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The structural and functional concepts of personality: The new Integrative Psychodynamic Model (IPM), the new Psychodiagnostic Investigation Model (PIM) and the two clinical interviews for the analysis of personality disorders (Perrotta Integrative Clinical Interview or PICI) for adults and teenagers (1TA version) and children (1C version)

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Author(s):

Giulio Perrotta*

Affliation(s):
Director, Department of Criminal and Investigative Psychology UNIFEDER, Italy

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***Corresponding author:** Giulio Perrotta, Director, Department of Criminal and Investigative Psychology UNIFEDER, Italy, Tel: +39 349 21 08 872; E-mail: info@giulioperrotta.com

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Giulio Perrotta

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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.

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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].

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).

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. Freud, neurologist, Austrian doctor, and father of psychoanalysis, presented five models to conceptualize personality: topographical, dynamic, economic, genetic, and structural. These five models sought to give shape to a complete scheme in which the personality of each of us could be articulated. Freud's personality theory is structural. The models we will explain below should not be understood as an absolute truth. However, they are very useful tools for understanding the dynamics of the human psyche. Even if they are explained here separately, they are all related to each other:

***Topographical model*:** Freud used the metaphor of the parts of the iceberg to make it easier to understand the three regions of the mind. The tip of the iceberg, which is the visible one, is equivalent to the conscious region. It has to do with everything that can be perceived at a particular time: perceptions, memories, thoughts, imagination, and feelings. The part of the iceberg that is submerged, but which also remains visible, is equivalent to the preconscious region of the mind. It concerns everything we can remember: moments that are no longer available in the present,

but that can be brought to the level of the conscious. The part of the iceberg that remains hidden underwater is equivalent to the unconscious region. In this area, all memories, feelings, and thoughts inaccessible to the conscious will be preserved. It preserves contents that may be unacceptable, unpleasant, painful, conflicting, and, above all, distressing for the person.

***Dynamic model*:** This model may be one of the most difficult to understand in Sigmund Freud's personality theory. It reflects the psychic dynamic that occurs in the subject's mind, between the impulses that seek gratification beyond measure and the defense mechanisms that seek to inhibit such impulses. The psychic regulatory dynamic has as its primordial aim that each person can act and adapt in the social sphere. The defense mechanisms that derive from this model are repression, reactive formation, displacement, intellectualization, regression, projection, introjection, and sublimation; they are important pillars of Sigmund Freud's theory of personality.

***Economic model*:** It has to do with the way what Freud called "drive" works, which can be broadly understood as the energy that drives us to seek a specific end. The drive is the engine and the energy that moves us. In this sense, Freud argued that all behavior was motivated by drives, which were divided into the drive for life (Eros) and the drive for death (Thanatos). The life drive is related to the individual's capacity for self-preservation, the impulse to create, to protect oneself, to relate. On the contrary, the death drive is related to the destructive tendencies of the human being towards himself or his neighbor, relating them to the principle of Nirvana, which is nothingness, non-existence, emptiness.

***Genetic model*:** This model follows the five phases of psychosexual development. It is characterized by the search for gratification in the erogenous zones of the body, whose importance depends on age. Freud discovered that not only the adult finds satisfaction in the erogenous zones, but also the child. Excessive gratification in these phases or the sudden frustration of some of them will determine the development of one personality rather than another. The phases or stages of psychosexual development in Sigmund Freud's personality theory are:

aa) **Oral phase:** 0 to 18 months. The focus of pleasure is the mouth; sucking, kissing, and biting. Fixation in this phase will result in a receptive oral personality that continues to seek pleasure through the mouth. On the contrary, sudden frustration is related to an orally aggressive personality: you get pleasure by being aggressive and hostile to others from a verbal point of view.

bb) **Anal phase:** From 18 months to 4 years. The fulcrum of pleasure is the anus; hold and expel. A very strict control of the same is related to a retentive anal fixation and a thrifty and order-obsessed personality. Or, on the contrary, an expulsive anal character and a disorderly and destructive personality will develop.

cc) **Phallic phase:** 4 to 7 years of age. The focus of pleasure is on the genitals. Masturbation at these ages is quite common. The child identifies with the father or mother. In this phase, the Oedipus complex is resolved. This complex gives a structure to the personality and serves for the individual to accept social norms.

dd) **Latency period:** From 7 to 12 years. Freud stated that in this period the sexual drive is suppressed in the service of learning, to facilitate a cultural integration of the subject in his environment.

ee) **Genital phase:** From 12 years and up. It represents the appearance of the sexual drive in adolescence,

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directed more specifically to sexual relations. The sexual identity of man or woman is reaffirmed.

ff) ***Structural model*:** This model, in Sigmund Freud's personality theory, stands out for the separation of the mind into three components. These three components would develop during childhood. Each component has different functions that act on different levels of the mind, but still work together and connected to form a unique personality structure:

aa) **Id (biological component):** It is the primitive and innate part of the personality, whose only purpose is to satisfy the impulses of the person. It represents the most elementary needs and desires, the impulses, and is governed by the principle of pleasure.

bb) **Ego (psychological component):** It evolves with age, since it exists in the moment in which the Id comes into contact with reality and the Superego is formed. It, therefore, acts as an intermediary between the Id and the Superego and represents the way we face reality. It is the executive component.

cc) **Superego (social component):** It represents the moral and ethical thoughts we have received from culture and internalized. It represents the law and the norm (moral consciousness) and has the function of inhibiting, controlling and mediating the impulses of the Id, through guilt and shame.

For Freud, these models interact with each other. They cause the personality to result in a dynamic set of psychic characteristics that condition how each person acts in the face of the circumstances that present themselves to him or her.

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. The personality is formed by separate but interacting systems.

The ego is the conscious mind

The personal Unconscious is formed by experiences that have been removed, repressed, forgotten or ignored, and those that are too weak to leave a conscious trace in the person.

The Complexes indicate the active psychic contexts whose multiple elements (feelings, thoughts, perceptions, memories) are unified by the common affective tonality. An example is the maternal complex.

The collective Unconscious appears as the deposit of latent traces from man's ancestral past. It is the psychic residue of man's evolutionary development, accumulated as a result of the repeated experiences of countless generations. Thus, since human beings have always had a mother, every child is born with a predisposition to perceive and react to her. Everything we learn from personal experience is substantially influenced by the collective unconscious that exerts a direct action on the behavior of the individual from the beginning of life.

Archetypes are universal forms of thought endowed with emotional content. This form of thought creates images or visions that correspond, in the normal waking state, to certain aspects of conscious life. The child inherits a preformed conception of a generic mother, which in part determines the perception he will have from his mother. In this way, the child's experience is the result of an internal predisposition to perceive the world in a certain way and the actual nature of that reality. There is usually a correspondence between the two determinants, since the archetype itself is a product of the experiences of the world made by the human race, and these experiences are largely similar to those of any individual. Some examples are the Soul (female archetype in man) and the Animus (male archetype in woman).

The Person is a mask that the individual wears to meet the demands of social conventions. It is the function assigned to him by society, that is, the task that it awaits from him. This mask often hides the true nature of the individual. The person is the public personality, those aspects that are revealed to the world

or that public opinion attributes to the individual, as opposed to the private personality that exists behind the social facade.

The Shadow is made up of animal instincts inherited from man in his evolution. Consequently, the shadow symbolizes the animal side of human nature.

In Jung's personality theory the Self ("Selbst") occupies a central place, around which all the other systems are grouped, it keeps them together and gives the personality balance, stability and unity. The Self is the purpose of life, an end for which man constantly struggles but rarely manages to achieve. Jung conceived the personality or psyche as a system endowed with energy and partially closed because it must be added energy from external sources, for example from eating. To explain the dynamics of personality, Jung, like Freud, uses the concept of libido, but while for Freud libido is a collective concept of man's sexual tendencies, for Jung the term libido is synonymous with psychic energy and depending on whether the libido is directed primarily inward or outward, Jung distinguishes between introversion and extroversion. The introverted attitude tends to direct his psychic energy towards the inner world (thoughts and emotions) while the extroverted attitude directs his energy towards the outer world (facts and people). Both these opposite attitudes are present in the personality, but as a rule one of them is dominant and conscious, while the other is subordinate and unconscious. There are four psychologically fundamental functions: thought, feeling, sensation, and intuition. Each of these functions allows us to adapt to the world and life. Thought uses logical processes, feeling uses value judgments, feeling perceives facts and intuition perceives the possibilities behind the facts:

a) Thought is intellectual, with it man tries to understand the nature of the world and himself.

b) Feeling is the value of things about the subject.

c) Feeling has the perceptive function, it brings facts or concrete representations of the world.

d) Intuition is perception through processes of the unconscious, the intuitive man goes beyond facts and builds elaborate models of reality.

Thought and feeling are called rational functions because they make use of reasoning. Feeling and intuition are irrational functions, because they are based on the perception of the concrete and the particular. On this basis, Jung therefore theorizes eight possible combinations of distinct personalities:

a) **Extroverted reflection:** The extroverted reflective personality corresponds to rational individuals and objectives that act almost exclusively based on reason. They consider certain and secure only what is supported by sufficient evidence. They are insensitive and can even go so far as to be tyrants and manipulators with others.

b) **Introverted reflection:** The introverted reflective is a person with great intellectual activity who, however, has difficulty in relating to others. He is usually stubborn and tenacious when it comes to achieving his goals. Sometimes he is considered a misfit, harmless and at the same time interesting.

c) **Extrovert sentimental:** People with a great capacity for understanding and establishing social relationships are extrovert sentimental. However, they struggle to adapt and suffer when they are ignored by those in their environment. They are very adept at communication.

d) **Introvert sentimental:** The introverted sentimental personality corresponds to that of lonely people with great difficulty in establishing relationships with others. They can be moody and melancholic. They do everything possible to go unnoticed and love to remain silent, but they are still very sensitive to the needs of others.

e) **Extrovert:** Extrovert perceptive individuals have a particular weakness for objects to which they even attribute magical qualities, even if unconsciously. They are not passionate about ideas, but about the way concrete bodies take shape. They seek pleasure above all else.

f) **Introverted perception:** It's a personality type of musician and artist. The introverted perceptive

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people pay particular attention to sensory experiences: they attach great value to form, color, texture. Theirs is the world of form as the source of inner experiences.

g) **Extrovert intuitive:** Corresponds to the typical adventurer. Extroverted intuitive people are very active and restless. They need many stimuli of any kind. They are tenacious when they want to achieve their goals and, once they have achieved their goals, they move on to the next one forgetting the previous one. They do not care much about the well-being of those around them.

h) **Intuitive introverted:** They are extremely sensitive to the most subtle stimuli. The introverted intuitive personality corresponds to the type of people who almost "guess" what others think, feel, or are willing to do. They love to fantasize, are dreamers and idealists. It is difficult for them to "keep their feet on the ground".

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. Thus he defined the four levels of organization of the personality arranged hierarchically:

a) The more general level, or "types", composed of three fundamental personological dimensions: extroversion-introversion, neuroticism, and psychoticism;

b) The level of 'traits', i.e. relatively stable configurations of behavior;

c) The level of "recurring responses", i.e. actions that repeat frequently and create patterns of behavior that tend to repeat themselves in similar situations;

d) The level of "specific and occasional responses", which do not necessarily have the character of stability and are not necessarily indicators of personality.

On this basis, he also elaborated a questionnaire in two versions: the "Maudseley Personality Inventory" and the "Eysenck Personality Inventory" (EPI); the latter, in 57 items, foresees two fundamental dimensions: a) stability-instability, b) introversion-extroversion.

Cattell (factorial theory of personality), a few years later, expanded the two-dimensional model of Eysenck (considered too simplified) to sixteen factors/personality factors (questionnaire 16PF), identified with the letters of the alphabet. Thus he proposed a model that was no longer univariate but a multi-level personality model with a hierarchical structure, with "basic primary" factors (whose personality traits are expressed on a planetary level) and a broader level of "second-order", identified by higher-level traits of personality organization. Finally, he also developed other tests: the Adolescent Personality Questionnaire and the Children's Personality Questionnaire. Also on intelligence, he hypothesized the Gf-Gc theory, which distinguished between two types of intelligence:

a) Fluid intelligence (Gf), i.e. the ability to process information of different nature at a mental level, is distinguished by the lack of a specific content;

b) Crystallized intelligence (Gc), based on knowledge accumulated and consolidated over time. They form the general intelligence factor indicated with g.

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. He also distinguished personal traits in three different types:

a) **Cardinal traits:** They have the greatest influence on personality and behavior, and are the strongest and most pervasive;

b) **Central traits:** These are those that capture the essence of an individual (in several about 7-8), and influence a good part of our behavior;

c) **Secondary traits:** They are extremely specific, and only manifest themselves in particular circumstances.

McCrae and Costa identified five personality traits, starting with Cattell and Allport:

- Extroversion, understood as the degree of activation, confidence and enthusiasm in the conduct they adopt and in their choice;
- Pleasantness, understood as the quantity and quality of positive interpersonal relationships that the person undertakes, oriented towards caring for and welcoming the other;
- Conscientiousness, understood as the precision, reliability, methodological accuracy that the individual is oriented to offer through his conduct, as well as the will to succeed and perseverance;
- Neuroticism, understood as the degree of resistance to emotional stress (resilience), such as anxiety, instability, irritability;
- Openness to experience, understood as the willingness to seek cultural stimuli and thought external to one's ordinary context, as well as the search for a contact with a value orientation different from that of reference.

The five basic global traits are, to date, identified with the model of personality spread by the "*Big Five*".

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. There are a total of seven dimensions:

Novelty Seeking (NS): The search for novelty determines the approach to new experiences and new encounters and has a negative correlation with Dopamine which determines the degree of satisfaction of the person. If the person is not satisfied he will look for novelty;

Harm Avoidance (HA): The avoidance of danger is in contrast to NS and is determined by Serotonin which has a regulating function. It is more present in female persons;

Reward Dependence (RD): The need for a reward correlates with Noradrenaline and Adrenaline, which determine the attack and escape responses in the human body;

Persistence (P): Until recently, persistence was not thought to be an independent feature of the personality;

Self-Directedness: The ability to be independent is typical in poor attachment to others;

Cooperativeness: More present in women, the sense of altruism and cooperation is the basis of empathy;

Self-Transcendence: Typical of all people who feel in communion with nature and with others, it turned out to be also related to spiritual experiences and "exit" from the body (ecstasy), manifestations sometimes due to temporary lack of prefrontal areas.

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

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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).

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. The factors that predispose to the disease interact with the psychic structures and determine their observable symptoms. Psychopathology, therefore, would derive from a series of structures underlying the psyche that determine and substantiate the symptoms themselves causing discomfort. Kernberg coined the term "structural diagnosis" to define a tool for evaluating mental functioning based on the analysis of three instances: Ego, Es, and Superego, together with the description of mental structures that manifest themselves as a result of the results of internalized object relations. The structural diagnosis consists of the interview focused on the identification of symptoms, conflicts or difficulties presented by the patient starting from the dual interaction with the therapist. The aim of the clinician, for Kernberg, is to highlight the main conflicts that can be identified through the story of the subject to bring out the predominant structural organization that characterizes the psychic functioning of the patient. By personality organizations, we do not mean real symptomatological pictures, but psycho-structural differences that characterize a stable intrapsychic functioning mode of the subject. They are determined by specific parameters:

1. The integration of identity, i.e. the temporal and affective continuity that the patient has of himself and others. If one has healthy relationships with meaningful people, there is mental stability and deep relationships, characterized by warmth and empathy. The dispersion of identity, on the contrary, consists of a concept of the Self that is poorly integrated about significant others. It manifests itself, consequently, with contradictory behavior, which cannot be integrated, or through superficial, flat, and impoverished perceptions of others. An extremely important criterion for the evaluation of identity is the non-specific manifestations of weakness of the ego, i.e. the lack of control of anxiety and impulses and the lack of mature sublimatory channels.

