c) **“Schizotypal personality”:** like the schizoid personality shows social withdrawal and emotional detachment, but the behavior and also the thought are bizarre and atypical. There can be magical, mysterious, and paranoid thinking.



2) “Cluster B”. It is characterized by dramatic behavior and strong emotionality expressed, egocentricity, and little empathy; it includes:

- a) **“Borderline personality”**: It presents a pattern of instability in personal relationships, intense emotions and poor ability to regulate them, low self-esteem and impulsiveness, chronic sense of emptiness and loneliness; a vision of oneself and the other that can quickly pass from opposite and poorly integrated representations; extreme sensitivity to abandonment (real or imaginary) to which it can react with desperate attempts to avoid it, maladaptive coping of emotional states that can hesitate in self and hetero aggressiveness, up to the suicide attempts.
- b) **“Histrionic personality”**: It is characterized by a constant search for attention from others and the dramatic expression of feelings and emotions; always concerned about their image, people suffering from this disorder can use physical appearance and seduction to attract attention, but also show childish behavior or exasperate a condition of fragility to receive care and protection.
- c) **“Narcissistic personality”**: Characterized by a sense of superiority, need for admiration and lack of empathy for others; feeling grandiose they believe they are admired and envied by others and move as if they have a particular right to satisfy their own needs and desires, considering the other as a means to this end; they are sensitive to failure and criticism, which, by disconfirming their grandiosity, can provoke anger but also induce depressive states.
- d) **“Anti-social personality”**: Ignores or violates the rights of others, does not value the social norm and uses the other to achieve its ends (unlike the narcissistic personality, the exploitation of the other is purely utilitarian and not justified by its presumed superiority); it can lie repeatedly or deceive others and act impulsively.

3) “Cluster C”. It is characterized by anxious or fearful behavior and low self-esteem; it includes:

- a) **“Avoiding personality”**: Characterized by shyness, feelings of inadequacy and extreme sensitivity to criticism; the difficulty to be in relation pushes to isolation which, however, unlike the schizoid personality, is lived with suffering and hides a strong desire for acceptance and closeness from the other; criticism, rejection and abandonment increase social withdrawal and, unlike the borderline disorder, do not cause anger but shame and sadness.
- b) **“Dependent personality”**: People with dependent personalities are characterized by insecurity and low self-esteem, may have difficulty in making daily decisions without being reassured by others or may feel uncomfortable or helpless when they are alone, due to fear of being unable to take care of themselves; they tend to submit to the other by putting their needs and opinions in the background for fear that the other may resent and leave.
- c) **“Obsessive-compulsive personality”**: Characterized by a

concern for order, perfection, and control, often inflexible in terms of morality and values; intolerance to uncertainty and error makes it inflexible and adaptable to change and extremely slow in the decision-making process; the obsessive-compulsive personality can be overly focused on details or programs to be carried out to the extent that it struggles to complete a task or activity undertaken, can work excessively, taking time away from leisure and friendships; unlike obsessive-compulsive disorder, it does not present obsessive and ritualistic thoughts.

Taking into consideration the “PDM-2 (Psychodynamic Diagnostic Manual)” [15], unlike the first edition, which was divided into three specific parts, now proposes a diagnosis even more attentive to the life cycle and is organized into five specific sections: the first is dedicated to the classification of mental disorders in Adults (section I), the second to that of Adolescents (section II), the third is dedicated to Childhood (section III), the fourth to the First Childhood (section IV), the fifth to the Elderly (section V). The sixth section of the manual is dedicated to evaluation tools and clinical cases. The diagnosis in PDM-2 is articulated on three axes, which respectively highlight 3 macro-dimensions: a) P-axis, for the evaluation of styles and personality syndromes and, in children and adolescents, of emerging styles; b) M-axis, for the evaluation of mental abilities and mental functioning profile; c) S-axis, for the evaluation of symptomatological patterns and subjective experience of the patient. The order of evaluation changes according to the age group: in children, adolescents, and elderly people the M-axis is evaluated first, while in adults the personality is evaluated first. The classification, therefore, uses a multidimensional approach proposing a diagnostic evaluation articulated in three axes or dimensions: Axis P classifies patterns and personality disorders; Axis M enriches the classification through an articulated examination of the complexity of the mental functioning profile; Axis S completes the assessment through the consideration of symptomatological patterns, with an emphasis on the patient’s subjective experience. The dimension of patterns and personality disorders was first considered in the PDM system because of the evidence that a person’s symptoms or problems cannot be understood and assessed or treated in the absence of an understanding of the mental life of the person presenting the symptoms. The P-axis largely recalls Kernberg’s conceptualization of evolutionary levels of personality organization but, in comparison to this, does not consider the psychotic level of the personality structure. At the healthiest level of personality organization, a person possesses all these abilities and the existing difficulties are flexible enough not to hinder a good adaptation. On the neurotic level, however, there are limitations, albeit within an articulated functioning. Rigidity characterizes functioning because of the tendency to respond to stressful conditions with a limited range of defenses and coping mechanisms. At this level, the most common personality disorders are depressive, depressive-masochistic, hysterical, obsessive and/or compulsive disorders that involve suffering limited to one area of functioning; for example, sexuality for the hysterical person, control for the obsessive, loss, rejection, and self-criticism for the depressed person. In the descriptions of levels

of personality organization, there is an accentuated tendency to avoid the use of psychoanalytic language and to maintain adherence to empirical evidence, e.g. in the clarification of the limited empirical evidence of the usual distinction of the primitive and mature quality of defensive mechanisms. The conceptualization of defensive mechanisms, so central in Kernberg's diagnostic-structural hypothesis, does not appear, in fact, in the PDM, presumably due to insufficient empirical support. Likewise, no mention is made of the central conflict between desire and fear of desire, classically referred to the level of neurotic organization and the conflict between the anguish of abandonment and isolation, classically considered central to the level of borderline personality organization.

