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Research Article

Perrotta Integrative Clinical Interview (PICI-1): A new revision proposal for PICI-1TA. Two single cases

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Abstract

Purpose: This research aims to reinforce the credibility of the PICI-1 psychodiagnostic instrument by making some corrections that are immediately evident in several clinical cases. Among all, the proposed case represents the clearest and most effective example.

Methods: Clinical interview and administration of the MMPI-II, PICI-1 and PSM-1.

Results: On the basis of specific clinical observations, evident in the proposed cases, the following corrections to the basic PICI-1 model have been suggested: 1) at the diagnostic level: the diagnosis must take into account the first two highest levels of dysfunctional traits, considering the next three lower levels as elements of psychotherapeutic interest. In the hypothesis of dysfunctional hyperactivation, the diagnosis should be re-evaluated at the end of the psychotherapeutic pathway; 2) on the unitary diagnosis: the diagnosis takes into account, in its final formulation, the primary disorder (P, main diagnosis), co-primary disorders (M, mixed diagnosis), comorbidities (C), secondary disorders (S), and tertiary traits (T); 3) on the symptomatic persistence of symptoms and on the plasticity of the personality: mindfulness can aid change, as long as it is real, concrete, and current, and the complained of dysfunctional traits have not been present for a long time (more than 1 year, anyway); 4) on absorptions: anxiety disorder absorbs somatic disorder, phobic disorder, and manic disorder, the latter becoming specific traits of anxiety (main) disorder; psychotic disorders absorb all other neurotic disorders.

Conclusions: The results obtained from the two proposed clinical cases suggest the following modifications to the model. These corrections actually facilitate the psychological course and the diagnostic interpretation of the patients, who were able to alleviate their suffering to an acceptable level of tension, without pharmacological support.

Contents of the manuscript

Definitions and general profiles

Starting from the general concept of “personality”, according to the models known in the literature, it emphasises the importance of personality traits (from a structural point of view) and personality functioning (from a functional and strategic point of view) [1,2]. As a result, the modern psychodynamic paradigm [3] has been modified as a result of the theoretical integrations of the new model described, which is more responsive to clinical needs [4,5].

The tripartite theory of the Freudian model ‘Ego, Superego and Id’ becomes binary: Ego and Id, while the Superego (together with the Self) become functions of the Ego. The Ego and the Id thus remain the conscious and unconscious components of the person, while the Superego represents the function of filtering through defence mechanisms the instinctual impulses of the Id and the Self represents the boundary wall between conscious and unconscious. The Id is in turn endowed with two functions: that of maintaining and preserving removed memories (chamber function) and drives (Shadow), and of guarding ancestral energies (Past).

The whole model, including the individual internal and external parts, describes the personality of the individual, from the outermost levels to the innermost levels. The “personality” is, therefore, from a functional point of view, the stable and lasting organisation of the proposed model; from a structural point of view, instead, the personality becomes the totalitarian representation of the model (what the Gestaltists would label with the assumption that “the whole is more than the sum of its parts”); it is, therefore, the totalitarian whole of the single parts described and able to interact with the outside, according to precise adaptive mechanisms (in the absence of psychopathologies) or maladaptive ones (in the presence of psychopathologies). “Personality’s traits”, on the other hand, are nothing more than the expression of the personality in its individual parts (the social expression of internal trajectories).

The “psychopathologies” assume a completely different role: they are the product of the structural and functional alterations of the instances contained in the model itself, in response to the external (educational and social) environment, but in different terms from the classic and/or modern psychodynamic model (hypertrophic Ego - hypotrophic ID / hypotrophic Ego - hypertrophic ID); in this model attention will be paid exclusively to the “functions of the Ego” since physically the Ego and the Es remain structurally unchanged.