2. The defensive organization, i.e. the defense mechanisms, are more or less conscious mental operations aimed at resolving an extra psychic emotional conflict. These ways of organizing the mind are more or less stable and determine the way the subject deals with situations that involve him/her emotionally. The immature defense mechanisms, also called primitive ones, are characterized by a scarce capacity to reflect and accept one's psychic conflicts, typical of infantile modes of mental functioning. They derive from the splitting of the representations of oneself and the other in conflict with each other that are not integrated by the mind of the individual, but partially denied to consciousness. Mature defenses, instead, are the most creative and functional psychic strategies to deal with emotional and affective conflicts, they denote a capacity of the subject to tolerate his contradictory and ambivalent feelings and to find compromise solutions. Mature defenses allow an adequate vision of reality and do not lead to a massive distortion of it. The main mature defenses are removal, displacement, reactive training, intellectualization, isolation, rationalization, and retroactive cancellation.

3. The examination of reality is defined as the ability to differentiate the Self from the non-Self, about

shared social norms. From the clinical point of view, an adequate examination of reality consists of the absence of psychotic symptoms, absence of affections, inappropriate or bizarre thought contents, and attitudes, ability to feel empathy towards the interviewer, interacting collaboratively, and adequately. If there is a compromise of the real examination, the subject loses the ability to adequately perceive the external world and alters the relationship based on his subjective vision. The manifestation of various psychic symptoms is clear evidence of the presence of the loss of the real examination.

Below, the three personality organizations will be presented about the respective criteria mentioned above. According to Kernberg, the psychotic organization of personality is characterized by the poor integration of images of oneself and the other, by a massive use of defense mechanisms centered on splitting and by the loss of the examination of reality. The immature defenses used by the psychotic organization aim to keep good representations separate from persecutory ones because the latter could annihilate and destroy idealized internal images. The defenses put in place allow the person to be protected from a good part of their internal objects. The psychotic structure is mainly characterized by the presence of delusions and hallucinations and the loss of the examination of reality is the manifestation of their internal indifferentiation, between representations of self and representations of the other, in the presence of particularly intense affections and emotions. Psychotic structural organization is typical of patients with schizophrenia or other psychotic forms. The internal anguish, in this case, is so pervasive that it floods the ego, the defenses, then, serve to protect the patient from total disintegration and fusion between the Self and the object. The borderline subject, on the other hand, is characterized by a widespread identity, represented by the fact that the contradictory aspects of the Self and the significant others are kept separate; moreover, the image and perception of the Self appear unstable and subject to frequent fluctuations, and there is an examination of compromised reality in some emotionally intense, stressful or conflictual situations. The functioning of the ego is intermittent, discontinuous, and characterized by a considerable weakness that can be seen in the inability to control anxiety and impulses. The defense mechanisms are mainly archaic and are splitting, projection, idealization and devaluation, negation, acting-out, projective identification. Again according to Kernberg, the defense mechanism, more acted by people with this organization of personality, is projective identification, a complex defense characterized by three moments and based on the fact that its aspects are disowned and attributed to someone else, but differently than simple projection. In the therapeutic relationship, the three phases follow one another in this way: 1) the patient projects a representation of the Self or the object onto the therapist; 2) the therapist unconsciously identifies with what is projected and behaves in a way that conforms to the projected representation; 3) the therapist elaborates the projected material, interprets it and, afterward, returns it to the patient who re-introjects it. At the basis of the process of projective identification, there is the unconscious desire to get rid of a part of oneself and to put it inside someone else, projecting out of oneself parts defined as “bad”, which he fears may destroy the other “good” parts of the self. Kernberg argues that the presence of drive conflicts, caused by a chaotic objective relationship between the caregiver and the child, would lead to the implementation of the splitting mechanism. Kernberg also points out that the main defensive problem of this organization is the lack of integration between the primitive split images of the Self and the object, i.e. a separation of internalized object relations into good and bad. The splitting mechanism used by patients with borderline disorder, allows to keep separate contradictory states of the ego, linked to the original object relations. The image of self and object in the borderline patient is sufficiently differentiated, contrary to what happens in psychosis, which allows to maintain the integrity of the ego’s boundaries in almost all existential areas. These boundaries become, however, more blurred or absent when the subject carries out projective identification and fusion with idealized objects. The dichotomous object images and the inability of borderline patients to integrate them do not allow the individual to functionally complete the process of structuring the Superego. Finally, the neurotic organization of the personality is characterized by a non diffused identity, by the use of mature defense mechanisms centered on removal and have a strong relationship with reality. They are individuals capable of deep relationships, who have a certain strength of the Ego that allows them to tolerate anxiety and sublimate their impulses. They are often effective and creative at work and can integrate

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love and sexuality. Their life is sometimes disturbed by unconscious guilt that can be connected to sexual intimacy. This type of structure is often found in clinical manifestations such as hysterical, depressive-masochistic, obsessive, avoidant, and phobic personalities. Sometimes, we encounter cases that present specific inhibitions or phobias and relational problems of varying severity that can be evinced through the so-called negative symptoms, i.e. emotional withdrawal, apathy, abulia, and autism.

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. Subsequent investigations have made it possible to identify five determinants underlying this construct: neuroticism - anxiety, activity, sociality, impulsive sensation seeking, aggression - hostility. Each of these dimensions can be evaluated through the "Zuckerman-Kuhlman Personality Questionnaire", a self-report questionnaire with dichotomous answers. Unlike biological trait models, which seek to explore the genetic origins of personality, factorial theories use the lexical approach to study the general architecture 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) [13-17].

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>> [18].

The "*personality structure*" [15,13] 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 [15,13].

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" [13,15,19], 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) [20], to control impulses, judgment, mentalization or reflexive function, to use the ego defense mechanisms [21], 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 [22] and the ability to relate to oneself (concerning emotions) and to others (concerning affections and feelings) [23].

***"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.

***"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. In neurotic individuals, discomfort and symptoms result from conflict. For example, they may have sexual temptations and at the same time experience those desires as forbidden and inconvenient; or, experience anger and hatred, and at the same time feel these reactions as wrong and excessive. In neurosis, ultimately, suffering is the result of different personality tendencies

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in opposition to each other. On a neurotic level, high-level defenses are applied to resolve the conflict. We define them as high level to distinguish them from those used by borderline subjects who, being more primitive, define themselves as low level. These are mechanisms that the mind uses to resolve the impasses of an emotional nature. They serve to create a forced balance when internal aspects and instances no longer coexist in harmony. The most used defenses in neurosis are removal, reactive formation, isolation, repression, retroactive cancellation. These are a series of "corrective measures" that can be brought to emotional experiences, so that they do not conflict with each other, to preserve psychic peace. For example, if I hate and desire evil for a person and, at the same time, I consider it serious and immoral to manifest feelings of this kind, I can segregate my hatred in the unconscious and then keep it away from the surface (from consciousness) with a "corrective", such as reactive training. It is a mental mechanism that transforms a feeling into its opposite. Thus at the level of consciousness, we will see an excessive attitude of kindness and attention that hides a feeling of hostility and aversion. The use of defenses is a solution, but it introduces elements of rigidity and distortion into the personality. Neurotic subjects use defenses only in some partial problem areas, as opposed to borderline ones that strongly distort the whole scenario of mental representations. For example, if the problematic relational area of a neurotic subject is that of authority, the defenses can create rigid patterns in that specific area, while the other relational areas will remain unharmed. On the other hand, if a borderline subject applies a low-level defense (e.g. splitting), the whole relational area is compromised in a single blow. The neurotic who has a problem with authority will tend not to be fully "lucid" when the dimension of power prevails in the relationship but will know how to be objective when other dimensions are at stake, for example, that of tenderness, sensuality, bond, distance. On the contrary, the borderline subject who applies strongly distorting defenses will no longer be able to have a serene experience of his relationships because he will see everywhere he abandons or persecutory aims or attempts at devaluation. For the reasons told so far, outside specific areas of malaise, neurotic people have satisfactory work histories, good relationships can endure suffering without being impulsive, and are cooperative in psychotherapy. The neurotic subjects represent themselves and those around them as a mixture of good and bad characteristics, they can grasp the nuances, the various gradations present in a person, unlike borderline subjects that work for extremes. Moreover, neurotic subjects have a reasonably stable identity over time, even if their Superego (i.e. the instance that inside us tells us how we should be and what our duties are) tends to be a bit severe, and this can lead them to self-denigration and guilt. The reflective function in these people is intact, so they can read the minds of others and understand their behavior, being able to grasp their motivations.

***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. They often have serious relational problems, especially if a condition of emotional intimacy is involved. For borderline subjects, it is difficult to maintain a lasting emotional relationship. They have difficulty in maintaining a job, are unable to regulate their impulses adequately, and this often leads them to abusive behavior, e.g. substance abuse, or addiction (from gambling, petty theft, binge eating, sex, video games or the Internet). When the discomfort becomes high (e.g. if a relationship they need is in danger), there is a risk that they hurt themselves through risky behavior: self-mutilation, dangerous driving, risky sexual behavior, disorderly accumulation of debt and other self-destructive activities, up to suicide. Or they can be destructive to the outside world and others, with impetuous behavior, aggression, damage. All these behaviors are normally implemented in a desperate attempt to regulate unsustainable affections and overwhelming impulses. The borderline level of personality organization can be divided into a high functioning level (bordering on neurotic) and a low functioning level (bordering on psychotic). These subjects can be recognized by the raw and extreme character of the emotions and by the use of primitive defenses. These defense mechanisms are very expensive in terms of mental functioning, such as splitting or projective identification. Splitting is a compartmentalization of experiences, of oneself and others. All representations are kept within a good-bad opposition logic, a black-white caricatured categorization. This leads to a failure of the integration

of different aspects of one's own and others' identities. This leads to a diffusion of identity: attitudes, values, objectives, and feelings are unstable and changeable and self-perception tends to oscillate between extreme and polarized positions. These people may seem very different, in different situations, depending on the aspect of identity that is prevalent at that moment. For example, if they feel well they may seem carefree and happy, completely indifferent to the suicidal depression manifested, perhaps, the week before. Likewise, if they are depressed or angry they have no access to their positive feelings of the previous day or even ten minutes before, and they live everything completely black, as if white never existed. Projective identification does not allow them to recognize the disturbing aspects of their personality. These aspects are attributed to those with whom they relate and then made to act on them. Those who are victims of projective identification feel acted upon, colonized by something alien. To give an example, the anger that is not recognized by a subject is, by projective identification, incised in the mind of another and made to act by him. When we meet a person who can make our blood rise to our head or make us lose our calm, even if we are normally peaceful people, it may be that we are victims of a projective identification. Other typical defenses of the borderline area include denial (i.e., ignoring an aspect of oneself or reality as if it did not exist); withdrawal into fantasy; introspective identification, i.e., completely taking on another person's characteristics, attitudes, and even ways of doing things; omnipotent control, i.e. treating the other as an extension of the self, barely recognizing that he or she is a separate human being; acting out, i.e. manifesting, in the form of often destructive behavior, an internal emotion that cannot be felt or conceptualized; somatization, i.e. the development of physical symptoms under stressful conditions; serious forms of dissociation, i.e. incongruous disconnections between different aspects of experience or sudden changes in the states of the self, without any continuity of experience; primitive idealization, i.e. seeing another person only as totally good and endowed with extraordinary powers; primitive devaluation, i.e. seeing the other person only as completely useless, worthless, without qualities that can redeem him.

***"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 [24].

Taking into consideration the "DSM-V (Diagnostic Statistical Manual)" [15], 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 conflitti between individual and society, are not (per se) mental illnesses. Mental disorders are distributed as follows, beyond dysfunctional conditions of cognitive

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[25,26], neurodegenerative [27-29] and developmental [30-32] processes.

a) Neurotic area (anxiety [33], doc [34,35], panic [36], tic [37], traumatic events [38,39], somatic [40,41] and type C personality disorders);

b) Borderline area (bipolar [42], depressive [43,44], nutrition [45], addictions [46-48], paraphilias and sexual identity disorders [49,50], suicide risk [51], personality disorders type B [52]);

c) Psychotic area (schizophrenia, psychotics [53], dissociative [54-56], 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 [57-60]. With reference, in particular, to personality disorders, the DSM-V groups them into three clusters, based on descriptive similarities:

«Cluster A»

It is characterized by eccentric behavior, distrust, and a tendency to isolation; it includes the following three personality types:

"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.

"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.

"Schizotypical 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.

«Cluster B»

It is characterized by dramatic behavior and strong emotionality expressed, egocentricity, and little empathy; it includes:

***"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.*

***"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.*

***"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.*

*"**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.*

«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

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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.

For the present, only the P-axis (evaluation of styles and personality syndromes) will be studied in depth. The PDM-2, unlike the DSM-V (which has only ten), includes fifteen personality disorders [15].

The *schizoid personality disorder* is characterized by hyper-sensitivity and hyper-reactivity to interpersonal stimuli, which therefore respond with a defensive retreat. They fear being invaded, overwhelmed, traumatized, and associate this danger with relational involvement. The DSM distinguishes between "schizoid" and "schizotomy", indicating the latter as characterized by cognitive and perceptual distortions, as well as strangeness and eccentricity. However, empirical research has not confirmed this theory. The presence of eccentricities is more a transversal trait than a personality type. Despite appearances, clinical experience does not confirm that schizoid persons are satisfied with their isolation. The clinical literature also disconfirms the DSM theory that these individuals do not experience strong emotions. They often experience pain that is so excruciating than to resist it, they have to create a defensive detachment. They benefit from psychotherapy because it allows them to experience emotional intimacy while respecting their need to move in a suitable interpersonal space.

Paranoid personality disorder is characterized by projected negative feelings and ideas. It can include the expectation of being treated badly and consequently the need to attack first. This personality disorder is organized defensively around the theme of power, the persecutory theme of others, and the megalomaniac theme attributed to oneself. They cannot conceive that thoughts are different from actions. The clinical reports contain stories of seductive or manipulative parents. Although the DSM describes paranoids in a one-dimensional way, it is a much more complex disorder.

The *psychopathic disorder* replaces the antisocial disorder described by the DSM and differs significantly. No importance is given to conduct that is susceptible to arrest, pre-existence in the adolescence of the conduct disorder, and lack of planning ability. Concerning Henderson's description, the psychopathic disorder is considered in a dual-mode of expression: passive (more dependent, less aggressive, characterized by a predominantly non-violent manipulative attitude) or aggressive (and violent). The emphasis is placed on the inalienable need for power and control over the other.

Narcissistic disorder is considered in two possible manifestations: arrogant or depressed/empty. The arrogant type recalls the phallic narcissistic character described by Reich or the "oblivious" narcissist described by Gabbard or the "thick-skinned" by Rosenfeld or the "overt" type described by Akhtar. The depressed type refers to Gabbard's "hyper-vigilant narcissist", Rosenfeld's "thin-skinned", Akhtar's "covert" type. The PDM recommends the need to distinguish, within the disorder, between neurotic functioning and the organization of personalities at the most pathological levels characterized by the spread of identity and lack of an internal and coherent sense of morality. It is here clear the reference to Kernberg's concept of malignant narcissism, narcissism imbued with sadistic aggressiveness closely related to the psychopathic disorder.