Finally, considering the "ICD-10 (International Classification of Diseases)" [15], this presents different diagnostic and defining criteria (Chapter V, Sections F 0-99) but substantial clinical conditions.

### The new "integrative psychodiagnostic model" (IPM) and the definitive revision process of the basic psychodynamic model

It seems all too evident, to respond to the structural and functional needs of the personality (known today), that the basic dynamic model of the pure psychoanalytic school (by S. Freud and disciples), already integrated by the modern and post-modern psychoanalytic school (by A. Freud, Hartmann, Mahler, Spitz, Klein, Winnicott, Bion, Lacan, and Fromm), should be further separated and integrated with the subsequent theories of the individual school (by Adler), the analytical school (by Jung, Hillman, and Neumann), the school of the Self (by Kohut, Jacobson, Stern, and Fonagy) and the humanistic school (by Maslow and Rogers), passing through the theories of attachment (by Bowlby and Ainsworth), traits (by Allport), cognitive thread (Bandura) and systemic-strategic thread (by Bateson and Palo Alto) [14].

And if, therefore, on the one hand, the Freudian model, of a hermetic matrix, remains the basis on which to graft the modifications, on the other hand, the interventions to be made are immediate and functional. Below, I propose a definitive revision of the psychoanalytic model, according to the new psychodiagnostic structural proposal.

The "mind", we know, is the hypothetical structure that turns out to be the set of cognitive functions, according to a cognitive approach, and is composed of three systems communicating among them, according to the first topical S. Freud: "preconscious" (the middle ground between the other two levels, where removal has not yet taken place and memory is accessible, of the Kantian matrix), "conscious" (it is the upper level that makes us aware of ourselves and our relationship with the environment) and "unconscious" (it is the lower, inaccessible level, where the deepest and most intimate instances of an individual reside). At this level, in the writer's opinion, the "first corrective" must intervene, transforming the "tripartite theory of the first topical" (topographic model) into a "binary theory of structuring" where only "conscious" and "unconscious" exist, while the "preconscious" becomes one of

the functions of the conscious, until the memory is deposited at the unconscious level.

Let us continue, always according to S. Freud, by examining the "tripartite model of the second topic" (structural model), we know that there are three components that work together, to maintain equilibrium: the Ego (biological component), the primitive part supported by the pleasure principle; the Ego (psychological component), the executive part and in contact with reality; the Super-Ego (social component), the part that mediates, inhibits, controls and mediates the impulses of the Ego, through the sense of guilt and shame. We have said that for Freud, these models interact with each other and make the personality result in a dynamic set of psychic characteristics that condition how each person acts in the face of the circumstances that present themselves. At this level, in the writer's opinion, the "second corrective" must intervene, transforming the "tripartite theory of the second topical" (structural model) into a "binary theory of function", where only "Ego" and "Id" exist, while the "Super-Ego" becomes one of the Ego's functions, that function which, thanks to the defense mechanisms later expanded by A. Freud, Klein, and Perry, can mediate the instinctive and irrational impulses of Es.

We continue integrating the basic theory with the insights of the analytical school and modern and post-modern psychoanalysts. Jung, in particular, preserving much of the Freudian structure, speaks (as we have already observed) of "personal and collective unconscious", but also of "psychic complexes", "archetypes" and "Self", referring to a more oriental and shamanic school. Certainly suggestive ideas, but also very useful to better understand the person in his totalitarian whole (of gestalt and humanistic school) and about the external environment (of systemic school-relation). At this level, in the writer's opinion, the "corrective third party" must intervene, transforming the "psychic structure" (of the Jungian model) into a "binary theory of execution", where "Ego" and "Id" have specific functions:

1) the *Ego* is the antagonistic instance of the *Id*, totally conscious. It is an endowment present at birth but during the first two years of the individual's life it strengthens until it finds its dimension (slightly larger than the *Id*, in the absence of psychopathological conditions). It manifests itself externally through the "Person", which in turn masks itself through the "Character" (or the masks of the Person). The *Ego* has two main functions in the interaction with the unconscious world: the "Self" and the "Super-Ego" (through the "defense mechanisms". The *Self*, which is formed after the first year of life, creating a clear separation with the unconscious world in order to contain it. And if on the one hand it must contain it, on the other hand it allows the passage to the *Ego* through the defense mechanisms of the *Super-Ego*, which act as real energy filters.