The Ego functions (superego/self) are hyperactive (superego + / self +). Their functions of filtering (Self) and of energetic depotentiation (Super-Ego) are “hyper-vigilant”. ID consequently experiences an energetic depletion. In this hypothesis, we see the onset of psychopathological conditions classified as neurotic (cluster A, which according to the new classification provided by the model is the family of neurotic disorders, unlike the DSM-V which identifies it as the family of psychotic disorders). Ego functions (superego/self) are unstable (superego + / self -, or superego - / self +). Their functions of filtering (Self) and energy depletion (Superego) are “fragile”. ID consequently has a greater possibility of allowing more enhanced energy to filter through to the conscious level. In this hypothesis, we see the onset of psychopathological conditions classified as borderline (or at the limit, cluster B). The functions of the Ego (Super-Ego / Self) are shattered (Super-Ego - / Self -). Their functions of filtering (Self) and energy depletion (Super-Ego) are “fragmented”. The ID consequently has a full and total possibility of allowing the enhanced energy to filter through to the conscious level. In this hypothesis, we see the onset of psychopathological conditions classified as psychotic (cluster C, which according to the new classification provided by the model is the family of psychotic disorders, unlike the DSM-V which identifies it as the family of neurotic disorders).

The new model provides for a new classification of disorders (PIM), integrating the knowledge of the DSM-V with the PDM-II, establishing that the diagnosis is always personological, on the basis of dysfunctional traits, classifying disorders into 3 clusters (18 for children, 24 for adolescents and adults and 12 commons). Personality disorders thus become “creative adaptations of the mind” which, in terms of structure and functioning, are modelled on the basis of the main traumatic event, on the basis of the internal response to external stimuli,

reinforcing themselves positively or negatively on the basis of these. Two different clinical interviews were created, one for children (PICI-1C) with 150 items, and one for adolescents and adults (PICI-1TA) with 195 items, both on a YES/NO scale,

New research has compared the PICI-1 with the MMPI-II, in a study with a sample of 472 subjects, demonstrating diagnostic reliability of 98.73% compared with the diagnoses obtained from the integrated clinical interview of the Minnesota test alone, and with a greater indication of the dysfunctional traits to be treated in psychotherapy [6]. However, both during the drafting of the PICI-1 and during the elaboration of the above-mentioned research, some critical points emerged referring precisely to the neurotic profiles: it was noted in fact that, in the presence of symptomatological hyperactivation, a whole series of traits referring to different disorders were active, in addition to the five dysfunctional traits for each category. This inconsistency was analysed during the above-mentioned research and the final diagnosis was not compromised with respect to the MMPI-II data. In this paper, however, we would like to examine this very aspect, specifically favouring a series of corrections to the proposed model capable of refining this psychodiagnostic discrepancy, in order to refine the PICI-1 even further.

Proposed interpretative revision

Maintaining the PICI-1 in terms of structure and function, we suggest the following corrective interpretations of the data, as proposed in the “single case” of the following paragraph.

In fact, the current interpretation framework of the data obtained through the PICI-1 refers to the following rules [4,5]:

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



Attitude, inclination, predisposition, and other psychopathological nature.

Diagnosis	Criteria
Dysfunctional behavior	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 "obsessive behavior" (because, in the proposed example, the specific item is part of the obsessive model).
Dysfunctional personality traits	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 "obsessive trait" (because, in the proposed example, the specific item is part of the obsessive model).
Psychopathological inclination	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 "anxious inclination" (mild form) or "anxious-obsessive inclination" (moderate form), because, in the proposed example, the specific items are part of the anxious and obsessive model.
Psychopathological attitude	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 "anxious attitude", because, in the proposed example, the item belongs to the anxious model.
Psychopathological predisposition	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 "anxious predisposition", because in our example the item is part of the anxious pattern.
Specific personality disorder	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 "anxious personality disorder", 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 "anxious personality disorder with phobic traits", 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).
Specific disorder	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 "anxious disorder", because in the proposed example the item is part of the anxious model.
Mixed personality disorder	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). In this case, the diagnosis will be "mixed anxiety-phobic personality disorder", because in the proposed examples the items fall within the anxiety-phobic.
Dysfunctional hyperactivation	<p>It is the diagnosis, for adolescents and adults, in the presence of at least five different nosographic categories with at least 5 dysfunctional traits in each category, the primary diagnosis is the sum of the first two highest values, except for possible absorbances, the third highest value will represent a "consolidated tendency" of the patient (according to the main orientations, neurotic, borderline or psychotic) and all other values will have only a clinical interest for the purposes of psychotherapy. In its final formulation:</p> <p>a) Primary disorder (P, main diagnosis): is represented by the disorder with the highest score (e.g. 9 anxiety traits).</p> <p>b) Co-primary disorder (Mp, mixed primary diagnosis): is represented by the disorder with the highest score, tied with another disorder higher than all the others (e.g. 9 anxious traits and 9 obsessive traits).</p> <p>c) Secondary disorders (S): is represented by the disorder with the second highest score (e.g. 9 anxious traits and 8 phobic traits)</p> <p>d) Co-secondary disorders (Mc, mixed secondary diagnosis): is represented by the disorder with the second highest score, with the same score with another disorder (e.g. 9 anxious traits, 8 phobic traits and 8 obsessive traits).</p> <p>e) Tertiary traits (T): is represented by the disorder with the third, fourth, and fifth highest scores, provided there are at least 5 dysfunctional traits (e.g., 9 anxious traits, 8 phobic traits, 7 obsessive traits, 6 somatic traits, 5 manic traits).</p> <p>f) Co-tertiary traits (Tt): is represented by the disorder with the third, fourth and fifth highest scores, with the same score with another disorder, provided that there are always at least 5 dysfunctional traits (e.g. 9 anxious traits, 8 phobic traits, 7 obsessive traits, 7 depressive traits, ... the two 7s are the co-tertiary traits).</p> <p>g) Comorbidity (C): is represented by all those conditions of comorbidity with common psychopathologies.</p>