The *sadistic personality disorder* and the sadomasochistic personality disorder. According to the PDM, they should be considered as separate clinical entities. Appearing as temporary in DSM III-R, sadistic personality disorder was then eliminated in later editions due to the easy overlap with antisocial personality disorder. The PDM instead maintains the differentiation as a result of the clinical consideration that not all sadists are psychopaths and vice versa. The PDM considers the need to humiliate to be central to the sadistic disorder, while it considers the need to control and manipulate to be central to the psychopathic disorder. While the sadist shows the peculiar need to humiliate others by inflicting pain and physical suffering on them, the sadomasochistic type is considered to be an intermediate manifestation that presents a greater capacity for attachment, although prone to get involved in intense and explosive relationships.

Masochistic disorder ("self-defeating") is differentiated into two subtypes depending on whether it is characterized in a moral or relational sense. While sharing many central themes (sensitivity to rejection and loss, feelings of inferiority, unconscious guilt, inhibition of conscious anger towards others) with depressed people, these patients show evident masochistic traits. Moved by excessive as well as unconscious needs of addiction, they have the primary need to show that they are victims of injustice. Their suffering, an expression of unconscious guilt, allows them to feel "morally superior" by exercising a function of regulating narcissistic balance. The PDM places the moral masochistic disorder at a neurotic level of personality organization towards the introjective pole, while it considers the relational masochistic pattern at a borderline evolutionary level and the anaclytic pole.

Depressive personality disorder is considered in three subtypes: introjective, analytical, and in the opposite manifestation of hypomanic personality disorder. The diagnosis of depressive personality disorder is considered appropriate especially for the introjective type, characterized by guilt, self-criticism, and perfectionism. When the analytic dynamics are pervasive (intense feelings of shame, high reactivity to loss and rejection, feelings of inadequacy, and emptiness) there is instead a need for differential diagnosis with the dependent disorder or narcissistic disorder, depending on relational abilities. People with a depressive personality should be differentiated from those with mood disorders, as far as the co-presence of personality and depressive disorder is possible. Central to the mood disorder are vegetative symptoms and the intensity of dysphoric affections.

The *somatizing personality disorder* is very similar to the general clinical picture of the undifferentiated somatoform disorder of DSM, although it does not present the diagnostic items and the cut-off criterion. The authors of the PDM emphasize that the same diagnostic criterion of the DSM related to the onset of the disorder before the age of thirty years lays down for a personality disorder, describing a condition of suffering often chronic that implies the use of the somatization character defense and that is accompanied by a chronic alexithymic condition.

The *dependent disorder* is described in two variants: passive-aggressive and counter-dependent. At each level, from the neurotic to the borderline one, the analytical problem appears central. The Authors discuss the opportunity to consider the passive-aggressive pattern as a separate personality disorder because, while there is not enough evidence to classify the passive-aggressive pattern as a separate personality disorder because the tendency to punish others indirectly is a characteristic of many personality disorders organized at borderline level, on the other hand, the relational mode of hostile dependence is frequently observed in the clinic. With greater confidence, the counter-dependent disorder characterized by the need to deny needs, to show lack of dependence, and to avoid awareness of emotions considered a sign of weakness is considered in its own right.

Phobic personality disorder includes both those who are dominated by a specific phobia and those who have multiple phobias. The central dynamic is the attempt to deal with anxiety by tying it to specific and feared situations that, at that point, are constantly avoided. The subjects who fall into this diagnosis feel inadequate when they are alone and face these feelings trying to provoke a protective reaction. They are people who can also fear their affections, thus avoiding awareness of their emotional states. They can be both verbal and behavioral avoidance and shut down as soon as they feel something disturbing. It can happen that phobic patients, once they have managed to give up their desire to gratify their addiction, find themselves less scared and have a depressive reaction. There is also the opposite reaction, the counterphobic one: it is a response to anxiety that, instead of escaping the source of fear in the manner of a phobia, actively seeks out, in the hope of overcoming the original anxiety. Dangerous activities are often carried out in a counterphobic spirit, such as a denial of fears to them, which can only be in part. Acting, in general, may have a counterphobic source, reflecting an overly compulsive preoccupied false self doing to preserve a sense of power and control. Sex is a key area for counterphobic activity, sometimes fueling hypersexuality in people who are afraid of the objects they believe they love. Teenagers, fearing sex, may jump over a kind of spurious full sexuality; adults may overestimate sex to cover an unconscious fear of the damage it can do. Such a counterphobic approach can be socially celebrated in a postmodern view of sex as gymnastic

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performance or hygiene, fueled by what Wilber described as "an exuberant, fearless superficiality. Car accidents have been linked to a manic, counterphobic attitude in the driver.

The *anxiety personality disorder* is practically identical to the generalized anxiety disorder of the DSM and also in this case, as in the somatizing disorder, the authors of the PDM consider the diagnosis of a personality disorder more appropriate considering anxiety the experience that organizes psychologically the people suffering from it. Anxious people are aware of their anxiety because their attempts to defend themselves cannot keep their anxiety outside of consciousness. They experience fluctuating anxiety without often having any idea what is frightening them.

Obsessive-compulsive disorder is mostly superimposable on obsessive personality disorder. However, the authors of the PDM point out that often obsessive and compulsive traits accompany other personality types (especially narcissistic and depressive-introitive) and that, for this reason, the diagnosis of obsessive-compulsive personality disorder requires an understanding of the patient's internal experience and not only of his behavior. Unlike DSM, moreover, both the obsessive type, needing to invest in the functioning of thought, and the compulsive type, needing to act and always being busy in meticulous activities carried out with perfectionism, are considered.

Hysteria, in its classic psychoanalytic conceptualization, appears in the PDM as a *hysterical personality disorder*, in two variants: demonstrative and inhibited. The description of the first type recalls the histrionic disorder of DSM, while the inhibited type is characterized by emotional confidentiality, naivety about sexuality, inexperience, and inhibition, symptoms of conversion and somatization. They can, therefore, present themselves as excessive and attention-seeking people or as naive, conventional, and inhibited individuals. They can exercise power through seduction. Sexual intimacy is a source of great conflict, also because of a poorly authentic body image. Some avoid sexuality and others flaunt it, some resemble the theatrical type described by the DSM, and others are inhibited and reserved. The cognitive style is impressionistic because they don't pay too much attention to details which they fear to be overwhelmed by. They try to be reassured of their value and yet are capable of stable forms of attachment.

Dissociative personality disorder has the same clinical picture described by the DSM as Dissociative Identity Disorder, originating from physical or sexual trauma and characterized by the massive recourse to the defense of dissociation. When dissociative defenses are the fundamental and habitual response to stress and negative affects, dissociation becomes an element of character in the same way that any other defense can rigidly attach itself to the personality. The phenomenon has been called "multiple personality" for years and currently gathers conflicting opinions. The clinical reading places at the base of these conditions a traumatic history that creates in the subject a disposition to please the authoritative figures. Such patients may express concerns about parts of the body or self that they feel are alien.

Finally, *mixed personality disorder* or *other personality disorder* is proposed, including to enable the diagnosis of patients with a combination of different personality disorders and people with personality patterns not described in Axis P.

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)

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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 Figure 1.

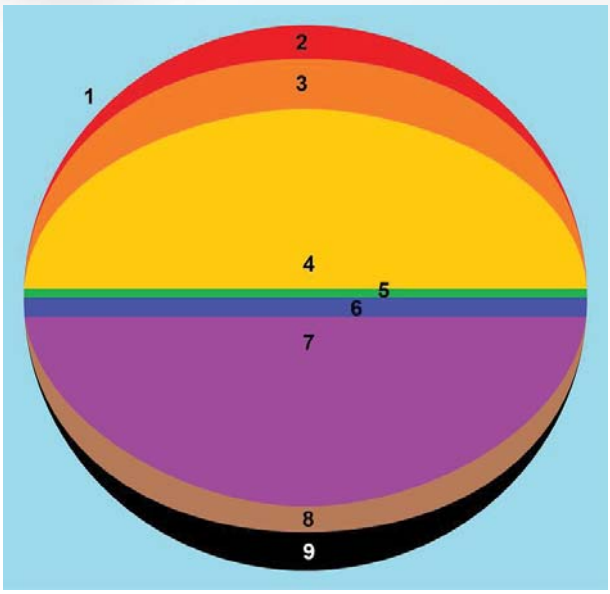

Figure 1: "IPM Model" by G. Perrotta (2020).

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 "hypervigilent". 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).

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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
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 attitude	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 mild, if it is two traits in two or more disorders (for example, two anxious traits and two obsessive traits) the form will be moderate. In this case, the diagnosis will be an "anxious attitude" (mild form) or "anxious-obsessive attitude" (moderate form), because, in the proposed example, the specific items are part of the anxious and obsessive model.
Psychopathological inclination	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 inclination", 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.
Personality disorder of another type or not otherwise specified	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 "personality disorder of another type or not otherwise specified with anxious-obsessive and phobic-paranoid traits", 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).
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, or six phobic traits and six obsessive traits). In this case, the diagnosis will be "mixed anxiety-phobic personality disorder" or "mixed phobic-obsessive personality disorder", 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 "mixed anxiety-phobic personality disorder with obsessive traits", because in the proposed example the items are part of the anxiety-phobic and obsessive (in the form of traits) models.
Mixed disorder	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 "mixed anxiety-phobic disorder" or "mixed phobic-obsessive disorder", 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 "mixed anxiety-phobic disorder with obsessive traits", because in the proposed example the items are part of the anxiety-phobic and obsessive model (in the form of traits).

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Psychopathological condition common to all disorders	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 (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).

The trinary components of the individual disturbances: Each specific disorder / personality disorder contains in itself a series of traits that belong both to the neurotic sphere and to the borderline and psychotic sphere:

Specific disorders in children	
Anxious (1)	Neurotic traits: 1, 2, 3, 4, 5, 6, 7, 8, 9 Limit sections: - Psychotic traits: -
Phobic (2)	Neurotic traits: 1, 2, 3, 4, 5, 6, 7, 8, 9 Limit sections: - Psychotic traits: -
Avoiding (3)	Neurotic traits: 2, 3, 4, 5, 6, 8 Limit sections: 1, 7, 9 Psychotic traits: -
Obsessive (4)	Neurotic traits: 1, 2, 3, 4, 5, 6, 7 Limit sections: 8 Psychotic traits: 9
Somatic (5)	Neurotic traits: 1, 2, 3, 4, 5, 6, 9 Limit sections: 8 Psychotic traits: 7
Maniacal (6)	Neurotic traits: 2, 3, 5, 7, 9 Limit sections: 1, 4, 6 Psychotic traits: 8
Bipolar (7)	Neurotic traits: 1, 4, 6 Limit sections: 2, 3, 5, 7, 8, 9 Psychotic traits: -
Disruptive mood (8)	Neurotic traits: 8 Limit sections: 1, 2, 3, 4, 5, 6, 7, 9 Psychotic traits: -
Separazione disadattativa (9)	Neurotic traits: 5, 6, 8, 9 Limit sections: 1, 2, 3, 4, 7 Psychotic traits: -
Oppositional-Provocative (10)	Neurotic traits: 8, 9 Limit sections: 1, 2, 3, 4, 5, 6, 7 Psychotic traits: -
Explosive-intermitting (11)	Neurotic traits: 8 Limit sections: 1, 2, 3, 4, 5, 6, 7, 9 Psychotic traits: -
Uninhibited social commitment (12)	Neurotic traits: 8 Limit sections: 1, 2, 3, 4, 5, 6, 7, 9 Psychotic traits: -
Attachment (13a)	Neurotic traits: 8 Limit sections: 1, 2, 3, 4, 5, 6, 7, 9 Psychotic traits: -

Attachment (13b)	Neurotic traits: 8 Limit sections: 1, 2, 3, 4, 5, 6, 7, 9 Psychotic traits: -
Dependence (14)	Neurotic traits: 3, 4, 6, 9 Limit sections: 1, 2, 5, 7, 8, Psychotic traits: -
Depressive (15)	Neurotic traits: 1, 2, 5, 8 Limit sections: 3, 4, 7, 6 Psychotic traits: 9
Egoistic (16)	Neurotic traits: - Limit sections: 1, 2, 3, 4, 5, 6, 7, 8, 9 Psychotic traits: -
Libidic (17)	Neurotic traits: 6, 8 Limit sections: 1,2, 3, 4, 5, 9 Psychotic traits: 7
Psychotic (18)	Neurotic traits: - Limit sections: - Psychotic traits: 1, 2, 3, 4, 5, 6, 7, 8, 9

Personality disorders in teenagers and adults	
Anxious (1)	Neurotic traits: 1, 2, 3, 4, 5, 6, 7, 8, 9 Limit sections: - Tratti psicotici: -
Phobic (2)	Neurotic traits: 1, 2, 3, 4, 5, 6, 7, 8, 9 Limit sections: - Tratti psicotici: -
Avoiding (3)	Neurotic traits: 2, 3, 4, 5, 6, 8 Limit sections: 1, 7, 9 Tratti psicotici: -
Obsessive (4)	Neurotic traits: 1, 2, 3, 4, 5, 6, 7 Limit sections: 8 Psychotic traits: 9
Somatic (5)	Neurotic traits: 1, 2, 3, 4, 5, 6, 9 Limit sections: 8 Psychotic traits: 7
Maniacal (6)	Neurotic traits: 2, 3, 5, 7, 9 Limit sections: 1, 4, 6 Psychotic traits: 8
Bipolar (7)	Neurotic traits: 1, 4, 6 Limit sections: 2, 3, 5, 7, 8, 9 Psychotic traits: -
Emotive-behavioural (8)	Neurotic traits: 4 Limit sections: 1, 2, 3, 5, 6 Psychotic traits: 7, 8, 9
Dependent (9)	Neurotic traits: 3, 4, 6, 9 Limit sections: 1, 2, 5, 7, 8, Psychotic traits: -
Depressive (10)	Neurotic traits: 1, 2, 5, 8 Limit sections: 3, 4, 7, 6 Psychotic traits: 9
Borderline (11)	Neurotic traits: 7 Limit sections: 1, 2, 3, 4, 8 Psychotic traits: 5, 6, 9
Histrionic (12)	Neurotic traits: 2 Limit sections: 1, 3, 4, 5, 6, 7, 8, 9 Psychotic traits: -
Narcissistic type overt (13a)	Neurotic traits: 3, 5 Limit sections: 2, 4, 6, 8, 9 Psychotic traits: 1, 7

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Narcissistic type covert (13b)	Neurotic traits: 1, 2, 3 Limit sections: 4, 5, 7, 9 Psychotic traits: 6, 8
Antisocial (14)	Neurotic traits: 7 Limit sections: 6, 8, 9 Psychotic traits: 1, 2, 3, 4, 5,
Sadistic (15)	Neurotic traits: 4 Limit sections: 3, 9 Psychotic traits: 1, 2, 5, 6, 7, 8
Masochist (16)	Neurotic traits: 8 Limit sections: 1, 2, 3, 5, 6, 7 Psychotic traits: 4, 9
Psycotic (17)	Neurotic traits: - Limit sections: 4, 5, 6, 7 Psychotic traits: 1, 2, 3, 8, 9
Schizophrenic (18)	Neurotic traits: - Limit sections: - Psychotic traits: 1, 2, 3, 4, 5, 6, 7, 8, 9
Schizoid (19)	Neurotic traits: - Limit sections: 7 Psychotic traits: 1, 2, 3, 4, 5, 6, 8, 9
Schizotypic (20)	Neurotic traits: - Limit sections: 1, 5 Psychotic traits: 2, 3, 4, 6, 7, 8, 9
Schizoaffective (21)	Neurotic traits: 4, 5, 6 Limit sections: 7 Psychotic traits: 1, 2, 3, 8, 9
Delusional (22)	Neurotic traits: 2, 6 Limit sections: 8 Psychotic traits: 1, 3, 4, 5, 7, 9
Paranoic (23)	Neurotic traits: 5, 7 Limit sections: 3, 4, 6 Psychotic traits: 1, 2, 8, 9
Dissociative (24)	Neurotic traits: 3, 4 Limit sections: 5 Psychotic traits: 1, 2, 6, 7, 8, 9

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, [58-60] 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).