2) The *Id* is the main instance par excellence; it is the operative system of endowment from birth. During the first year of life it gives part of itself to the conscious plan, to make it develop. It is in continuous contact with the deepest parts and

acts as an anti-chamber containing the “Shadows” (the real container of the drive and destructive energies, governed by the dominion of the egoistic and individule principle of pleasure) that are nourished by the “Past” (of collective memories and ancestral memories of forbidden access to the conscious).

3) The “*personality*” is, from a functional point of view, therefore, the stable and durable organization of the proposed model; from a structural point of view, instead, the personality is the totalitarian representation of the model (what the Gestaltics would label with the assumption that “the whole is more than the sum of the individual parts”); it is therefore the totalitarian whole of the individual parts described and able to interact with the outside world, according to precise adaptive (in the absence of psychopathologies) or maladaptive (in the presence of psychopathologies) mechanisms. The “personality traits”, instead, are nothing but the expression of the personality in its single parts (the social expression of internal trajectories).

Finally, we continue by integrating the following model with Kernberg’s work which, as already mentioned, supported the thesis that the psychopathology of personality was determined by the psychic structures deriving from affective experiences with primary significant objects (internalized objective relations). At this level, in the writer’s opinion, the “*corrective quarter*” (or “*binary theory of vigilance*”) must intervene, adding other evaluation parameters beyond those indicated in the literature. The investigations, during the clinical interview, on these specific parameters are decisive:

- a) analysis on the integration of identity (understood as the inner representation of the person);
- b) analysis of the defensive organization (means of defense);
- c) examination of reality (understood as the integrity of the Self and the Superego component);
- d) analysis of internalized relational objects and attachment styles in the family environment (investigation of the Id and its unconscious contents);
- e) the examination of awareness of emotions and perceptions (understood as the integrity of the Ego).

Graphically, the following result of the proposed “*IPM Model*” is shown:

- 1) The blue colour represents the *external environment*;
- 2) the red colour represents the *Person*, intended as the social representation of the *Character* (or “physical body”);
- 3) the orange colour represents the *Character*, understood as the synthesis between the Ego and the process of mediation with the Id through the Super-Ego and Self functions. According to this perspective, the four dimensions of the Person are:

- intelligence represents the cognitive dimension (or “mental body”), which uses cognitive functions to elaborate external reality and adapt in the best possible way;
  - the character represents the emotional-affective dimension (or “emotional body”), which feeds on desires, needs and necessities;
  - temperament represents the intimate and relational dimension (or “spiritual body”), which feeds on emotions and feelings;
  - constitution represents the physical dimension (or “physical body”), which is represented by the Person (or the masks of the Person).
- 4) the yellow color represents the *Ego* (or “etheric body”);
  - 5) the green color represents the *Super-Ego* function (or “social body”), which uses defense mechanisms to filter the instances coming from the Id and already partially depowered by the Self.
  - 6) the blue color represents the *Self* (or “causal body”), understood as the function of the Ego and the wall of separation between conscious and unconscious, filtering for the instances coming from the Id. It limits and depotentiates the pleasure principle, containing in fact the Shadow and the Past.

Above the blue line is the conscious plane (*Conscious*). Immediately below begins the unconscious plane (*Unconscious*).

- 7) the color purple represents the *Id* (or “soul body”), the container of memories removed but from which it is still possible to access with certain techniques of hypnotic induction;
- 8) the color brown represents the *Shadow* (or “dark body”), the container of the most destructive energies and drives;
- 9) the black color represents the *Past* (or “ancient body”), the container of the collective Unconscious that communicates with the Shadows through Archetypes.

In this new model, the “*personality*” is, from a functional point of view, as already mentioned, the stable and durable organization of a person’s character, temperament, and cognitive functions; from a structural point of view, on the other hand, the personality is the totalitarian representation of the model (what the Gestaltics would label with the assumption that “the whole is more than the sum of the individual parts”). It is therefore the totalitarian whole of the single parts but able to interact with the outside world. The “personality traits”, instead, are nothing more than the social expression of the personality (the external expression of an inner trajectory), respecting the theories of Eysenck and Allport.



Still in this new theoretical model, “psychopathologies” assume a completely different role: they are the product of structural and functional alterations of the instances contained in the model itself, in response to the external environment (educational and social), but in different terms from the classical and/or modern psychodynamic model (hypertrophic IO - hypotrophic ID / hypotrophic IO - hypertrophic ID); in this model, instead, attention will be paid exclusively to the “functions of the Ego”, since physically the Ego and the Id remain structurally unchanged. Therefore, three distinct relevant psychodiagnostic hypotheses can be verified:

- a) *the functions of the Ego (Superego / Self) are hyperactive (Superego + / Self +)*. Their filter (Self) and energy depowering (Superego) functions are more intense and powerful than necessary and the functional mechanism of the Ego is “hypervigilant”. The Id consequently experiences an energy depletion. In this hypothesis we witness the onset of psychopathological conditions classified as neurotic (*cluster A*, according to the new classification indicated in the following chapters).
- b) *the functions of the Ego (Superego / Self) are unstable (Superego + / Self - or Superego - / Self +)*. Their filter (Self) and energy depowering (Superego) functions are oriented towards an overall functional weakness of the Ego, which is therefore “vulnerable”. As a result, the Id is more likely to let more enhanced energy filter at the conscious level. In this hypothesis we see the onset of psychopathological conditions classified as borderline (*cluster B*, according to the new classification indicated in the following chapters).
- c) *the functions of the Ego (Superego / Self) are shattered (Superego - / Self -)*. Their filter (Self) and energy depowering (Superego) functions are oriented towards a full functional weakness of the Ego, which is therefore “fragmented”. The Id consequently has a full and complete possibility to let the enhanced energy filter at a conscious level. In this hypothesis we witness the onset of psychopathological conditions classified as psychotic (*cluster C*, according to the new classification indicated in the following chapters).