<p><i>Psychopathological condition common to all disorders</i></p>	<p>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:</p> <ul style="list-style-type: none"> a) neurodevelopmental disorders (28.1); b) short or acute psychotic disorder (28.2); c) catatonic disorder (28.3); d) selective mutism (28.4); e) nutrition disorders (28.5); f) evacuation disorders (28.6); g) sleep-wake disturbance (28.7); h) gender identity disorders (28.8); i) paraphiliac disorders (28.9); j) sexual dysfunction disorders in adolescents and adults, in the absence of organic basis (28.10); k) drug and/or behavioral addiction disorders (28.11); l) suicidal tendencies (28.12).
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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.

Absorbances

In the diagnostic phase, for adolescent and adult patients, the following psychopathological categories are absorbent concerning:

The absorption occurs only if the number of traits of the absorbing pathology is greater than the number of traits of

<i>Absorbent (what absorbs)</i>	<i>Absorbed (what is absorbed)</i>
anxiety disorder	fobic disorder; somatic disorder; maniacal disorder;
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; neurotic disorders;
antisocial personality disorder	emotive-behavioral disorder;
schizophrenic personality disorder	all other psychotic disorders (cluster C);
schizoaffective personality disorder	depressive personality disorder;
psychotic disorder	neurotic disorders; all other psychotic disorders (cluster C), a exclusion of schizophrenic disorder of personality;
psychopathic disorder	neurotic disorders;

the absorbed pathology (for example, normally the bipolar disorder absorbs the manic disorder but if the latter has a greater number of traits, the diagnosis will be a manic disorder with bipolar traits). However, the absorption occurs equally,

without following the previous rule, in the hypothesis of dysfunctional hyperactivation. Absorption does not obscure the absorbed traits but simply incorporates them; therefore, for the purposes of psychotherapy, it is necessary for the therapist to consider the absorbed traits as well.

Below are the corrections already included in the above definitions grid.

The *first corrective* suggested concerns the diagnostic level to be considered in reference to the dysfunctional traits found. In fact, unlike the previous version, it is suggested to consider only the first two highest levels of the traits found. If, for example, six traits of anxiety disorder, five traits of phobic disorder, five traits of obsessive disorder and four traits of somatic disorder are found, only the first two highest levels (six and five traits) should be considered; the diagnosis, in this hypothesis, will be “anxiety disorder with phobic-obsessive traits”. Different is the hypothesis of “dysfunctional hyperactivation”, for which must be taken into account all nosographic categories that have a value equal to or greater than five dysfunctional traits in each category.

The *second corrective* more adequately clarifies definitions with respect to psychodiagnostic profiles, especially with respect to mixed diagnoses, comorbidities, secondary and tertiary diagnoses, and the new category of “dysfunctional hyperactivation” (*in the presence of at least five different nosographic categories with at least 5 dysfunctional traits in each category, the primary diagnosis is the sum of the first two highest values, except for possible absorbances, the third highest value will represent a “consolidated tendency” of the patient -according to the main orientations, neurotic, borderline or psychotic- and all other values will have only a clinical interest for the purposes of psychotherapy*) [4,5,7].