The individual models

Below are the individual dysfunctional classes of the new personality disorders, according to the new model partially revised to give space also to the nosographic classifications more suitable for children:

Model for teenagers and adults

Neurotic domain area (Cluster A)

1) Anxious personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning in childhood but evolves structurally in adolescence, characterized by a state of perceived dysfunctional anxiety, low tolerance to anxiety and high vulnerability to frustration:

1.1) perceived dysfunctional anxiety;

1.2) rigidity of thought;

1.3) complaints and/or ruminations;

1.4) fixed or obsessive thoughts related to the anxious state;

1.5) easy irritability and/or fatigue;

1.6) low tolerance of anxiety and/or frustration;

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1.7) total or partial inability to perform normal daily activities;

1.8) marked episodes of anxiety leading to panic and/or hysterical symptoms;

1.9) psychomotor agitation, with restlessness, muscle tension, and/or difficulty in finding concentration.

The only anxious episode for a specific event, without chronic and persistent symptoms, is not sufficient for the diagnosis of an anxious personality disorder but should be defined as an "anxious episode". If, however, the anxious episodes follow one another, with or without specific events, for at least one month, one will have to speak of "multiple complex anxious episodes"; if they last for more than six months one will have to speak of "generalized anxious personality disorder".

When the anxiety focuses on the social context, giving rise to a free anxiogenic phenomenon, without phobic symptoms, one should speak of "anxious personality disorder of a social type".

When the anxious state manifests itself with deep anxiety, fear of death, and striking somatic symptoms (e.g. chest oppression, sweating, shortness of breath, flushing, and tingling), one should speak of "anxious personality disorder of the panic type".

When the anxious state manifests itself with intense fear and feelings of helplessness or horror, recurring and intrusive unpleasant memories (images, thoughts, or perceptions, nightmares and unpleasant dreams, acting or feeling as if the traumatic event were reoccurring, intense psychological discomfort at exposure to internal or external triggers that symbolize or resemble some aspect of the traumatic event, physiological reactivity or exposure to internal or external triggers that symbolize or resemble some aspect of the traumatic event, persistent avoidance of stimuli associated with trauma and attenuation of general reactivity, difficulty in falling asleep or maintaining sleep, irritability or outbursts of anger, difficulty in concentrating, hypervigilance and exaggerated alarm responses), following a traumatic event, it should be referred to as "post-traumatic stress disorder", which if not effectively reworked could first turn into "adaptation disorder" (as codified by the DSM-V) and then into "anxious post-traumatic personality disorder".

2) Phobic personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning in childhood but evolves structurally in adolescence, characterized by phobic manifestations not justified by the possible source of danger, rigidity of thought and avoidance:

2.1) phobic manifestations not justified by the possible source of danger;

2.2) rigidity of thought;

2.3) avoidance of the possible source of danger;

2.4) fixation and/or obsession;

2.5) chronic phobia and/or multiple manifestations on multiple phobic objects;

2.6) total or partial inability to perform normal daily activities;

2.7) low tolerance of anxiety and/or frustration;

2.8) marked discomfort experienced in potentially non-hazardous or stressful situations;

2.9) marked episodes of anxiety leading to panic and/or hysterical symptoms.

The only phobia for a specific object (e.g. spiders) with chronic and/or obsessive symptoms, is not sufficient for the diagnosis of phobic personality disorder but should be defined as "single specific phobia"; if the sources are multiple, we will speak of "multiple specific phobias".

When the phobia focuses on the social context, giving rise to a free anxiogenic phenomenon, it will he'll have to talk about "phobic social personality disorder".

3) Avoiding personality disorder

It is a habitual, stable, persistent, and pervasive model, with a beginning in childhood but evolves structurally in adolescence, characterized by excessive fear to the point of paranoia, avoidance (which, however, involves suffering for social isolation) and low self-esteem:

3.1) excessive and/or unfounded fear;

3.2) avoidance of potentially stressful circumstances and/or attempts at avoidance;

3.3) delegation of responsibility;

3.4) low self-esteem;

3.5) lack of willingness to be involved in common and/or collective activities;

3.6) marked anxiety when activities become common and/or collective;

3.7) marked concern about people's judgment, criticism, and rejection;

3.8) reluctance to take risks and dangers, including calculable ones;

3.9) fear of derision and/or humiliation for one's own mistakes.

4) Obsessive personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning in childhood but evolves structurally in adolescence, characterized by obsessions, mental rigidity and need for control:

4.1) obsessions;

4.2) compulsions;

4.3) perfectionism;

4.4) mental rigidity;

4.5) need for control;

4.6) marked discomfort in public;

4.7) concern about one's own and/or others' state of health, with no apparent justification;

4.8) altered perceptual state, without delusions or hallucinations, about one's own or others' bodies;

4.9) delusional and/or paranoid thoughts and/or beliefs.

When the obsession is without compulsion we will speak of "simple obsessive personality disorder"; if instead the obsessions are multiple but always without compulsions we will speak of "obsessive personality complex disorder". If there are both obsessions and compulsions we will speak of "obsessive personality disorder of compulsive type".

When the obsession concerns the aesthetic appearance we will speak of "obsessive personality disorder of dysmorphic body type".

When the obsession concerns accumulation, it should be called "obsessive personality disorder of the accumulative type".

When the obsession concerns setting fires, one should speak of "obsessive personality disorder of the pyromaniac type", unless otherwise attributed psychopathologically (for example, pyromania as a symptom of antisociality or psychopathy).

When the obsession concerns the theft of objects, one should speak of the "obsessive personality disorder of the kleptomaniac type".

When the obsession concerns the tearing of hair or bruises, it should be called "obsessive personality

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disorder".

5) Somatic personality disorder

It is a habitual, stable, persistent, and pervasive model, with a beginning in childhood but evolves structurally in adolescence, characterized by somatic symptoms in the absence of relevant clinical data, concern about health status and low tolerance to frustration:

5.1) somatic symptoms in the absence of relevant clinical data;

5.2) concern about health status;

5.3) concern about one or more diseases;

5.4) low tolerance to anxiety and frustration;

5.5) search for responses outside the health field, despite doctoral advice;

5.6) difficulty in concentrating and fulfilling one's tasks and duties;

5.7) obsessive and/or paranoid thinking;

5.8) complaints and ruminations about the state of health or symptom;

5.9) low self-esteem and/or insecurity.

6) Maniacal personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning between five and ten years old, but it evolves structurally in adolescence, characterized by a dysfunctional alteration of mood tone, flight of ideas, and psychomotor agitation:

6.1) dysfunctional alteration of mood tone;

6.2) flight of ideas;

6.3) psychomotor agitation;

6.4) prodigality and/or excessive expenditure;

6.5) flight of ideas and/or increase in the speed of ideas, whether or not they involve forgetfulness and/or activities that have remained unfinished while new ones were being started;

6.6) increased libido and/or sociability and/or the need to stay at home or in the office by postponing appointments to work on the idea;

6.7) ideas of grandiosity and/or increased self-esteem;

6.8) tendency to delusional episodes;

6.9) hyperactivation and/or hyperactivity, with or without sudden weariness and/or change in thought flows.

There are two forms of this disorder:

1) Manic personality disorder type I: the form described above;

2) Manic personality disorder type II: in the absence of delusional tendency and modest hyperactivation the episodes are hypomanic.

The co-presence of depressive or dysthymic symptoms and maniacal or hypomaniacality configures the diagnosis of "bipolar personality disorder".

Latent domain area (Cluster B)

7) Bipolar personality disorder

It is a habitual, stable, persistent and pervasive pattern, with a beginning between five and ten years old, but it evolves structurally in adolescence, characterized by sudden mood fluctuations, mania and/or depressive states and/or sudden alternation and emotional instability:

7.1) sudden mood swings;

7.2) emotional instability;

7.3) relational and/or social instability;

7.4) manic, depressive and/or mixed episodes;

7.5) tendency to active and/or passive manipulation;

7.6) low tolerance to frustration and anxiety;

7.7) tendency to irritability;

7.8) low tolerance to criticism;

7.9) dysphoric mood (with or without unpleasant feelings, frustration, pessimism, tension, irritability, anxiety, and psychomotor agitation).

There are four main forms:

a) Type I bipolarity: a marked alternation of manic and depressive episodes;

b) Type II bipolarity: alternating hypomanic episodes with depressive or dysthymic episodes;

c) Type III bipolarity: prevalence of depressive or manic state, with a tendency to fluctuating dysthymic or hypomanic episodes.

d) Type IV (or cyclotomic) bipolarity: alternation of hypomania and dysthymic episodes.

8) Emotional-behavioral personality disorder

It is a habitual, stable, persistent and pervasive model, beginning around the age of five but evolving structurally in adolescence, characterized by the systematic and persistent violation of social and civil community norms (not necessarily in violation of the law), negative consequences deriving from behaviors and dysfunctional management of one's basic emotions:

8.1) systematic and persistent violation of social and/or civil commonality rules;

8.2) negative consequences deriving from behavior;

8.3) dysfunctional management of one's own basic emotions;

8.4) low tolerance of anxiety and/or frustration;

8.5) episodes of explosive and/or uncontrolled anger or in any case unjustified about the event, then compensated with guilt, shame or remorse;

8.6) impulsiveness and/or tendency to active manipulation;

8.7) unconsciousness and/or excessive instinctiveness;

8.8) verbal and/or physical aggression to objects, people and/or animals;

8.9) violation of rules and/or regulations, relevant to national law.

The symptoms suffered must not meet the requirements of the "antisocial or borderline personality disorder".

9) Dependent personality disorder

It is a habitual, stable, persistent, and pervasive model, with a beginning around the age of twelve but

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evolves structurally in adolescence and adulthood, characterized by strong insecurity, a tendency to need approval and delegation of responsibility:

9.1) strong insecurity and/or tendency to passive manipulation;

9.2) tendency to need approval from other people;

9.3) Delegation of responsibility;

9.4) difficulty in making day-to-day decisions;

9.5) tendency to strive for the benefit and support of others;

9.6) feelings of discomfort and/or helplessness when alone without asking for help or advice;

9.7) unrealistic and excessive concerns;

9.8) fear that they are abundant and have to take care of themselves alone;

9.9) low self-esteem.

10) Depressive personality disorder

It is a habitual, stable, persistent, and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by depressed mood, low self-esteem, and a marked decrease in interests and pleasures:

10.1) depressed mood;

10.2) low self-esteem and/or tendency to passive manipulation;

10.3) marked a decrease of pleasure in carrying out interests and activities and/or tendency to boredom;

10.4) significant weight gain or loss;

10.5) psychomotor agitation and/or slowdown;

10.6) lack of energy and/or easy tiredness;

10.7) feelings of self-devaluation, inappropriateness and/or marked feelings of guilt;

10.8) reduced ability to concentrate on activities;

10.9) recurring negative or melancholy and/or death related thoughts, not caused by real events (for example, grief).

The “grieving” event can trigger a depressive tendency, leading to a “persistent grieving personality disorder”.

When the symptomatology suffered allows one to carry out one’s work or activities, even if maintaining the behavioral and humoral characteristics of the depressed patient, one must speak of the attenuated form of “dysthymic personality disorder”.

If the depressive manifestation is caused by the birth of a child and persists for more than one month, we should talk about “acute depressive disorder of post-partum personality” (category applicable, by extension, also to patients under twelve years of age who complete a gestation), while if you exceed six months we should talk about “chronic depressive disorder of post-partum personality” (in which there may also be symptoms of psychotic activation).

11) Borderline personality disorder

It is a habitual, stable, persistent, and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by emotional instability, sudden mood swings, and impulsiveness:

11.1) emotional instability and/or impulsiveness in interpersonal relationships;

11.2) sudden mood swings;

11.3) active and/or passive manipulative tendency;

11.4) desperate efforts to avoid abandonment (real and/or imaginary);

11.5) dysfunctional and/or unstable self-image;

11.6) marked impulsiveness capable of damaging them;

11.7) persistent feelings of emptiness;

11.8) sudden anger and unjustified aggressiveness;

11.9) irrational thoughts and beliefs, leading in whole or in part to the psychotic sphere.

12) Histrionic personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by an immense need for attention, fear of abandonment (real or presumed), theatricality and drama of the actions:

12.1) immense need for attention;

12.2) discomfort when they are not the center of attention;

12.3) real and/or presumed fear of abandonment;

12.4) theatricality and drama of their Self;

12.5) high suggestibility;

12.6) vague and/or impressionistic language;

12.7) changing personal and/or relational instability;

12.8) constant use of the physical aspect to attract attention, also through more or less explicit sexual conduct;

12.9) manipulative, provocative, and/or seductive modes of expression.

13) Narcissistic personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized in the "overt" form by low empathy, grandiosity, and excessive self-esteem, while it is characterized by low self-esteem, intolerance to criticism and judgment, complaints and passive-aggressive conduct in the "covert" form:

OVERT (13a)

13a.1) little or no empathy;

13a.2) wholly or partly unfounded beliefs of being unique and special and/or ideas of grandeur;

13a.3) excessive self-esteem and/or arrogance;

13a.4) irrational beliefs of being envied by others for his position and/or his intrinsic human, personal and/or moral qualities;

13a.5) concerns about fantasies of success and/or perfection;

13a.6) need for admiration;

13a.7) irrational belief that he deserves what he wishes and/or dreams and/or aspires to;

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13a.8) manipulative exploitation of people and/or circumstances for personal gain, whether or not using guilt, shame, personal relationships, professional activity and/or sex;

13a.9) use of physical, verbal, and/or psychological violence, with or without aggression.

COVERT (13b)

13b.1) low self-esteem, aimed at attracting attention;

13b.2) low tolerance to criticism and/or judgment;

13b.3) use of complaints and/or grievances to get attention;

13b.4) passive-aggressive conduct;

13b.5) exaggerated underestimation;

13b.6) irrational fixations and/or beliefs;

13b.7) somatic and/or hysterical symptoms;

13b.8) lack of empathy and/or little or no sensitivity to the needs of others;

13b.9) excessive need for control.

14) Antisocial personality disorder

It is a habitual, stable, persistent, and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by lack of empathy, lack of remorse, lack of respect for rules and social roles:

14.1) narcissistic tendencies;

14.2) lack of empathy;

14.3) lack of remorse, guilt and/or shame;

14.4) lack of respect for social rules and roles;

14.5) marked tendency to delinquency and/or active manipulation, even without a criminal record or legal problems;

14.6) tendency to aggressiveness and/or provocation;

14.7) low tolerance of frustration and/or anxiety;

14.8) prevalence of negative feelings;

14.9) tendency to impulsiveness and/or irresponsibility.