Based on the new model, however, I realized that even psychopathological investigations had to completely change the focus, because if everything is “personality” and not just a simple stable and lasting representation, it seems evident that a diagnosis of a psychopathological condition such as anxiety or obsessive disorder had to be necessarily framed within a new theorization and classification of personality disorders (while until now personality disorders have always been distinguished from other psychopathological disorders, possibly related to clinically relevant comorbidities), taking into account not only categorical and structural but also and above all functional, dynamic and neurobiological profiles [4].

## Clinical implications based on the new “Integrative Psychodiagnostic Model” (IPM) and the new Psychopathological Investigation Model (PIM)

Based on the new model, the psychopathological investigations also change the focus completely. If everything is “personality” and not just a simple stable and lasting representation, it is clear that a diagnosis of a psychopathological condition such as anxiety or obsessive disorder must necessarily be framed within a new theorization and classification of personality disorders (while up to now personality disorders have always been distinguished from other psychopathological disorders, possibly connected by clinically relevant comorbidities), which however takes into account not only categorical and structural profiles, but also and above all functional, dynamic and clinical profiles.

Continuing to trace this line of investigation, we propose a new *Psychopathological Investigation Model (PIM)* that takes into account the following rules of style:

### Diagnosis in the psychological clinic and psychiatry

Psychopathological diagnosis is always “personological” and always refers to a habitual, stable, persistent, and pervasive pattern of experiences and behaviors that differ significantly from the culture to which the individual belongs and manifests itself in at least two areas between cognitive experience, affective, interpersonal functioning and impulse control. The “*personological diagnosis*” can be made from the age of twelve years, while for patients below the threshold the diagnosis is always of “*psychopathological presumption of personality*”, deserving of clinical treatment if the number of traits and/or dysfunctional behaviors found to cause significant anomalies that deserve intervention. In these cases, we will not talk about personality disorders but simply about “specific disorders” (as the requirement of stability is missing in a personality not yet perfectly structured) and they will be followed by a precise nosographic categorization that tends to be different from the actual personality disorders. In adolescents and adults, on the other hand, each diagnosis is framed in a precise personological framework that defines the specific personality disorder, according to the specific nosographic list.

### Dysfunctional traits and behaviors

Each personality disorder is described in its nine fundamental characteristics, called “*dysfunctional personality traits*”, and to be diagnosed it must present five or more specific traits of the same personality disorder, in a dysfunctional personality pattern that is habitual, stable, persistent and pervasive, on a scale ranging from mild (or oriented, with five traits), significant (or sensitive, with six traits), moderate (or vulnerable, with seven traits), severe (or compromised, with eight traits) and extreme (or severely compromised, with nine traits). To be considered a “dysfunctional trait”, however, the symptoms must have persisted for at least three months continuously, otherwise, we will have to speak of “*dysfunctional behavior*” and this circumstance will not contribute to the diagnosis of a personality disorder, even though it may still be worthy of psychological support.