The *third corrective* suggested concerns “the temporal duration of the symptomatological manifestation”. In fact, because of the different psychopathological dynamics and the patient’s anamnesis, it is possible to label or derubricate a diagnosis of personality disorder. In the first version of the PICI-1 it was in fact argued that the temporal variant of persistence of the described symptoms should be between three and six months, depending on the type of disorder; here we prefer to apply the following corrective:

- a) when the symptoms of a specific disorder have been present for at least three months (and less than six months), one should speak of “psychopathological elevation”, which is manageable with psychological support;
- b) when the symptoms of a specific disorder have been present for at least six months (and less than twelve months) one must speak of “psychopathological morbidity in the structuring”, which can be managed with psychotherapeutic support;
- c) when the symptoms of a specific disorder have been present for at least twelve months, one must speak of “full-blown or structured psychopathology”, which can be managed with psychotherapy and pharmacological support if necessary.

The *fourth corrective* suggested concerns “personality plasticity”. In fact, the longer the time spent in constancy of clinical symptoms, the lower the chances of remodelling one’s personality in a functional and adaptive way. This is because the general tendency is to adapt to the best possible condition [9] and psychopathology (observed from the patient’s side) is the condition of equilibrium as a result of one or more traumas suffered, which generates discomfort and suffering only when the person relates to other people and the surrounding environment. As an example, the avoidant patient is happy and serene when he avoids the stressful circumstance; it becomes a problem when he is forced, for personal, environmental and/or family reasons, to interact with the feared circumstance [3,8]. Therefore, it is reasonable to deduce that the time factor negatively affects the patient’s chances, but the right awareness and the real need to change are able to produce the desired result [9]. As it happens for our brain [10], our personality is also plastic and by implementing corrective behaviours able to generate positive experiences [11-15] we are able to transform traumas into events that are no longer harmful [16-19] and therefore able to alleviate the symptoms suffered until their total resolution. Awareness can help change, as long as it is real, concrete and current and the dysfunctional traits complained of are not present for a long time (in any case longer than 1 year), according to the subjective perception of the patient, because the more they persist for a long time and the more the personality is modeled on them creating anchors, resistance and persistence.

The *fifth corrective* suggested concerns “absorptions”, adding some categories not present in the first version of PICI-1TA.

“Single case”: Miss A

The present research work focuses the attention on the single case presented.

The patient “A”, female, 23 years old, single, comes to the psychological support presenting the need to face her sentimental situation, very complex.

She declares herself homosexual, with only one sexual

experience with a boy consisting in some preliminary activities without penetration and without active sex on the part of the patient. Disgusted by the sensations she felt, from the age of 16 she approached female peers, having only two purely sentimental homosexual experiences, of the same age and with few sexual results. With the first girl he establishes a relationship similar to a sentimental one, but it ends in a few months because of character differences; with her he has physical and sexual dynamics but the relationship is not complete. With the second girl he establishes a dysfunctional and unsatisfactory relationship, due to the conduct of the other person, strictly elusive, illusory, false and purely fantastic, where the few points of contact are tainted by dozens of negative experiences that culminate with the removal of the alleged beloved after a furious argument initiated by the patient. Four years have passed since the end of that experience and despite some attempts to meet new people, always female, she remains bound to the idea that only she could make her happy and only she was the right person, deserving of a clarification and a request for forgiveness.

She comes to psychological support because she feels pressing the suffering of this relationship never born and cut off, she approaches the therapy in an extremely needy way. She complains of specific phobias (rape, violence, kidnapping, drowning) which in the form of obsessions disturb her daily and of fears for her health and her daily state of well-being. She never mentions suffering from anxiety. The initial diagnosis appears to be obsessive-compulsive disorder [20-30].

During the first session interesting clinical elements emerge, which need a textual support with the administration of an MMPI-II and two interviews suggested by the writer: PICI-1 and PSM-1, to investigate the personality picture and its sexual matrix. The patient is informed that the last two interviews are not currently recognised with a certified protocol and that the results are merely functional for comparison with the MMPI-II data. The meeting is completed by the drawing up of a complete personal and family anamnesis, from which dysfunctional parental traits and a probable childhood trauma not better recognised emerge [31-34].