15) Sadistic personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by taking pleasure from other people's suffering (outside the sexual sphere), manipulation of people and/or situations for personal gain (to the detriment of other people) and prevalence of negative feelings:

15.1) enjoyment from the suffering of others, outside the sexual sphere;

15.2) manipulation of people and circumstances for personal gain, to the detriment of other people;

15.3) prevalence of negative feelings;

15.4) discomfort in the presence of pleasant events and positive feelings;

15.5) need to make people suffer, humiliate and inflict pain, to gain pleasure from it;

15.6) pathogenic belief that one has the right to make others suffer;

15.7) unconscious abuse of primitive defense mechanisms;

15.8) narcissistic tendencies;

15.9) emotional and/or situational reversal of pleasure/pain.

If the symptomatology is alternated with the masochistic model, with a greater or lesser prevalence, one must speak of "sadomasochistic personality disorder".

16) Masochistic (or self-destructive) personality disorder

It is a habitual, stable, persistent, and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by self-destructive trends, submission, and high emotional sensitivity:

16.1) self-destructive tendencies;

16.2) submission and/or desire to be dominated (outside the sexual sphere);

16.3) high emotional sensitivity with tendency to passive manipulation;

16.4) unconscious search for people and/or situations that may cause disappointment and/or failure and/or live in a situation of distress and/or mistreatment;

16.5) refusal to receive help and/or concrete support;

16.6) response to positive events with depression and guilt;

16.7) discomfort in the presence of pleasant and/or goliardic situations;

16.8) inability to remain focused on assigned tasks;

16.9) withdrawal from all forms of positive attention.

If the symptomatology is alternated with the sadistic model, with a greater or lesser prevalence, one must speak of "sadomasochistic personality disorder".

Psychotic domain area (Cluster C)

17) Psychopathic personality disorder

It is a habitual, stable, persistent, and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by antisocial behavior and narcissistic tendencies, manipulation, empathy deficit, remorse, and guilt:

17.1) more or less manifest antisocial behavior;

17.2) deficit or absence of empathy;

17.3) absence of remorse, guilt and/or shame;

17.4) egocentricity and/or strong propensity to impress the interlocutor;

17.5) use of deception and/or manipulation to obtain personal benefits and advantages;

17.6) impulsiveness and/or poor judgment;

17.7) irresponsibility and/or unreliability;

17.8) narcissistic tendencies;

17.9) little or no awareness of one's condition and/or emotions.

18) Schizophrenic personality disorder

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It is a habitual, stable, persistent, and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by delusions, hallucinations, and disorganized speech:

18.1) delusions and hallucinations;

18.2) little adherence to reality and little or no awareness of one's schizophrenic state;

18.3) paranoia;

18.4) disorganized, incoherent and/or derailed speech;

18.5) coarse and disorganized and/or catatonic behavior;

18.6) decrease in facial expressions and basic emotions, to the point of abulia;

18.7) total or partial inability to take care of oneself and others;

18.8) extravagant and/or bizarre beliefs;

18.9) unusual or highly irrational behavioral and/or perceptual experiences.

The "schizophreniform personality disorder", currently codified in the DSM-V, is characterized by symptoms identical to those of schizophrenia but lasting more than one month and less than six months, is considered here as an "attenuated form of schizophrenic personality disorder".

19) Schizoid personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by voluntary isolation, paranoia about human contacts and disinterest in sociality:

19.1) difficulty and/or lack of desire in establishing social relationships;

19.2) voluntary isolation;

19.3) disinterest in sociality and/or strong interest in solitary activities;

19.4) little adherence to reality and/or low awareness of one's psychotic state;

19.5) tendency to paranoia;

19.6) non-existent perceptions of threats;

19.7) emotional flattening;

19.8) cold detachment from human relationships and/or absence of close intimate relationships;

19.9) profound need to establish interpersonal spaces and limits of sociality, even where there is no need to.

20) Schizotypic personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by eccentric behavior, bizarre beliefs, and unusual experiences without hallucinatory connotations:

20.1) eccentric behaviors;

20.2) bizarre and/or magical beliefs;

20.3) unusual perceptual experiences without hallucinatory connotations;

20.4) prevalence to social detachment;

20.5) social unease;

20.6) rigid affectivity, reduced, contained and/or inappropriate to the context;

20.7) use of language that is deliberately unclear and/or rich in metaphors;

20.8) little or no awareness of one's own emotions;

20.9) paranoid and/or obsessive thoughts.

21) Schizoaffective personality disorder

It is a habitual, stable, persistent and pervasive pattern, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by schizophrenic symptoms, depressive symptoms and extravagant and/or unusual beliefs:

21.1) Delusions;

21.2) Hallucinations;

21.3) Little adherence to reality and/or low awareness of one's psychotic state;

21.4) Low tolerance of anxiety and/or frustration;

21.5) Manic or hypomanic episodes;

21.6) Volatile and/or fluctuating moods;

21.7) Bipolar tendency;

21.8) Extravagant emotional and relational beliefs that make relationships unstable;

21.9) unusual and/or highly irrational behavioral and/or perceptual experiences.

It is considered an intermediate form between depressive personality disorder and schizophrenic personality disorder.

22) Delusional personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by delusional beliefs, absence of persistent hallucinations, and low or no tolerance to criticism (relative to the delusional idea):

22.1) Delusional belief put into practice and/or pursued;

22.2) Low or no tolerance to criticism, judgment, anxiety and/or frustration (regarding the delusional idea);

22.3) Oddities and/or extravagances markedly detached from reality;

22.4) Little adherence to reality and/or low awareness of one's delusional state;

22.5) Absence of persistent hallucinations and/or irrelevant or insignificant presence;

22.6) Somatic symptoms, without clinical evidence;

22.7) Disorganized and/or coarse speech with little adherence to reality;

22.8) Conducted to the limits and/or beyond the legal prescriptions;

22.9) Unrealistic ideas of persecutory, relational, sentimental, somatic, and/or grandiose nature, then not pursued.

The condition must not meet the requirements for schizophrenic personality disorder, depressive personality disorder, and/or a specific medical condition (not related to psychopathologies).

23) Paranoid personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning around the age of twelve but

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evolves structurally in adolescence and adulthood, characterized by a tendency to paranoia, persecution mania, distrust and suspicion:

23.1) Tendency to paranoia;

23.2) Persecution delusions;

23.3) Distrust and suspicion;

23.4) Unjustified doubts;

23.5) Low tolerance of anxiety and/or frustration;

23.6) Prevalence of negative emotions and/or feelings;

23.7) Phobias and/or obsessions;

23.8) Tendency to social withdrawal;

23.9) refusal of confrontation and/or clarification, if not consistent with his point of view, seeing the interlocutor as an enemy and/or opponent.

24) Dissociative personality disorder

It is a habitual, stable, persistent and pervasive model, with a beginning around the age of twelve but evolves structurally in adolescence and adulthood, characterized by dissociative episodes of identity, altered perception of reality and somatic symptoms:

24.1) Dissociative episodes of identity;

24.2) Altered perception of reality;

24.3) Body-related somatic symptoms;

24.4) Low tolerance to frustration and/or anxiety;

24.5) Amnesic episodes;

24.6) Psychotic episodes related to dissociation;

24.7) Dissociative flight (e.g. unexpected departure from home or wandering);

24.8) Depersonalization episodes;

24.9) Episodes of derealization.

Mixed Or residual domain area (Cluster D)

25) Mixed personality disorder

26) Personological disorder of another type or not otherwise specified

27) Common psychopathological conditions

28) Concomitant or triggering medical conditions

29) Concomitant or triggering socio-environmental conditions (relationship problems; problems related to raising children; problems related to the primary support group (family); abuse and neglect; problems related to education; problems related to work; housing problems; economic problems; problems related to the social environment; problems related to the justice system; problems related to the health system and medical care; religious, spiritual and mystical beliefs; other personal conditions and needs).

Model for children

Neurotic domain area (Cluster A)

1) Anxiety disorder

It is a habitual, persistent, and pervasive model, with an onset around three years of age, characterized by a state of perceived dysfunctional anxiety, low tolerance to anxiety and high vulnerability to frustration:

1.1) perceived dysfunctional anxiety;

1.2) rigidity of thought;

1.3) complaints and/or ruminations;

1.4) fixed or obsessive thoughts related to the anxious state;

1.5) easy irritability and/or fatigue;

1.6) low tolerance of anxiety and/or frustration;

1.7) total or partial inability to perform normal daily activities;

1.8) marked episodes of anxiety leading to panic and/or hysterical symptoms;

1.9) psychomotor agitation, with restlessness, muscle tension, and/or difficulty in finding concentration.

The only anxiety episode for a specific event, without chronic and persistent symptoms, is not sufficient for the diagnosis of an anxiety disorder but should be defined as an "anxiety episode". If, however, the anxious episodes follow one another, with or without specific events, for at least one month, one must speak of "multiple complex anxious episodes"; if they last for more than six months, one must finally speak of "generalized anxiety disorder".

When the anxiety focuses on the social context, giving rise to a free anxiogenic phenomenon, without phobic symptoms, one should speak of "anxiety disorder of a social type".

When the anxious state manifests itself with deep anxiety, fear of death, and striking somatic symptoms (e.g. chest oppression, sweating, shortness of breath, flushing, and tingling), one should speak of "anxiety disorder of the panic type".

When the anxious state manifests itself with intense fear and feelings of helplessness or horror, recurring and intrusive unpleasant memories (images, thoughts, or perceptions, nightmares and unpleasant dreams, acting or feeling as if the traumatic event were reoccurring, intense psychological discomfort at exposure to internal or external triggers that symbolize or resemble some aspect of the traumatic event, physiological reactivity or exposure to internal or external triggers that symbolize or resemble some aspect of the traumatic event, persistent avoidance of stimuli associated with trauma and attenuation of general reactivity, difficulty in falling asleep or maintaining sleep, irritability or outbursts of anger, difficulty in concentrating, hypervigilance and exaggerated alarm responses), following a traumatic event, one will have to speak of "post-traumatic stress disorder", which if not effectively reworked could first turn into "adaptation disorder" (as codified by the DSM-V) and then into "post-traumatic anxiety disorder".

2) Phobic personality disorder

It is a habitual, persistent and pervasive model, beginning around three years old, characterized by phobic manifestations not justified by the possible source of danger, rigidity of thought and avoidance:

2.1) phobic manifestations not justified by the possible source of danger;

2.2) rigidity of thought;

2.3) avoidance of the possible source of danger;

2.4) fixation and/or obsession;

2.5) chronic phobia and/or multiple manifestations on several phobic objects;

2.6) total or partial inability to perform elementary daily activities;

2.7) low tolerance of anxiety and/or frustration;

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2.8) marked discomfort experienced in potentially non-hazardous or stressful situations;

2.9) marked episodes of anxiety leading to panic and/or hysterical symptoms.

The only phobia for a specific object (e.g. spiders) with chronic and/or obsessive symptoms, is not sufficient for the diagnosis of phobic personality disorder but should be defined as "single specific phobia"; if the sources are multiple, we will speak of "multiple specific phobias".

When the phobia focuses on the social context, giving rise to a free anxiogenic phenomenon, it will he's gonna have to talk about "social phobic disorder".

3) Avoiding disorder

It is a habitual, persistent and pervasive model, beginning around the age of five, characterized by excessive fear to the point of paranoia, avoidance (which, however, involves suffering for social isolation) and low self-esteem:

3.1) excessive and/or unfounded fear;

3.2) avoidance of potentially stressful circumstances and/or attempts at avoidance;

3.3) delegation of responsibility;

3.4) low self-esteem;

3.5) lack of willingness to be involved in common and/or collective activities;

3.6) marked anxiety when activities become common and/or collective;

3.7) marked concern about judgment, criticism, and rejection by those closest to them;

3.8) reluctance to take risks and dangers, including calculable ones;

3.9) fear of derision and/or humiliation for one's own mistakes.

4) Obsessive disorder

It is a habitual, persistent, and pervasive model, beginning around the age of four to five years, characterized by obsessions, mental rigidity and need for control:

4.1) obsessions;

4.2) compulsions;

4.3) perfectionism;

4.4) mental rigidity;

4.5) need for control;

4.6) marked discomfort in public;

4.7) concern about one's own and/or others' state of health, with no apparent justification;

4.8) altered perceptual state, without delusions or hallucinations, about one's own or others' bodies;

4.9) delusional and/or paranoid thoughts and/or beliefs.

When the obsession is without compulsion we will speak of "simple obsessive disorder"; if instead the obsessions are multiple but always without compulsions we will speak of "complex obsessive disorder". If there are both obsessions and compulsions, we will speak of "compulsive obsessive disorder".

When the obsession concerns the aesthetic appearance we will speak of "obsessive disorder of dysmorphic body type".

When the obsession concerns accumulation, we should speak of "obsessive disorder of the accumulative

type".

When the obsession concerns setting fires, one should speak of "obsessive disorder of the pyromaniac type", unless otherwise psychopathologically attributed (for example, pyromania as a symptom of oppositional-provocative or psychopathic behavior).

When the obsession concerns the theft of objects, one should speak of "obsessive kleptomaniac type disorder".

When the obsession concerns the tearing of hair or bruises, we should speak of "obsessive disorder of the injurious type".

5) Somatic disorder

It is a habitual, persistent, and pervasive model, beginning around two to three years, characterized by somatic symptoms in the absence of relevant clinical data, concern about health status and low tolerance to frustration:

5.1) somatic symptoms, in the absence of relevant clinical data;

5.2) concern about health status;

5.3) concern about one or more diseases;

5.4) low tolerance to anxiety and frustration;

5.5) search for responses outside the health field;

5.6) difficulty in concentrating and fulfilling one's tasks and duties;

5.7) obsessive and/or paranoid thinking;

5.8) complaints and ruminations about the state of health or symptom;

5.9) low self-esteem and/or insecurity.

6) Maniacal disorder

It's a habitual, persistent and pervasive model, with a beginning between five and ten years old, characterized by a dysfunctional alteration of mood tone, flight of ideas and psychomotor agitation:

6.1) dysfunctional alteration of mood tone;

6.2) flight of ideas;

6.3) psychomotor agitation;

6.4) need to buy material goods continuously;

6.5) flight of ideas and/or increasing the speed of ideas, starting or not starting activities without completing them;

6.6) increased sociability and/or the need to stay at home to reflect on the idea;

6.7) ideas of grandeur;

6.8) tendency to psychotic episodes;

6.9) hyperactivation, with or without sudden weariness and/or change in thought flows.

In children, this disorder is strongly attenuated, and then evolves towards the age of twelve, becoming structurally a personality disorder.

Latent domain area (Cluster B)

7) Bipolar disorder

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It is a habitual, persistent and pervasive model, with an onset between five and ten years of age, characterized by sudden mood fluctuations, maniacally and/or depressive states and/or sudden alternation and emotional instability:

7.1) sudden mood swings;

7.2) emotional instability;

7.3) relational and/or social instability;

7.4) manic, depressive and/or mixed episodes;

7.5) tendency to active and/or passive manipulation;

7.6) low tolerance to frustration and anxiety;

7.7) tendency to irritability;

7.8) low tolerance to criticism;

7.9) dysphoric mood (with or without unpleasant feelings, frustration, pessimism, tension, irritability, anxiety, and psychomotor agitation).

In children, this disorder is attenuated, becoming increasingly stable in adolescence and adulthood.