## Attitude, inclination, predisposition, and other psychopathological nature

Diagnosis	Criteria
<i>Dysfunctional behavior</i>	It is a personality trait that has been present in the patient for less than three months (for example, having obsessions). In this case, the diagnosis will be " <i>obsessive behavior</i> " (because, in the proposed example, the specific item is part of the obsessive model).
<i>Dysfunctional personality traits</i>	It is a personality trait that has been present in the patient for at least three months (for example, having obsessions). In this case, the diagnosis will be an " <i>obsessive trait</i> " (because, in the proposed example, the specific item is part of the obsessive model).
<i>Psychopathological attitude</i>	In the absence of a diagnosis of specific personality disorder (in adolescents and adults) / specific disorder (in children), it is the diagnosis in the presence of two traits in one or more specific disorders. If the disorder is only one (for example, two anxious traits) the form will be <i>mild</i> , if it is two traits in two or more disorders (for example, two anxious traits and two obsessive traits) the form will be <i>moderate</i> . In this case, the diagnosis will be an " <i>anxious attitude</i> " (mild form) or " <i>anxious-obsessive attitude</i> " (moderate form), because, in the proposed example, the specific items are part of the anxious and obsessive model.
<i>Psychopathological inclination</i>	In the absence of a diagnosis of a specific personality disorder (in adolescents and adults) / specific disorder (in children), it is the diagnosis in the presence of three traits (significantly dysfunctional form) of the same disorder (for example, three anxious traits). In this case, the diagnosis will be " <i>anxious inclination</i> ", because, in the proposed example, the item belongs to the anxious model.
<i>Psychopathological predisposition</i>	In the absence of a diagnosis of specific personality disorder (in adolescents and adults) / specific disorder (in children), it is the diagnosis in the presence of four traits (moderately dysfunctional form) of the same disorder (for example, four anxious traits). In this case the diagnosis will be " <i>anxious predisposition</i> ", because in our example the item is part of the anxious pattern.
<i>Personality disorder of another type or not otherwise specified</i>	In the absence of a diagnosis of specific personality disorder (in adolescents and adults) / specific disorder (in children), is the diagnosis in the presence of: a) three simultaneous traits in two or more different disorders (e.g. three anxious and three obsessive traits); b) four simultaneous traits in two or more different disorders (e.g. four anxious and four obsessive traits); c) three or four simultaneous traits in two or more different disorders (for example, four anxious and three obsessive traits); d) at least twelve traits in different disorders, of which at least one has four (e.g. four anxious, three obsessive, three phobic, two paranoid). In this case, the diagnosis will be " <i>personality disorder of another type or not otherwise specified with anxious-obsessive and phobic-paranoid traits</i> ", because in our example the specific items fall into all those patterns. This category is completely absorbed if there are five or more dysfunctional traits of the same disorder (for example, six obsessive traits).
<i>Specific personality disorder</i>	It is the diagnosis, for adolescents and adults, of five or more traits of the same disorder (for example, five anxious traits). In this case, the diagnosis will be " <i>anxious personality disorder</i> ", because in the proposed example the item is part of the anxious model. The diagnosis of personality disorder absorbs the diagnoses of aptitude, predisposition, inclination, and other types or not otherwise specified; the possible presence of two or more traits of a specific disorder (for example, six anxious, three phobic, one obsessive) turns the diagnosis into " <i>anxious personality disorder with phobic traits</i> ", because in the proposed example the items are part of the anxious and phobic model (but not the obsessive model, because the trait is only one).
<i>Specific disorder</i>	It is the diagnosis, for children, of five or more traits of the same disorder (for example, five anxious traits). In this case, the diagnosis will be " <i>anxious disorder</i> ", because in the proposed example the item is part of the anxious model.
<i>Mixed personality disorder</i>	It is the diagnosis, for adolescents and adults, in the presence of equal traits in two or more disorders, in the number equal to or greater than five (for example, five anxious traits and five phobic traits, or six phobic traits and six obsessive traits). In this case, the diagnosis will be " <i>mixed anxiety-phobic personality disorder</i> " or " <i>mixed phobic-obsessive personality disorder</i> ", because in the proposed examples the items fall within the anxiety-phobic and phobic-obsessive model. If two or more traits of a specific disorder (e.g. three obsessive traits) are present in addition to the mixed diagnosis, it becomes a " <i>mixed anxiety-phobic personality disorder with obsessive traits</i> ", because in the proposed example the items are part of the anxiety-phobic and obsessive (in the form of traits) models.
<i>Mixed disorder</i>	It is the diagnosis, for children, in the presence of equal traits in two or more disorders, in the number equal to or greater than five (for example, five anxious traits and five phobic traits, or six phobic traits and six obsessive traits). In this case, the diagnosis will be " <i>mixed anxiety-phobic disorder</i> " or " <i>mixed phobic-obsessive disorder</i> ", because in the proposed examples the items fall within the anxiety-phobic and phobic-obsessive model. If two or more traits of a specific disorder (e.g. three obsessive traits) are present in addition to the mixed diagnosis, it becomes a " <i>mixed anxiety-phobic disorder with obsessive traits</i> ", because in the proposed example the items are part of the anxiety-phobic and obsessive model (in the form of traits).
<i>Psychopathological condition common to all disorders</i>	These are psychopathological conditions that can be common to all personality disorders, always according to a comorbidity profile, and are in any case related to the personological sphere: a) neurodevelopmental disorders; b) short or acute psychotic disorder; c) catatonic disorder; d) selective mutism; e) nutrition disorders; f) evacuation disorders; g) sleep-wake disturbance; h) gender identity disorders; i) paraphiliac disorders; j) sexual dysfunction disorders in adolescents and adults, in the absence of organic basis; k) drug and/or behavioral addiction disorders; l) suicidal tendencies.



### Comorbidity and unitary diagnosis

The disorder with the most dysfunctional traits represents the main diagnosis, while all the other disorders with at least five traits represent the representative trait (for example, in a patient with seven anxious traits, five phobic traits, and four obsessive traits, the main diagnosis will be “personality anxiety disorder, with phobic traits”, while the four obsessive traits will not be reported but will serve the therapist to build a psychotherapeutic work more focused on the patient’s needs, working also on the obsessive components). The traits of other disorders that better define the main disorder must be numerically the most other of all the disorders present in the graph; if at least four dysfunctional traits are present in other disorders, they must be considered as “psychopathological traits” worthy of a clinical study.