At the second meeting the MMPI-II [35] was administered, obtaining specific results in conformity with the clinical history: elevation above 65 correct points for the clinical scales of depression (66), hypochondria (72), hysteria (71), psychopathic deviation (72) and hypomania (69), while for the content scales we find above threshold values for anxiety (75), fears (68), obsessions (71), low self-esteem (78) and anger (76). These results are compatible with the general orientative diagnosis of obsessive-compulsive disorder.

At the third meeting, as agreed with the patient, the PICI-1 [4-6] was administered, finding greater evidence of the patient’s clinical history; clinical data that deserve greater attention in the therapeutic support phase. In fact, unlike the MMPI-II, the PICI-1 elaborated a much more complex and articulated personality picture, focusing on all the traits identified during the clinical history: 6 traits for anxiety, phobic and somatic disorders, 5 traits for obsessive disorder



and 4 traits for bipolar disorder. The diagnosis that emerged, taking into account the correctives proposed in this research, is: “mixed anxiety-phobic personality disorder, with obsessive traits”, as the somatic component is absorbed by the anxiety disorder, while the bipolar traits are interesting only for the purposes of psychotherapy and not for the diagnosis, having a value of four (and not five, as for the obsessive disorder). This diagnosis allowed the patient to focus her attention no longer on obsessive and phobic disorders but on the *anxiety disorder* that originates the dysfunctional and toxic mechanism.

At the fourth meeting, as agreed with the patient, the PSM-1 [36] was administered, finding further confirmation of the clinical history, since the attention (in the therapist's opinion) was necessarily focused on the patient's sexual history. In fact, the PSM-1 revealed several critical points. The patient declares herself homosexual but in the interview she indicates the answer “bisexuality”, showing a clear interpretative conflict about her sexual orientation. During the interview the patient in fact manifested the indicated contradiction, correcting her initial approach. The evident difference in approach is due to the fact that the patient, not having sufficient sexual experience, identifies herself from time to time with the person with whom she relates, even if the initial approach of disgust in front of the male body remains in her. Childhood traumas, although emerged in their manifestation, the patient was not able to identify the events and details. No sexual conduct disorders or specific paraphilias are present.

At the fifth meeting, the patient, using as prescribed some strategic techniques with a constructivist approach, spontaneously focused her attention on the anxiety mechanism that pervades her personality, understanding how anticipatory anxiety was the origin of the obsessive-phobic mechanism and consequently also of all the compensatory mechanisms to relieve anxiety, through compulsions. In this way it was easier to understand how the origin of the suffering was not the obsession towards the ex-girlfriend but the anxiogenic fear of facing a new relationship and of investing one's emotionality towards someone who could make her suffer (anticipatory anxiety). This new awareness, a consequence of her structural, functional and constructivist analysis of reality [37-38], allowed in the following three sessions to stabilise the patient, without the pharmacological therapy suggested by the psychiatrist for the obsessive disorder, and to reduce it to an anxiety-phobic disorder with obsessive traits.

“Single case”: Mister S

The present research work focuses the attention also on the second single case proposed.

The patient “S”, male, 31 years old, single, requires psychological support presenting the need to address his emotional and work situation, very complex.

He declares himself heterosexual, with a strong curiosity towards the male sex; few sentimental experiences, all female, only one lasting and serious ended a year ago after eleven years of relationship (including five-year cohabitation). With the

male sex has only experienced sexual attraction and curiosity to experience a soft sexuality in the role of passive, never happened until now for several fears and insecurities about the consequences of that possible choice.