8) Disruptive mood disorder

It is a habitual, persistent, and pervasive model, starting between five and ten years old, characterized by systematic and persistent irritability that leads to fits of anger, aggression, and frequent mood swings:

8.1) severe outbursts of anger;

8.2) recurring outbursts of anger, at least three episodes per week;

8.3) violent physical and/or verbal reactions;

8.4) disproportionate physical and/or verbal reactions in both duration and intensity;

8.5) age-incompatible reactions of anger and/or violence;

8.6) irritable mood for most of the day;

8.7) negative feelings towards the family, friends and/or school environment;

8.8) low tolerance of anxiety and/or frustration;

8.9) intolerance towards any form of education contrary to the child's wishes and/or expectations.

9) Disadaptive separation disorder

It is a habitual, persistent and pervasive model, beginning between two and four years of age, characterized by systematic and persistent difficulty in letting go of parents or one's caregiver, constant and excessive fear that something tragic might happen to them and systematic refusal to leave home or stay alone at home:

9.1) difficulty in letting go of parents or caregiver;

9.2) explosions of anger;

9.3) violent physical and/or verbal reactions;

9.4) disproportionate physical and/or verbal reactions in both duration and intensity;

9.5) constant and/or excessive fear that something tragic may happen to parents or caregiver;

9.6) easily irritable, anxious and/or depressed mood (with notes of apathy, restlessness and strong melancholy) in the presence of a separating circumstance;

9.7) negative feelings towards the separating event;

9.8) low tolerance of anxiety and/or frustration;

9.9) systematic refusal to move away from home and/or remain alone at home.

10) Oppositional-provocative disorder

It is a habitual, persistent, and pervasive model, beginning between five and ten years, characterized by systematic and persistent difficulty in regulating and controlling one's emotions and behavior:

10.1) an angry and/or easily irritable mood;

10.2) explosions of anger;

10.3) violent physical and/or verbal reactions;

10.4) disproportionate physical and/or verbal reactions in both duration and intensity;

10.5) opposing behavior;

10.6) vindictive behavior;

10.7) negative feelings towards those who exercise authority;

10.8) low tolerance of anxiety and/or frustration;

10.9) traits of hyperactivity.

11) Explosive-intermittent disorder

It is a habitual, persistent, and pervasive model, beginning between four and eight years of age, characterized by systematic and persistent difficulty in managing anger and rage:

11.1) an angry and/or easily irritable mood;

11.2) explosions of anger;

11.3) violent physical and/or verbal reactions;

11.4) disproportionate physical and/or verbal reactions in both duration and intensity;

11.5) behaviors in reaction to events wrongly perceived as damaging to one's sphere;

11.6) poor management of anger and/or anger, even in completely harmless events;

11.7) negative feelings towards third parties;

11.8) low tolerance of anxiety and/or frustration;

11.9) poor ability to resist aggressive and/or violent impulses.

12) Uninhibited social commitment disorder

It is a habitual, persistent and pervasive model, with a beginning between five and ten years, characterized by the systematic and persistent manifestation of behavior, towards third parties, excessively physical and uninhibited:

12.1) unstable mood;

12.2) uninhibited verbal behavior with persons not belonging to the household;

12.3) uninhibited physical behavior with persons not belonging to the family nucleus;

12.4) direct and excessively friendly approach with non-family members;

12.5) seeking attention with strangers or strangers;

12.6) constant need for physical contact with non-family members;

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12.7) overly trusting feelings towards third parties (not previously known);

12.8) low tolerance of anxiety and/or frustration concerning seeking contact and attention;

12.9) lack of reticence or hesitation in leaving a safe place with unknown persons.

13) Attachment disorder

It is a habitual, persistent and pervasive model, beginning between two and five years of age, which refers to the disturbed and/or inadequate social-relational modality that characterizes the child concerning his or her level of psychosocial development, either due to a distortion of the secure base or to a total or partial absence of attachment. I know two main clinical forms of it:

Inbited Type (13a)

13a.1) difficulties in establishing interpersonal relationships;

13a.2) dysfunctional adaptation to common life circumstances;

13a.3) excessive inhibition;

13a.4) excessive hypervigilance;

13a.5) contradictory attitude towards his carers;

13a.6) low social involvement;

13a.7) difficulties in emotional regulation;

13a.8) low tolerance of anxiety and/or frustration;

13a.9) inexplicable fear and/or outbursts of anger.

Uninhibited Type (13b)

13b.1) ease of interpersonal relations;

13b.2) independent and overly functional adaptation to common life circumstances;

13b.3) excessive disinhibition;

13b.4) excessive hypovigilance;

13b.5) excessive detachment and separation from caregivers;

13b.6) excessive social involvement and/or excessive sociability;

13b.7) emotional over-regulation;

13b.8) low tolerance of anxiety and/or frustration concerning loneliness;

13b.9) lack of shyness towards the stranger with whom he has contact.

14) Dependent disorder

It is a habitual, persistent and pervasive model, beginning between five and ten years, characterized by strong insecurity, tendency to need approval and delegation of responsibility:

14.1) strong insecurity and/or tendency to passive manipulation;

14.2) tendency to need approval by others;

14.3) delegation of responsibility;

14.4) difficulty in making day-to-day decisions;

14.5) inclination to strive for the benefit and support of others;

14.6) feelings of discomfort and/or helplessness when alone without asking for help or advice;

14.7) unrealistic and excessive concerns;

14.8) fear that they are abundant and have to take care of themselves alone;

14.9) low self-esteem.

15) Depressive disorder

It's a habitual, persistent and pervasive model, with a beginning between five and ten years old, characterized by depressed mood, low self-esteem, and a marked decrease in interests and pleasures:

15.1) Depressed mood;

15.2) Low self-esteem and/or tendency to passive manipulation;

15.3) Marked decrease in pleasure in carrying out interests and activities and/or tendency to boredom;

15.4) Significant weight gain or loss;

15.5) Psychomotor agitation and/or slowdown;

15.6) Lack of energy and/or easy tiredness;

15.7) Feelings of self-devaluation, inappropriateness and/or marked feelings of guilt;

15.8) Reduced ability to concentrate on activities;

15.9) Recurring negative or melancholy and/or death related thoughts, not caused by real events (for example, grief).

The "grieving" event can trigger a depressive tendency to the point of "persistent mourning depressive disorder".

When the symptomatology suffered allows one to carry out one's work or activities, while maintaining the behavioral and humoral characteristics of the depressed patient, one must speak of the attenuated form of "dysthymic type depressive disorder".

16) Selfish disorder

It's a habitual, persistent and pervasive model, with a beginning between five and ten years old, characterized by marked selfishness, emotional instability and sudden mood swings:

16.1) emotional instability;

16.2) sudden mood swings;

16.3) marked selfishness and/or empathy deficit;

16.4) desperate efforts to avoid estrangement and/or abandonment (real and/or imaginary);

16.5) disproportionate need for care to the detriment of other people;

16.6) theatricality and/or drama;

16.7) active and/or passive-aggressive manipulative tendency;

16.8) sudden anger and unjustified aggressiveness, with the use of physical, verbal and/or psychological violence, with or without aggressiveness;

16.9) failure to respect the rules and civil standards of coexistence.

17) Libidinal disorder

It is a habitual, persistent, and pervasive model, beginning around the age of three to four years,

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characterized by an inability to control the libidinal impulse and one's unconscious energies:

17.1) Selfish tendencies and/or empathy deficits;

17.2) manipulation of people and circumstances for personal gain, to the detriment of other people;

17.3) marked a sense of possession and ownership over people and/or objects;

17.4) lack of or no feeling of sharing;

17.5) high emotional sensitivity;

17.6) impatience and/or manic or hypomaniacal behavior;

17.7) unconscious abuse of primitive defense mechanisms;

17.8) low tolerance of anxiety and/or frustration;

17.9) total or partial inability to resist impulses and desires, to be realized immediately.

Psychotic domain area (Cluster C)

Psychopathic disorder

It's a habitual, persistent and pervasive model, with a beginning around five years old, characterized by destructive and/or self-destructive tendencies, high emotional sensitivity and psychotic symptoms:

18.1) destructive and self-destructive tendencies;

18.2) high emotional sensitivity with tendency to active and/or passive manipulation and deception;

18.3) seeking attention, to the detriment of third parties;

18.4) actions and/or attitudes that are aggressive, violent and/or in violation of social and/or behavioral norms, more or less manifest;

18.5) lack or absence of sensitivity, marked selfishness and/or empathy deficit;

18.6) absence or lack of remorse, guilt and/or shame;

18.7) egocentricity;

18.8) excessive use of primitive defense mechanisms;

18.9) psychotic symptoms.

Mixed Or Residual domain area (Cluster D)

19) mixed disturbance

20) disorder not otherwise specified

21) common psychopathological conditions

22) concomitant or triggering medical conditions

23) socio-environmental conditions concomitant or triggering (relationship problems; problems related to the primary support group (family); abuse and neglect; problems related to education; indirect housing problems; indirect economic problems; problems related to the social environment; problems related to the justice system; problems related to the health system and medical care; religious, spiritual and mystical beliefs; other personal conditions and needs).

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].

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;

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.

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.

Relevance of the answers: Only positive answers to items define the presence of dysfunctional traits and possibly the presence of one or more disorders.

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 Figures 2,3.

Perrotta Integrative Clinical Interview for Childrens (**PICI-1C**)

Perrotta Integrative Clinical Interview for Childrens (**PICI-1C**)			
Num.	**Item**	**Si**	**No**
1	Throughout the day, do you feel restless several times?		
2	Do you sometimes feel that you are too rigid in your positions?		
3	Do you tend to complain for futile or apparent reasons?		
4	Do you tend to stay focused on the same thought for too long?		
5	Do your concerns manifest themselves in repetitive thoughts?		
6	Do you get irritated easily?		
7	Do you get mentally and/or physically tired easily?		
8	Do you feel that daily worries or tensions overwhelm you?		
9	Do you feel that you can't finish all the daily activities planned?		
10	Do you feel that when you feel stressed you let yourself go into excessive behavior?		
11	When you feel stressed do you have obvious physical behaviors or symptoms?		
12	Throughout the day, do you feel restless, tense, and agitated several times?		
13	Do you have one or more unjustified fears?		
14	Do you tend to avoid the source of your fear?		
15	Do you tend to obsess or fixate on your fear?		
16	When you are afraid, do you tend not to face the source of your fear?		
17	Do you feel marked discomfort when you are in contact with the source of your fear?		
18	Do you feel excessive and/or unfounded fear about a collective activity?		
19	Do you tend to avoid the circumstance that causes you discomfort?		

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20	Do you tend to delegate your responsibility to someone else?		
21	Do you feel your self-esteem and security are low?		
22	Do you tend to avoid being involved in collective and/or public activities?		
23	Do you feel uneasy and/or intolerant when you have to do collective and/or public activities?		
24	Are you influenced by people's judgment of what you do?		
25	Are you influenced by people's criticism of what you do?		
26	Are you influenced by the rejection you receive from people about your work?		
27	Do you avoid taking risks, even if they are calculated?		
28	Do you worry about being mocked or mocked for your mistakes?		
29	Do you tend to obsessively fixate on an idea, an object, or a person?		
30	Do you tend to have compulsive actions in reaction to your fixations/obsessions?		
31	Do you consider yourself a perfectionist or do you aspire to perfection at all costs?		
32	Do you feel better if you tend to control the circumstances of life or the actions of the people you relate to?		
33	Do you feel uncomfortable in public, about your fixations and/or obsessions?		
34	Do you worry about your state of health, even in the absence of obvious symptoms?		
35	Have you ever had the impression that your body was different but that no one around you understood your state of mind about your perception?		
36	Have you ever been convinced of something wrongly but still believe it to be true?		
37	Have you ever felt one or more symptoms not explained by the doctors you consulted?		
38	Have you ever consulted external sources for your health problems, relying on people other than health professionals or qualified personnel?		
39	Do you feel that your mood is not always stable?		
40	Do you feel that your ideas overlap?		
41	Do you tend not to be thrifty and/or overspend?		
42	Do you feel that your ideas travel fast and/or leave one or more activities unfinished?		
43	Do you feel excited several times a day?		
44	Do you feel needy for human contact in public several times a day?		
45	Do you feel need to lock yourself indoors several times a day to think about your ideas?		
46	Do you think your ideas are brilliant or important?		
47	Do you feel hyperactive at certain times of the day?		
48	At certain times of the day, do you feel that you're feeling worn out?		
49	Do you feel emotionally unstable?		
50	Are your social relationships affected by your mood?		
51	Have you ever felt both depressed and euphoric at certain times of the day?		
52	Have you ever tried to actively achieve something against the will of the other person?		
53	Have you ever tried, with passive-aggressive attitudes, to achieve something against the will of the other person?		
54	Does criticism hurt you, even if it is deserved?		
55	Do you tend to have unpleasant feelings and/or negative and pessimistic ideas more often?		
56	Have you ever had one or more outbursts of anger?		
57	Have you ever had a recurring outburst of anger?		
58	Have you ever had violent physical and/or verbal reactions?		
59	Have you ever had disproportionate physical and/or verbal reactions?		
60	Have you ever had violent outbursts of violence?		
61	Have you ever had negative feelings towards your family, friends, and/or school environment?		
62	Have you ever had episodes of intolerance towards one or more forms of education, because perceived by you as contrary to your wishes and/or expectations?		

63	Have you ever had difficulty letting go of the caregiver?		
64	Have you ever been afraid that something tragic might happen to those you love and that it would make you feel deeply ill?		
65	Have you ever felt irritated, depressed, or anxious about a temporary separation with your caregiver?		
66	Have you ever felt negative feelings coinciding with an event of temporary separation from your loved ones and/or caregivers?		
67	Have you ever refused to be alone at home?		
68	Have you ever forced the caregiver to stay there and not go away, even if not necessary?		
69	Have you ever strongly and violently opposed an order from someone who cares for you?		
70	Have you ever taken revenge against an order from someone who cares for you?		
71	Have you ever had negative feelings at the time of a request, order, or command from a caregiver or an authority?		
72	Have you ever felt the need to react with anger and rage, even in the face of completely harmless events?		
73	Have you ever decided to react with anger and rage, even knowing that the events were all harmless?		
74	Have you ever decided on the overwhelming impulse to react with anger and rage, even knowing that the events were all harmless or just annoying?		
75	Have you ever had uninhibited verbal behavior with non-family members?		
76	Have you ever had uninhibited physical behavior with non-family members?		
77	Have you ever had a direct and excessively friendly approach to people outside the household?		
78	Have you ever sought attention from strangers or strangers?		
79	Have you ever had a constant need for physical contact with non-family members?		
80	Have you ever had overly trusting feelings towards (unknown) third parties?		
81	Have you ever been tense and nervous if you could not seek contact or attention from people outside your family?		
82	Have you ever had the pleasure of going away with strangers or people outside your household without notifying your parents or caregivers?		
83	Have you ever had difficulty in entering into interpersonal relationships?		
84	Have you ever had difficulty adapting to the circumstances of life?		
85	Have you ever had excessive inhibition?		
86	Have you ever had excessive hypervigilance?		
87	Have you ever had contradictory attitudes towards your carers?		
88	Have you ever had little social involvement?		
89	Have you ever had difficulty in emotional regulation?		
90	Have you ever had negative feelings or fears about someone or something without knowing them?		
91	Have you ever had difficulty in entering into interpersonal relationships?		
92	Have you ever had any ease in adapting to life's circumstances?		
93	Have you ever had excessive disinhibition?		
94	Have you ever had excessive hypovigilance?		
95	Have you ever had attitudes of excessive detachment and separation from caregivers?		
96	Have you ever had excessive social involvement and/or excessive sociability?		
97	Have you ever had too much emotional manifestation?		
98	Have you ever felt irritated, depressed, or anxious at the idea of being alone, despite your desire for sociability?		
99	Have you ever had an absence of shyness in the presence of a stranger at first contact?		
100	Do you feel more confident if you get the approval of others before you start a business?		
101	Do you have difficulty making everyday decisions, even simple ones, and/or would you be able to make them yourself, without asking for advice, suggestions or help?		
102	Do you have difficulty carrying out activities that would bring you advantages and/or benefits, without asking for advice, suggestion, and/or help?		