### Absorbances

In the diagnostic phase, for patients under twelve years of age, the following psychopathological categories are absorbent concerning:

Absorbent (what absorbs)	Absorbed (what is absorbed)
bipolar disorder	maniacal disorder; depressive disorder
attachment disorder	maladjustment disorder
psychotic disorder	all other latent disorders (cluster B) and psychotics (cluster C)

During the diagnostic phase, for patients aged twelve years and over, the following psychopathological categories are absorbent concerning:

Absorbent (what absorbs)	Absorbed (what is absorbed)
bipolar personality disorder	manic personality disorder; depressive personality disorder
borderline personality disorder	manic personality disorder (only if there are at least five bipolar traits); emotive-behavioral disorder
antisocial personality disorder	emotive-behavioral disorder
schizophrenic personality disorder	all other psychotic disorders (cluster C)
schizoaffective personality disorder	depressive personality disorder
psychotic personality disorder	anxious personality disorder; all other psychotic disorders (cluster C), a exclusion of schizophrenic disorder of personality

Absorption occurs only if the number of traits of the absorbent pathology is higher than the number of traits of the absorbed pathology (for example, normally the bipolar disorder absorbs the manic disorder but if the latter has a higher number of traits, the diagnosis will be a manic disorder with bipolar traits).

### Health diagnosis

The absence of pathological traits is equivalent to a diagnosis of “healthy subject”.

Finally, the work concluded with the listing of the new

personological psychopathological classes and with the listing, for each class, of the nine dysfunctional traits, according to four areas of domination (neurotic, latent, psychotic, mixed or residual), also leaving room for the psychopathological conditions common to all twenty-seven personality disorders and any medical and socio-environmental conditions relevant to the diagnosis.

For a better adherence to the DSM-V and the PDM-II, [50,59,60] we proceed with a partial but significant modification of the individual psychopathological traits, which is a unitary framework define the new classes of personality disorders, distinguishing the psychopathological forms for children and patients aged twelve years and over (adolescents and adults).

### Elaboration proposal of a clinical interview for the analysis of personality disorders (Perrotta Integrative Clinical Interview or PICI-1)

Based on the proposed model, revised as follows, two distinct clinical interviews are structured below, which must follow the following style rules [7].

- a) **Age limits and previous clinical conditions:** The clinical interview must respect the reference age (PICI-1C for patients aged between four and twelve years old, PICI-1TA for patients aged twelve years and over). The reference age may be waived at the discretion of the therapist’s clinical evaluation of a psychophysical and neurobiological nature if there is sufficient evidence of mild mental retardation or significant immaturity. Moderate or severe retardation or other pathology of neurodevelopment that significantly impairs cognitive abilities and functions are not preclusive to the administration of interviews.
- b) **Modalities of administration:** The two clinical interviews are administered during or after the clinical and anamnestic interview, both personal and family, and are completed exclusively by the therapist, with or without the patient’s involvement, and serve to frame the patient more systematically, both concerning specific disorders and to individual dysfunctional personality traits. It is preferable to administer the interviews in a single solution.
- c) **Structure of clinical interviews:** The children’s version contains one hundred and fifty items, while the adolescents’ and adults’ version contains one hundred and ninety-five items; in both cases, the items contain only one correct answer “Yes/No” and the answers “Maybe”, “Don’t know”, abstention from answering and partial answers (“More or less”, “Almost”, “In short”) are not allowed. Several items may refer to the same dysfunctional trait; therefore, a positive answer to even one item of the same dysfunctional trait is sufficient to consider that specific trait present.
- d) **Relevance of the answers:** Only positive answers to items

define the presence of dysfunctional traits and possibly the presence of one or more disorders.

- e) **Outcome of the clinical interview:** The final result of the clinical interview must always be compared with anamnestic data, with family feedback and with the implications deriving from the socio-educational context of reference, especially concerning the patient under twelve years of age.

The clinical interview referring to children takes into consideration the following specific personality disorders: anxious (1), phobic (2), avoidant (3), obsessive (4), somatic (5), manic (6), bipolar (7), disruptive mood dysregulation (8), maladaptive separation (9), oppositional-provocative (10), explosive-intermittent (11), uninhibited social commitment (12), attachment (13), dependent (14), depressive (15), selfish (16), libidinal (17), psychotic (18).

The clinical interview referring to adolescents and adults takes into consideration the following specific personality disorders: anxious (1), phobic (2), avoidant (3), obsessive (4), somatic (5), manic (6), bipolar (7), emotional-behavioral (8), dependent (9), depressive (10), borderline (11), histrionic (12), overt narcissistic (13a), covert narcissistic (13b), antisocial (14), sadistic (15), masochistic (16), psychopathic (17), schizophrenic (18), schizoid (19), schizotypic (20), schizoaffective (21), delusional (22), paranoid (23), dissociative (24).

### Practical example of clinical interview administration

The patient is forty years old, has an excellent cultural and professional level, and comes from a close family. The father has difficulty in physically manifesting affection and feelings for his childhood past but is present and available for the needs of all members; the mother has an attention deficit, a slight fluency disorder, and a manic personality disorder, she cannot physically manifest affection but is always present, even if she has never developed a good level of empathy. The patient has siblings who have found their familiar and professional place. The patient is vigilant, conscious, well oriented and available, he has had some childhood traumas (related to sexual abuse), he has had up to six years of age different reference figures (closer relatives on the mother's side), he has a slight fluency disorder that becomes acute in moments of stress, he has suffered a major mourning around the age of six, not simple but not traumatic adolescence and the first years of adulthood have been marked by some emotional and love disappointments. He has always dedicated himself to study and work and appears attentive and curious. He manifests a clinical symptomatology worthy of investigation.