All therapeutic support is focused on the sentimental relationship now ended and accidentally on the consequences that this “emotional mourning” has also in the other spheres of his life (mainly on his work and academic situation). He works occasionally as a social media manager and is an out-of-school student at the University, with his thesis not yet completed. His family of origin is living, he has a sister with whom he does not have an idyllic relationship because, according to him, of the remarkable similarities with his parents' character defects; with his father he has a more linear relationship, although he describes him as deeply anxious and obsessive, while with his mother he has a more conflicting relationship, defining her as hyper-controlling. The latter, although he tends to justify her rationally, considers her the cause of his presumed “abandonment syndrome” (self-diagnosed on the basis of some readings on the internet), as in the early years her work commitments have led her, according to him, to give him less care and to rely more on the care of grandparents and other family members. The theme of abandonment recurs frequently in the patient, thus justifying his progressive and increasingly dependent attachment to pornography in adolescence; in that age group (15-16 years old) he thus experiences a sexuality particularly focused on the use of photos and videos on the net, becoming a real addiction over the years able to deprive the time devoted to socializing and daily commitments such as academic study. The patient himself perceives his addiction egodistically and has been trying for years to avoid further chronicization, trying to mitigate as much as possible the daily use, with poor results (except in recent weeks, driven by his desire to undertake the path of psychological support). She often mentions a state of perennial anxiety that surrounds her whole existence. He has carried out a path of psychological support with another therapist, two years before, to recover and save the relationship with his former partner, without results (both individual and couple). The initial diagnosis, following the clinical interview, seems to be a neurotic disorder with a psychotic tendency. [20-30]

During the first session interesting clinical elements emerge, which need a textual support with the administration of an MMPI-II and two interviews suggested by the writer: PICI-1 and PSM-1, to investigate the personality framework and its sexual matrix. The patient is informed that the last two interviews are not currently recognized with a certified protocol and that the results are only functional for comparison with the data of the MMPI-II. The meeting is completed by the writing of a complete personal and family history, from which dysfunctional parental traits and a probable childhood trauma related to the theme of abandonment (perceived) emerge [31-34], as well as a very rich and varied narration of the relationship ended with his ex-partner, reporting clinical dynamics related to a picture of narcissistic personality type covert [26]: in particular, the patient recounted how his former partner was extremely capricious, emotionally unstable, using



the physical body to attract the attention of the male sex; the latter conduct was in the last years of the relationship exacerbated, citing an alleged revenge of the same against the patient because of his sexual addiction to pornography and masturbation (“it’s your fault if I show myself”, “I am more beautiful than the others”, “I can be as dirty as those on which you masturbate”), decorating the conversations with insulting and judgmental statements. In the last two years, moreover, the ex-partner has used in an increasingly provocative and excessive way the various social network profiles publishing her increasingly provocative and sexually oriented photos, up to the publication of her body completely naked and seen from behind, together with the overexposure of sexually relevant episodes with users of the network. These circumstances are confirmed by the audio-video and photographic evidence produced by the patient.

At the second meeting, the MMPI-II [35] is administered, obtaining specific results consistent with the clinical history: elevation above 65 correct points for the clinical scales of depression (71), hysteria (72), psychopathic deviance (75) and hypomania (78), while for the content scales we find above-threshold values for anxiety (75), fears (69), obsessions (66), low self-esteem (69) and anger (79). These results are compatible with the general orienting diagnosis of the differently framed disorder.

At the third meeting, the PICI-1 was administered [4-6], which elaborated a much more complex and articulated personality picture, focusing on all the traits identified during the clinical history, consistent with the patient’s narrative: 9 traits (anxiety disorder); 8 traits (avoidant disorder); 7 traits (phobic disorder, schizoid disorder, and paranoid disorder); 6 traits (manic disorder, borderline disorder, and antisocial disorder); 5 traits (obsessive disorder, somatic disorder, bipolar disorder, emotional disorder, psychotic disorder, schizophrenic disorder, and schizotypal disorder). The diagnosis that emerged, taking into account the corrections proposed in this research and with respect to the absorptions, is: “anxious-avoidant disorder with a consolidated tendency to slip psychotic (schizo-paranoid type), associated with paraphiliac disorder”, as, in the presence of dysfunctional hyperactivation, the diagnosis focuses primarily on the traits more present in the first two disorders, and then color with the subsequent traits. In the present case, the presence of non-primary traits demonstrates the strong tendency of the patient to slip into the psychotic profile (psychotic slippage, as a tendency and not as a nosographic category): this circumstance is consistent with the patient’s narration of the events described. This diagnosis has allowed the patient to focus his attention no longer on the relationship concluded with his former partner (considered the cause of his current malaise) but on the unconscious dynamics that have led to the patient’s current constructivist trajectory; in fact, the patient himself is beginning to understand, at least at a conscious level, the following inner dynamics:

- a) The only affective-sentimental relationship, preceding the ten-year relationship, is not sufficient at an experiential level to be able to define satisfied at a cognitive level

- b) The paraphiliac profile is an element to be treated in psychotherapy regardless of the negative outcomes of the conclusion of the relationship, even if it was experienced negatively by the former partner;
- c) The curvatures of personality already present before the ten-year relationship have autonomous independence with respect to the former partner and the dynamics with the latter, so it is important to frame them and understand how they are concatenated with the curvatures of personality of the former partner;
- d) The current psychological state is also a consequence of the dynamics of interaction with the former partner, and its possible psychopathological profile
- e) The certainties manifested during conversations with the ex-partner are the result of his perceptual-reactive system and its functioning, but it does not necessarily mean that they are anchored in reality and are correct
- f) The toxic interdependence established during the relationship and in the year following the conclusion of the romantic relationship must be reworked according to a perspective of independence, detaching the dynamics from the dysfunctional and primordial idea of “abandonment”, in order not to make it the excuse for certain behaviors, such as those used by the ex-partner to avoid the sense of guilt during the naked exposure of her body through social networks.

At the fourth meeting, the PSM-1 [36] was administered, finding further confirmation of the clinical history; in fact, the PSM-1 revealed several critical points. The patient declares himself essentially heterosexual despite his distinctly bisexual fantasies, showing a clear interpretative conflict about his sexual orientation and a latent homosexuality that has never been accepted and reworked. During the interview, the patient in fact manifested the indicated contradiction, however correcting his initial approach, also due to a strong embarrassment, in bi-curious. There are several paraphilias that present the connotations of a real structured disorder, perceived by the patient in an egodystonic (and therefore dysfunctional) way; moreover, the following results emerged at the tests of the internal questionnaires of PSM-1: (a) the value at the test on sexual behavior is 37/50, with a positivity value if $> 20/50$, demonstrating a clear dysfunctional inclination; (b) the value at the test on monogamous sexual relational style (type A) is 18/50, with a positivity value if $> 27/50$, demonstrating a conforming functionality to the monogamous relational style; c) the value on the test on the sexual relational style tending towards monogamous but open (type B) is 42/75, with a positivity value if $> 35/75$, demonstrating a tendency towards dysfunctionality when opening to a non-monogamous relational style. The C test was not initiated not as the patient explicitly declared himself to be non-polygamous.

At the fifth meeting, the patient, using as prescribed some strategic techniques with a constructivist approach, spontaneously focused his attention on the anxious mechanism



that pervades his personality, although he still has extreme difficulty in letting go of the internal dynamics arising from the previous romantic relationship and therefore the concrete detachment from the figure of the former partner, of whom he keeps photographic material, constantly follows through social networks his virtual life (but no longer has direct contact because blocked telematically) and still shares some legal dynamics related to the apartment where they used to live (also because of her who tends to procrastinate the final detachment, while maintaining a style with mutual friends and acquaintances extremely rigid, aggressive, violent and altered compared to the plane of reality, imputing to him responsibilities that are actually both). These new understandings, consequences of his structural, functional and constructivist analysis of reality [37,38], allowed in the next three sessions to stabilize the patient, without the pharmacological therapy proposed by the psychiatrist for the unidentified disorder, and to crystallize his perception with respect to the conduct and internal and external dynamics of both, thus favoring the progressive detachment and the breaking of the bond of emotional dependence [28], a symptom of a more complex and articulated personality framework with an easy tendency to psychotic slip.

Conclusions

The present research focuses on the indication of certain criteria to improve the diagnostic profile through the PICI-1. Under consideration and in the process of publication, there is already the PICI-2 model, with the introduction of these correctives and a new questionnaire on patient functional traits (PICI-2FT) [39].

The need for a greater clinical contextualization of the PICI-1 instrument favored the present research work, which focuses on two specific clinical cases. Also based on a previous study [6], the present work suggests corrections to be made to the original model, on the diagnostic and clinical level. These corrections actually facilitate the psychological course and the diagnostic interpretation of the patients, who were able to alleviate their suffering to an acceptable level of tension, without pharmacological support. In the future, therefore, more in-depth studies are suggested to encourage the application of PICI-1 in clinical practice.

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