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103	Do you have feelings of helplessness and/or discomfort when you are alone and/or cannot ask for advice, suggestion, and/or help?		
104	Do you feel excessive or unrealistic concerns when you cannot ask for advice, suggestion, and/or help?		
105	Are you afraid to take care of yourself without the help of someone?		
106	Would you describe your mood as tendentially or always depressed?		
107	Do you experience one or more episodes of markedly diminished pleasure in carrying out interests and activities throughout the day?		
108	Do you experience one or more episodes of marked boredom and/or disinterest throughout the day, even though you have interesting activities to do?		
109	Have you had losses and/or weight gain as a result of your mood?		
110	Have you had any agitation and/or psychomotor slowdown as a result of your mood?		
111	Do you frequently experience feelings of inappropriateness, self-assessment, and/or marked feelings of guilt in the absence of a justifiable cause?		
112	Do you frequently experience negative or melancholic and/or death-related thoughts that are not caused by real events?		
113	Would you like it if other people always did what you want them to do?		
114	Do you think that people, after meeting you, mostly want to abandon you or drive you away?		
115	Would you like it if other people paid attention to you even if they were hurting someone else?		
116	When you are frustrated and/or under tension do you like to draw attention to drama and theatricality?		
117	Have you ever reacted with sudden anger and unjustified aggression, with/without the use of physical, verbal and/or psychological violence?		
118	Have you ever voluntarily violated one or more civil rules of cohabitation and/or legal rules?		
119	Do you refuse to lend, even temporarily, the objects you care about to other people, out of jealousy and/or possession?		
120	Do you refuse to share the objects you care about, to other people, out of jealousy and/or possession?		
121	Do you consider yourself an inpatient and/or rather hasty person?		
122	Do you tend to identify the outside with the inside and/or split the good and the bad?		
123	Do you feel an uncontrollable and/or irrepressible desire to achieve what you think and/or desire?		
124	If something cannot be yours, do you prefer to destroy it in order not to let someone else have it?		
125	Have you ever had actions and/or attitudes that are aggressive, violent, and/or in violation of social and/or behavioral norms, more or less manifest?		
126	Do you feel disinterested and/or irritated by what the other person feels emotionally and/or sentimentally, even if they are suffering and/or struggling?		
127	Do you feel remorse, guilt or shame if you do something wrong?		
128	Have you ever perceived strange creatures, mysterious beings, voices and/or sounds that no one else could see or hear?		
129	Do you have symptoms of an intellectual disability (mental retardation)?		
130	Do you have symptoms of a speech and/or phonetic-phonological disorder?		
131	Do you have symptoms of a phonetic-phonological disorder?		
132	Do you have symptoms of a social communication disorder?		
133	Do you have the symptoms of a fluency disorder?		
134	Do you have the symptoms of an autism spectrum disorder?		
135	Do you have the symptoms of attention deficit and hyperactivity disorder?		
136	Do you have the symptoms of a specific learning disorder?		
137	Do you have the symptoms of a coordination disorder?		
138	Do you have the symptoms of a stereotyped movement disorder?		
139	Do you have the symptoms of an ICT disorder?		
140	Have you ever had one or more acute psychotic episodes?		
141	Have you ever had one or more catatonic episodes?		
142	Do you have the symptoms of selective mutism disorder?		

143	Do you have the symptoms of a nutrition disorder?		
144	Do you have the symptoms of an evacuation disorder?		
145	Do you have the symptoms of a sleep-wake disorder?		
146	Do you have the symptoms of a gender identity disorder?		
147	Do you have symptoms of one or more forms of paraphilia?		
148	Do you have the symptoms of a substance addiction disorder?		
149	Do you have the symptoms of a behavioral addiction disorder?		
150	Have you ever thought and/or attempted suicide?		

Conversion table for Childrens (PICI-1C)

Perrotta Integrative Clinical Interview for Childrens (**PICI-1C**).	
Num.	**Reference dysfunctional trait**
1	1.1, 16.2
2	1.2, 2.2, 4.4
3	1.3, 5.8
4	1.3, 5.8
5	1.4,
6	1.5, 7.7, 8.6, 10.1, 11.1
7	1.5, 15.6
8	1.6, 5.4, 7.6, 8.8, 9.8, 10.8, 11.8, 14.9, 15.2, 17.8
9	1.7, 2.6, 5.6, 15.8
10	1.8, 2.9
11	1.8, 2.9
12	1.9, 2.7, 6.3
13	2.1
14	2.3
15	2.4
16	2.5
17	2.8
18	3.1
19	3.2
20	3.3, 14.3
21	3.4, 5.9, 14.1
22	3.5
23	3.6
24	3.7
25	3.7
26	3.7
27	3.8
28	3.9
29	4.1, 5.7
30	4.2
31	4.3
32	4.5
33	4.6
34	4.7, 5.2, 5.3

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35	4.8
36	4.9, 5.7, 6.8
37	5.1
38	5.5
39	6.1, 7.1, 12.1
40	6.2
41	6.4
42	6.5
43	6.6
44	6.6
45	6.6
46	6.7
47	6.9, 10.9
48	6.9
49	7.2, 16.1
50	7.3
51	7.4
52	7.5, 16.7, 17.2, 18.2
53	7.5, 14.1, 15.2, 16.7, 17.2, 18.2
54	7.8
55	7.9
56	8.1, 9.2
57	8.2, 10.2, 11.2
58	8.3, 9.3, 10.3, 11.3
59	8.4, 9.4, 10.4, 11.4
60	8.5
61	8.7, 11.7
62	8.9
63	9.1
64	9.5
65	9.6
66	9.7
67	9.9
68	9.9
69	10.5
70	10.6
71	10.7
72	11.5
73	11.6
74	11.9
75	12.2
76	12.3
77	12.4
78	12.5
79	12.6
80	12.7

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81	12.8
82	12.9
83	13.1
84	13.2
85	13.3
86	13.4
87	13.5
88	13.6
89	13.7, 17.5, 18.2
90	13.9
91	13.10
92	13.11
93	13.12
94	13.13
95	13.14
96	13.15
97	13.16
98	13.17
99	13.18
100	14.2
101	14.4
102	14.5
103	14.6
104	14.7
105	14.8
106	15.1
107	15.3
108	15.3
109	15.4
110	15.5
111	15.7
112	15.9
113	16.3, 17.1, 18.7
114	16.4
115	16.5, 18.3
116	16.6
117	16.8
118	16.9
119	17.3
120	17.4
121	17.6
122	17.7, 18.8
123	17.9
124	18.1
125	18.4
126	18.5

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127	18.6
128	18.9
129	28.1
130	28.1
131	28.1
132	28.1
133	28.1
134	28.1
135	28.1
136	28.1
137	28.1
138	28.1
139	28.1
140	28.2
141	28.3
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146	28.8
147	28.9
148	28.11
149	28.11
150	28.12

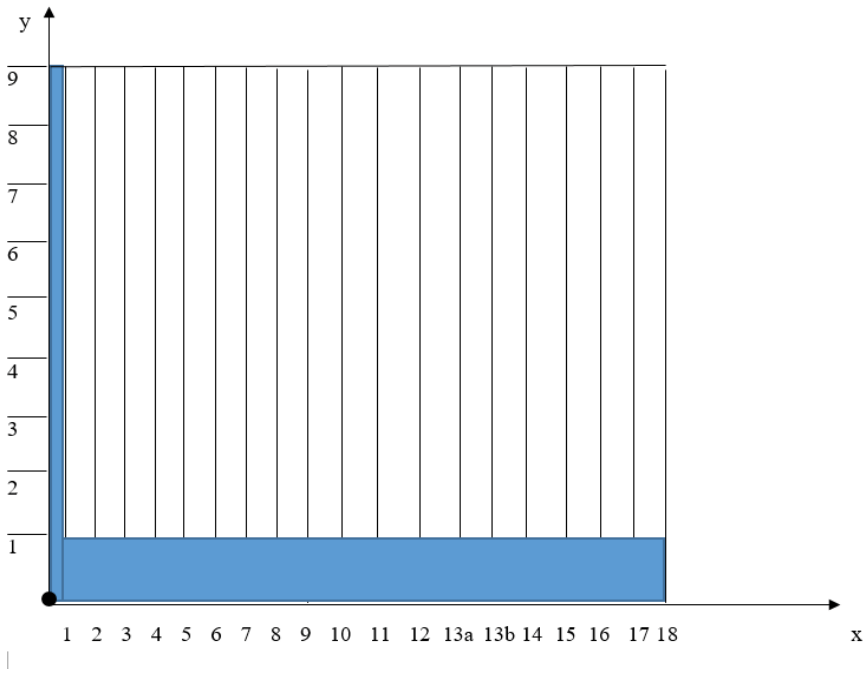

Figure 2: Graphic element for PICI-1C. In "X" we find the new single psychopathological categories, while in "Y" we find the single dysfunctional traits that characterize the single disorder.

The affirmative answers, concerning the dysfunctional traits, will then be reported in the clinical chart below, except for the answers to the items that refer to common psychopathological conditions (which will only better define the identified disorders, with their comorbidities). If they line the dysfunctional traits for the single categories of disorders are identified, while in the x line the different disorders are identified: 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).

Perrotta Integrative Clinical Interview for Teenagers and Adult (PICI-1TA)

Perrotta Integrative Clinical Interview for Teenagers and Adult (**PICI-1TA**)			
Num.	**Item**	**Si**	**No**
1	Throughout the day, do you feel restless several times?		
2	Do you sometimes feel that you are too rigid in your positions?		
3	Do you tend to complain for futile or apparent reasons?		
4	Do you tend to stay focused on the same thought for too long?		
5	Do your concerns manifest themselves in repetitive thoughts?		
6	Do you get irritated easily?		
7	Do you tire mentally and/or physically with ease?		
8	Do you feel that daily worries or tensions overwhelm you?		
9	Do you feel that you are unable to complete all the daily activities planned?		
10	When you feel stressed, do you let yourself go into excessive behavior?		
11	When you feel stressed do you have obvious physical behaviors or symptoms?		
12	Throughout the day, do you feel restless, tense, and agitated several times?		
13	Do you have one or more unjustified fears?		
14	Do you tend to avoid the source of your fear?		
15	Do you tend to obsess or fixate on your fear?		
16	When you are afraid, do you tend not to face the source of your fear?		
17	Do you feel marked discomfort when you are in contact with the source of your fear?		
18	Do you feel excessive and/or unfounded fear about a collective activity?		
19	Do you tend to avoid the circumstance that causes you discomfort?		
20	Do you tend to delegate your responsibility to someone else?		
21	Do you feel your self-esteem and security are low?		
22	Do you tend to avoid being involved in collective and/or public activities?		
23	Do you feel uneasy and/or intolerant when you have to do collective and/or public activities?		
24	Are you influenced by people's judgment of what you do?		
25	Are you influenced by people's criticism of what you do?		
26	Are you influenced by the rejection you receive from people about your work?		
27	Do you avoid taking risks, even if they are calculated?		
28	Do you worry about being mocked or mocked for your mistakes?		
29	Do you tend to obsessively fixate on an idea, an object, or a person?		
30	Do you tend to have compulsive actions in reaction to your fixations/obsessions?		
31	Do you consider yourself a perfectionist or do you aspire to perfection at all costs?		
32	Do you feel better if you tend to control the circumstances of life or the actions of the people you relate to?		
33	Do you feel uncomfortable in public, about your fixations and/or obsessions?		
34	Do you worry about your state of health, even in the absence of obvious symptoms?		

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35	Have you ever had the impression that your body was different but that no one around you understood your state of mind about your perception?		
36	Have you ever been convinced of something wrongly but still believe it to be true?		
37	Have you ever felt one or more symptoms not explained by the doctors you consulted?		
38	Have you ever consulted external sources for your health problems, relying on people other than health professionals or qualified personnel?		
39	Do you feel that your mood is not always stable?		
40	Do you feel that your ideas overlap?		
41	Do you tend not to be thrifty and/or overspend?		
42	Do you feel that your ideas travel fast and/or leave one or more activities unfinished?		
43	Do you feel excited several times a day?		
44	Do you feel needy for human contact in public several times a day?		
45	Do you feel needy several times a day to lock yourself in your home or office to work, even well beyond working hours and/or cancelling appointments?		
46	Do you think your ideas are brilliant or important?		
47	Do you feel hyperactive at certain times of the day?		
48	At certain times of the day, do you feel worn out?		
49	Do you feel emotionally unstable?		
50	Are your social relationships affected by your mood?		
51	Have you ever felt, on the same day and in close quarters, both depressed and euphoric?		
52	Have you ever tried to actively achieve something against the will of the other person?		
53	Have you ever tried, with passive-aggressive attitudes, to get something against the will of the other person?		
54	Does criticism hurt you, even if it is deserved?		
55	Do you tend to have unpleasant feelings and pessimism more often?		
56	Have you ever had the pleasure of voluntarily violating a social norm and/or civil commonality and not feeling sorry?		
57	Have you ever suffered warnings or punishments as a result of your behavior?		
58	Do you find it difficult to get into harmony with your emotions?		
59	Have you ever had episodes of explosive and/or uncontrolled anger or in any case unjustified about the event, but then compensated with a sense of guilt, shame, or remorse?		
60	Do you react to life events with impulsiveness?		
61	Do you react to life events with instinctiveness?		
62	Do you feel anger and/or physical and/or verbal aggression towards people, objects, and/or animals?		
63	Have you ever had the chance to voluntarily violate a legal rule of law and not to feel regret?		
64	Do you feel safer if you receive the approval of others before starting an activity?		
65	Do you find it difficult to make everyday decisions, even simple ones, and/or would you be able to make them yourself, without asking for advice, suggestions or help?		
66	Do you find it difficult to carry out activities that would bring you benefits and/or advantages, without asking for advice, suggestions and/or help?		
67	Do you have feelings of helplessness and/or discomfort when you are alone and/or cannot ask for advice, suggestion, and/or help?		
68	Do you feel excessive or unrealistic concerns when you cannot ask for advice, suggestion, and/or help?		
69	Are you afraid to take care of yourself without the help of someone?		
70	Would you describe your mood as tendentially or always depressed?		
71	Do you experience one or more episodes of markedly diminished pleasure in carrying out interests and activities throughout the day?		
72	Do you experience one or more episodes of marked boredom and/or disinte-rest throughout the day, even though you have interesting activities to do?		
73	Have you had losses and/or weight gain as a result of your mood?		
74	Have you had any agitation and/or psychomotor slowdown as a result of your mood?		