From the outcome of the clinical interview (PICI-1TA), the following items were found to be positive: 1, 2, 6, 11, 29, 30, 36, 37, 39, 40, 42, 43, 45, 47, 48, 49, 52, 53, 57, 61, 74, 79, 85, 87, 88, 94, 95, 104, 109, 117, 119, 142, 155, 173, 178, 184, 190, 192, 194. Using the correlated conversion table, recalling the points indicated above, the single dysfunctional traits to be marked are obtained Figure 1:

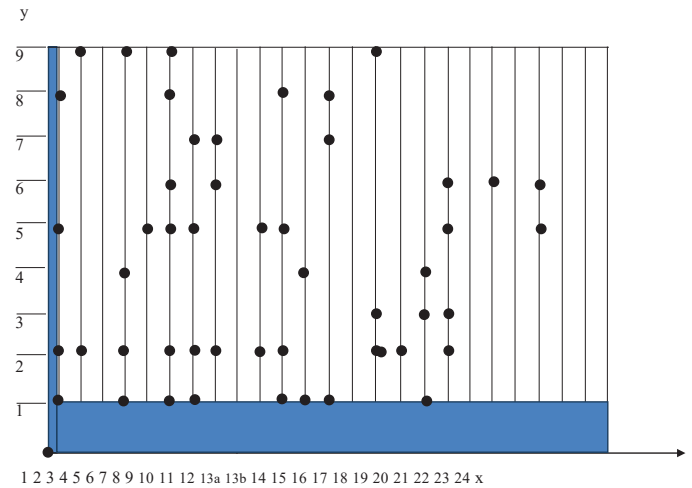


Figure 1: Graphic element of the proposed clinical case.

They turn out to be there:

- 1) four traits (1, 2, 5, 8) of the anxious personality disorder;
- 2) two traits (2, 9) of phobic personality disorder;
- 4) four traits (1, 2, 4, 9) of obsessive personality disorder;
- 5) one trait (5) of the somatic personality disorder;
- 6) six traits (1, 2, 5, 6, 8, 9) of the manic personality disorder;
- 7) four traits (1, 2, 5, 7) of bipolar personality disorder;
- 8) three traits (2, 6, 7) of the emotional-behavioral personality disorder;
- 10) two traits (2, 5) of depressive personality disorder;
- 11) four traits (1, 2, 5, 8) of borderline personality disorder;
- 12) two traits (1, 4) of histrionic personality disorder;
- 13a) three traits (1, 7, 8) of narcissistic overt personality disorder;
- 13b) one trait (2) of narcissistic covert personality disorder;
- 14) three traits (2, 3, 9) of antisocial personality disorder;
- 15) one trait (2) of sadistic personality disorder;
- 16) three traits (1, 3, 4) of masochistic personality disorder;
- 17) four traits (2, 3, 5, 6) of psychopathic personality disorder;
- 19) one trait (6) of schizoid personality disorder;
- 21) two traits (5, 6) of schizoaffective personality disorder.

Compared to the total traits typology, the patient is present on fifty dysfunctional traits: nineteen neurotic, eighteen at the limit, and thirteen psychotic.



Moreover, out of scale, on the value of the psychopathological class no. 28 (clinical conditions common to all disorders), further data emerge: fluency disorder, TIC disorder, paraphiliac disorder, and behavioral dependence disorder due to the internet and social network use.

From the outcome of the anamnestic, personal and family examination, from the previous clinical findings and the administration of the clinical interview, according to the rules determined by the clinical interview, it is therefore evident that the patient is suffering from “*manic personality disorder, with somatic, borderline and psychopathic traits, in the presence of fluency disorders, TIC disorder, paraphilias and Internet/social networks dependences*”, as:

a) the maniacal traits are the highest (6), so this disorder is the main one;

b) the anxious, somatic, bipolar, borderline and psychopathic traits are the psychopathological classes that total the number of traits (4) immediately after the manic traits, for which these characterize the personality of the patient as a whole, anchored to the main disorder. However, corrective measures must be taken:

- bipolar traits are absorbed by borderline traits;
- anxious traits are absorbed by manic traits.

Therefore, the somatic, borderline and psychopathic traits remain active.

All other psychopathological classes with three or less traits (3 / -), in this case, are not taken into account, although they can be examined during psychotherapy sessions to “adjust the shot”.

Let's take other examples:

1) after the main disorder (i.e. the largest number present of the same disorder), e.g. no. 7 of the narcissistic, the patient presents no. 6 traits of another disorder, e.g. borderline, and then no. 5 traits of another disorder, e.g. anxious; in this case, the diagnosis will be: “narcissistic personality disorder, with borderline traits and anxious characteristics”.

2) After the main disorder, e.g. no. 7 narcissistic disorder, the patient presents no. 5 traits of another disorder, e.g. borderline, and then no. 3 traits of another disorder, e.g. anxious; in this case, the diagnosis will be: “narcissistic personality disorder, with borderline traits” (since the other traits are less than 4 and cannot be taken into account even as “characteristics”). Secondary traits (i.e. those following the main disorder are taken into account if they are not less than 4 -of the same disorder).

3) after the main disorder, for example n. 6 of the narcissistic disorder, the patient presents n. 3 traits of another disorder, for example anxious; in this case, the diagnosis will be: “narcissistic personality disorder” (since the other traits are less than 4 -of the same disorder- and cannot be taken into consideration even as “characteristics”), however they will be elements to be considered in psychotherapy.

## Conclusions

Starting from the general concept of “personality”, therefore, we proceeded towards the analysis of the main theories, to conclude that a better understanding of this theme should pass through the modification of the psychodynamic model and then of the psychodiagnostic ones. On this assumption, the writer proceeded with the detailed analysis of the psychodynamic models referred to the theme under examination, to make three main corrections that would act as systematic ordinator for the creation of a new spherical model (the *integrated psychodynamic model, IPM*) with the following characteristics:

1) The *Ego* is equipped with the following functions:

a) mediation and filtering by the mechanisms of defense, and the sense of guilt and shame, on the instincts of the *Ego* (deriving from a specific function called “*Superego*”, which no longer appears to be an instance in itself, as in the Freudian model);

b) conservation, maintenance and re-enactment of the memories not removed, called “*Person*”;

c) relational contacts with the external environment, using perceptions, emotions and feelings, through the use of the mask, called “*Character*”;

d) relational contacts with the *Id*, through the borderline that divides them (and never directly), called “*Self*” (exactly the opposite of the Jungian theorization, which considers the *Ego* a part of the *Self*).

2) the *Id* is endowed with the following functions:

a) preservation and maintenance of the removed, partly inaccessible personal memories,

b) conservation and maintenance of destructive drives and energies, completely inaccessible, called the “*Shadow*”;

c) conservation and maintenance of ancient energies, deriving from an ancestral past (identified with the collective unconscious and the biological matrix of the family tree), called the “*Past*”.

Again on this assumption, the writer concluded that “personality” is, from a functional point of view, as already mentioned, the stable and lasting organization of a person's character, temperament, and cognitive functions; from a structural point of view, on the other hand, personality is the totalitarian representation of the model (what the Gestaltics would label with the assumption that “the whole is more than the sum of the individual parts”). It is therefore the totalitarian whole of the single parts but able to interact with the outside world. The “personality traits”, instead, are nothing but the social expression of the personality (the external expression of an inner trajectory), by the theories of Eysenck and Allport. Based on the new model, also the psychopathological investigations completely change the focus. If everything is “personality” and not only a simple stable and long-lasting representation, it is



clear that a diagnosis of a psychopathological condition such as anxiety or obsessive disorder must necessarily be framed within a new theorization and classification of personality disorders (while up to now personality disorders are always distinct from other psychopathological disorders, possibly connected by clinically relevant comorbidities), which however takes into account not only categorical and structural profiles, but also and above all functional, dynamic and clinical.

Finally, the work concludes with the listing of the new psychopathological personality disorders classes (twenty-seven) and with the listing, for each class, of the nine dysfunctional personality traits, according to four areas of domain (neurotic, latent, psychotic, mixed or residual), also leaving room for the psychopathological conditions common to all twenty-seven personality disorders and any medical and socio-environmental conditions relevant to the diagnosis.

This research work aims to lay the foundations for a structured investigation aimed at supporting the approval of the suggested model (more adherent and compatible with the best definition of "personality").

In the light of the integrative psychodynamic model and the first model of psychodiagnostic investigation, the present work has focused on the revision of these models (with the separation for patients under twelve years of age and those above this threshold), to refine these useful and functional tools to help the therapist in the clinical diagnosis, essential in a clinical interview and anamnestic study (personal and family), achieving the goal set at the beginning of the project: to reorganize the diagnostic profiles of psychopathologies based on nosographic and functional knowledge, integrating them, to achieve a better awareness of the knowledge shared until now by the scientific community on psychodiagnostic.

In particular, based on a sample of one hundred units for adolescents, one hundred units for adults and one hundred units for children, in compliance with the self-imposed rules indicated in the previous paragraphs, the proposed and revised model (PICI-1) is compatible with the current more widespread psychodiagnostic systems (mentioned in the research) and is even more detailed than the MMPI-II, as it focuses more on personality traits to provide a broader overview, necessary to build a personalized psychotherapeutic plan targeted and adapted to the patient, taking into account both nosographic and psychodynamic profiles and functional, cognitive and strategic ones. From a parallelism with the diagnoses made based on MMPI-II, the diagnoses obtained using PICI models are identical and more useful in practice (in psychotherapy); precisely for this reason, the proposed interviews do not need results about the validity and reliability of the instruments, as they adhere perfectly to the results of the MMPI-II and the nosography of the DSM-V (integrated with the psychodynamic profiles of the PDM-II), with specific variants that do not change the diagnosis at all but enrich it with technical details useful in psychotherapy. Again along the same lines, the limits only concern the descriptive content of the individual traits specific to each psychopathological disorder, which could be more enriched and varied in the future.

However, it should be borne in mind that by modifying the basic theoretical paradigm (the psychodynamic model), even the structure at the basis of the psychodiagnostic model cannot be compared with the current models in use; therefore, the basic idea is that of a clinical interview administered directly by the therapist, who before that moment proceeded to the clinical evaluation based on anamnestic and documentary evidence, with the testimonial evidence of the closest family members. On this basis, the implant appears to be solid and robust and functional to the set goal.

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