75	Do you frequently experience feelings of inappropriateness, self-devaluation, and/or marked feelings of guilt in the absence of a justifiable cause?		
76	Do you frequently experience negative or melancholic and/or death-related thoughts that are not caused by real events?		
77	Do you get the impression that people, after getting to know you, tend to push you away and/or abandon you?		
78	Do you do what you can, putting all your heart into it, to prevent people from moving away from you and/or abandoning you?		
79	Do you feel that your real being can't go outside and/or it's better not to go outside and/or it won't be understood if it goes outside?		
80	Do you feel a sense of emptiness in yourself despite the daily activities and your family, friends, and work circle?		
81	Have you ever been angry or aggressive in an unjustified and/or disproportionate manner to the offense or danger?		
82	Have you ever had sudden anger without a clear cause?		
83	Have you ever been convinced of something irrational by believing it to be true and/or living it in your life as if it were a fact?		
84	Have you ever heard voices and/or seen strange and/or bizarre things that others could not see and/or did not hear, believing them to be true even in the absence of further proof?		
85	Have you ever felt the need to attract attention to fill an inner void?		
86	Do you feel uncomfortable when you are not the center of attention?		
87	Do you feel comfortable if you manifest your emotions dramatically?		
88	Do you feel comfortable if you manifest your emotions with theatricality and/or particular exaggeration?		
89	Are you easily influenced?		
90	Do you sometimes use vague and/or impressionistic language to attract attention and/or narrate the events of your existence?		
91	Do you consider your social contacts, in the personal and relational field, unsafe and/or unstable and/or precarious and/or insecure?		
92	Do you voluntarily use your body to attract attention?		
93	Do you voluntarily use fascination and/or seduction and/or sexual techniques to attract attention?		
94	Do you voluntarily use fascination and/or seduction and/or sexual techniques to manipulate situations and/or people to achieve your goals?		
95	Don't you worry and/or are not impressed by other people's positive and/or negative life stories, because you can't always understand other people's positions?		
96	Do you consider yourself a more special person than others and/or much above average?		
97	Do you think your ideas are great and deserve a bigger and more important stage?		
98	Do you think you have a very high self-esteem that is arrogant in the eyes of other people?		
99	Do you think that others undeservedly envy your professional position and your successes?		
100	Are you worried when you fantasize about your future and your ideas/thoughts of success?		
101	Do you feel happy and satisfied when others admire you and envy you?		
102	Do you think you deserve much more than what you have, even if your titles and experience are not enough?		
103	Do you use the idea of having low self-esteem to attract attention?		
104	Do you feel that criticism and judgment can hurt you more than they should?		
105	Do you use complaints and/or grievances to get attention?		
106	Do you tend to irritate others with your position?		
107	Despite your skills and qualities, do you feel that you do not deserve success?		
108	Has anyone ever told you that you have narcissistic behavior or attitudes?		
109	Do you feel no remorse, guilt or shame if you do something wrong and/or hurt someone or something?		
110	Does it turn you on to see someone suffer?		
111	Do you feel discomfort or negative feelings if you have positive circumstances, situations, and/or feelings?		
112	Does it turn you on to be the cause of someone's suffering?		

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113	Do you think you have a right to make someone suffer without their consent?		
114	Do you tend to identify the outside with the inside and/or split the good and the bad?		
115	Do you feel pleasure in situations where you should feel suffering?		
116	Do you feel pain in situations where you should feel pleasure?		
117	Do you always tend to ruin everything you are building something positive?		
118	Do you like to submit and/or humiliate yourself outside the sexual sphere?		
119	Are you looking for people and/or situations that can cause you disappointment and/or failure and/or live in a situation of discomfort and/or mistreatment?		
120	If you are in trouble and you know you need help, do you tend not to ask for help and/or avoid external intervention from someone who could help you?		
121	Do you feel depressed and/or guilty if you are experiencing good times?		
122	Do you feel depressed and/or guilty if you have a good time?		
123	Do you avoid positive situations that could highlight you in the eyes of others?		
124	Do you tend to have antisocial attitudes?		
125	Do you tend to attract attention to appear?		
126	Do you tend to attract attention using impressionistic language?		
127	Do you tend to be unreliable and/or irresponsible?		
128	Are you aware that the reasons for your suffering depend on your behavior, but you still repeat them?		
129	Have you ever suffered from delusions and hallucinations?		
130	Do you tend to convince yourself that it is a fact without being aware of the genuineness of your interpretation?		
131	Do you tend to believe that your interpretation is correct without ascertaining its genuineness?		
132	Is your speech disorganized, incoherent, and/or derailed?		
133	Is your behavior coarse and disorganized and/or catatonic?		
134	Do your facial expressions and emotions tend to be abulia?		
135	Do you take care of yourself poorly or not at all?		
136	Do you have ideas, beliefs, or thoughts that others find extravagant and/or bizarre?		
137	Have you ever had unusual, strange, and/or irrational experiences, behaviors, and/or perceptions that others cannot explain?		
138	Do you have difficulties and/or lack of desire in establishing social relationships?		
139	Do you prefer voluntary isolation?		
140	Do you feel disinterested in sociality?		
141	Do you have a strong interest in solitary activities?		
142	Do you tend to perceive threatening facts, events, and/or people who are not?		
143	Do you feel that your emotions are increasingly cold and detached from the social context?		
144	Do you have few or no close emotional, sentimental, and/or friendly intimate relationships?		
145	Do you have a deep need to establish interpersonal spaces and limits with other people, even where there is no need?		
146	Do you have behaviors that others consider eccentric, and/or extravagant?		
147	Do you have special and/or paranormal beliefs, powers, and/or psychic faculties?		
148	The tendency that makes you feel more comfortable is social detachment?		
149	Do you feel uncomfortable and tense in the social sphere?		
150	Do you feel that when you are in the social context your affectivity is reduced, more contained, and/or inappropriate than the behavior of others?		
151	Do you prefer to use unclear language and/or rich in metaphors?		
152	Do you have the impression that your thoughts tend to repeat themselves obsessively and/or become paranoid, in the absence of evidence to the contrary and/or evident?		
153	Have you ever had delusional behavior put into practice and/or prosecuted?		
154	Have you ever suffered from hallucinations?		

155	Have you ever suffered from manic or hypomanic episodes?		
156	Have you ever suffered from bipolar tendencies?		
157	Have you had low or no tolerance for criticism and/or judgment?		
158	Is your speech disorganized and/or coarse?		
159	Have you ever had irrational ideas of a persecutory, relational nature?		
160	Have you ever suffered or suffer from paranoia (chronic delirium)?		
161	Have you ever suffered from persecution mania?		
162	Do you tend to be suspicious and suspicious?		
163	Do you get unjustifiably suspicious?		
164	Have you ever suffered from phobias and/or obsessions?		
165	The tendency that makes you feel more comfortable is social withdrawal?		
166	If someone has a contrary idea do you tend not to confront and/or see their opposition as a sign that they are an enemy?		
167	Have you ever suffered from dissociative episodes of identity?		
168	Have you ever had the impression that reality is not how you perceive it?		
169	Have you ever suffered amnestic episodes and/or memory lapses?		
170	Have you ever seen and/or heard anything or anyone during your		
171	During the dissociative episode, did you perceive/hear/hear something that someone else did not perceive/hear/hear?		
172	Have you ever wandered away from home without (or partly) realizing you were doing it?		
173	Have you ever felt a feeling of disconnection from your body or your thoughts, to observe your life from the outside?		
174	Have you ever experienced a feeling of disconnection from your body or thoughts, disassociating yourself from your surroundings?		
175	Do you have symptoms of an intellectual disability (mental retardation)?		
176	Do you have symptoms of a language and/or phonetic-phonological disorder?		
177	Do you have symptoms of a phonetic-phonological disorder?		
178	Do you have symptoms of a social communication disorder?		
179	Do you have the symptoms of a fluency disorder?		
180	Do you have the symptoms of an autism spectrum disorder?		
181	Do you have the symptoms of attention deficit and hyperactivity disorder?		
182	Do you have the symptoms of a specific learning disorder?		
183	Do you have the symptoms of a coordination disorder?		
184	Do you have the symptoms of a stereotyped movement disorder?		
185	Do you have the symptoms of an ICT disorder?		
186	Have you ever had one or more acute psychotic episodes?		
187	Have you ever had one or more catatonic episodes?		
188	Do you have the symptoms of selective mutism disorder?		
189	Do you have the symptoms of a nutrition disorder?		
190	Do you have the symptoms of an evacuation disorder?		
191	Do you have the symptoms of a sleep-wake disorder?		
192	Do you have the symptoms of a gender identity disorder?		
193	Do you have symptoms of one or more forms of paraphilia?		
194	Do you have symptoms of one or more forms of sexual dysfunction in the absence of diagnosed organic symptoms?		
195	Do you have the symptoms of a substance addiction disorder and/or		

Conversion table for Teenagers and Adult (PICI-1TA)

Perrotta Integrative Clinical Interview for Teenagers and Adult **(PICI-1TA).**

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Num.	Reference dysfunctional trait
1	1.1
2	1.2, 2.2, 4.4
3	1.3, 5.8
4	1.3, 5.8
5	1.4,
6	1.5, 7.7,
7	1.5, 10.6
8	1.6, 5.4, 7.6, 8.4, 9.9, 14.7, 21.4, 22.2, 23.5, 24.4
9	1.7, 2.6, 5.6, 10.8, 16.8
10	1.8, 2.9
11	1.8, 2.9
12	1.9, 2.7, 6.3
13	2.1
14	2.3
15	2.4
16	2.5
17	2.8
18	3.1
19	3.2
20	3.3, 9.3
21	3.4, 5.9, 9.1
22	3.5
23	3.6
24	3.7
25	3.7
26	3.7
27	3.8
28	3.9
29	4.1, 5.7
30	4.2
31	4.3
32	4.5, 13b.9
33	4.6
34	4.7, 5.2, 5.3
35	4.8
36	4.9, 5.7, 6.8
37	5.1, 13b.7, 22.6, 24.3
38	5.5, 13b.7
39	6.1, 7.1, 11.2, 21.6
40	6.2
41	6.4
42	6.5
43	6.6
44	6.6
45	6.6

46	6.7
47	6.9,
48	6.9
49	7.2, 11.1, 16.3
50	7.3
51	7.4
52	7.5, 11.3, 13a.8, 15.2, 17.5
53	7.5, 8.6, 10.2, 11.4, 15.2, 16.3, 17.5
54	7.8
55	7.9
56	8.1, 14.4
57	8.2
58	8.3
59	8.5
60	8.6, 11.6, 14.9, 17.6
61	8.7, 14.9, 17.6
62	8.8, 13a.9
63	9.9, 14.5, 22.8
64	9.2
65	9.4
66	9.5
67	9.6
68	9.7
69	9.8
70	10.1
71	10.3
72	10.3
73	10.4
74	10.5
75	10.7
76	10.9, 14.8, 15.3, 23.6
77	11.4, 12.3
78	11.4, 12.3
79	11.5
80	11.7
81	11.8, 14.6
82	11.8, 14.6
83	11.9
84	11.9, 13b.6
85	12.1
86	12.2
87	12.4
88	12.4
89	12.5
90	12.6
91	12.7

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92	12.8
93	12.8
94	12.9
95	13a.1, 13a.7, 14.2, 17.2
96	13a.2
97	13a.2
98	13a.3
99	13a.4
100	13a.5
101	13a.6
102	13a.7
103	13b.1
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107	13b.5
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111	15.4
112	15.5
113	15.6
114	15.7
115	15.9
116	15.9
117	16.1
118	16.2
119	16.4
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121	16.6
122	16.7
123	16.9
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126	17.4
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128	17.9, 18.2, 19.4, 20.8, 21.3, 22.4
129	18.1
130	18.3
131	18.3, 19.5
132	18.4
133	18.5
134	18.6
135	18.7
136	18.8, 21.8
137	18.9, 20.3, 21.9

138	19.1
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140	19.3
141	19.3
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144	19.8
145	19.9
146	20.1, 22.3
147	20.2
148	20.4
149	20.5
150	20.6
151	20.7
152	20.9
153	21.1, 22.1
154	21.2, 22.5
155	21.5
156	21.7
157	22.2
158	22.7
159	22.9
160	23.1
161	23.2
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163	23.4
164	23.7
165	23.8
166	23.9
167	24.1
168	24.2
169	24.5
170	24.6
171	24.7
172	24.8
173	24.9
174	28.1
175	28.1
176	28.1
177	28.1
178	28.1
179	28.1
180	28.1
181	28.1
182	28.1
183	28.1

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184	28.1
185	28.2
186	28.3
187	28.4
188	28.5
189	28.6
190	28.7
191	28.8
192	28.9
193	28.10
194	28.11
195	28.12

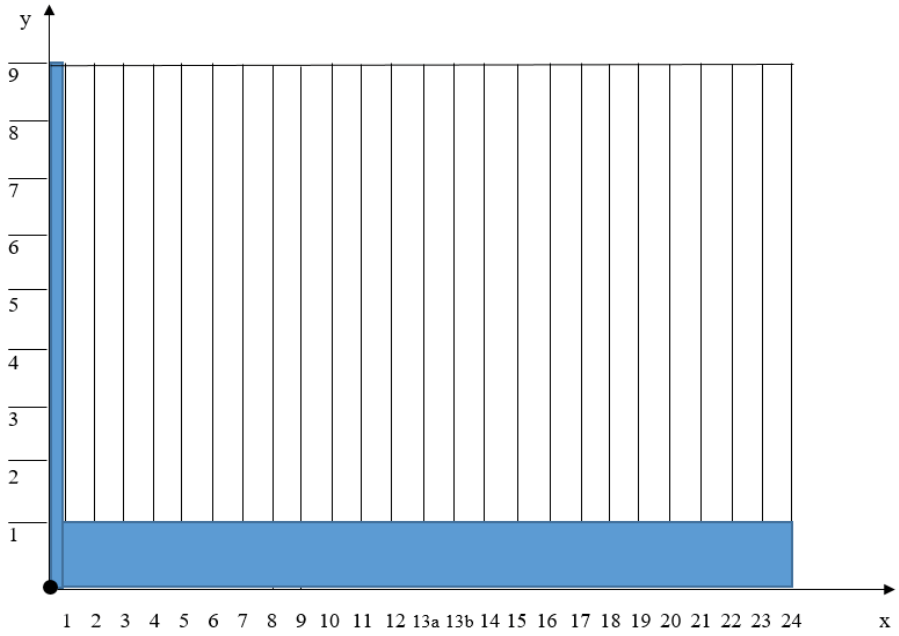

Figure 3: Graphic element for PICI-1TA. In "X" we find the new single psychopathological categories, while in "Y" we find the single dysfunctional traits that characterize the single disorder.

The affirmative answers, concerning the dysfunctional traits, will then be reported in the clinical chart below, except for the answers to the items that refer to common psychopathological conditions (which will only better define the identified disorders, with their comorbidities). If they line the dysfunctional traits for the single categories of disorders are identified, while in the x line the different disorders are identified: personality anxious (1), personality phobic (2), personality avoidant (3), personality obsessive (4), personality somatic (5), personality manic (6), personality bipolar (7), personality bipolar (8), personality emotional-behavioral (8), personality dependent (9), personality depressive (10), personality borderline (11), personality histrionic (12), personality overt narcissistic (13a), narcissistic covert personality type (13b), antisocial personality type (14), sadistic personality type (15), masochistic personality type (16), psychopathic personality type (17), schizophrenic personality type (18), schizoid personality type (19), schizotypic personality type (20), schizoaffective personality type (21), delusional personality type (22), paranoid personality type (23), dissociative personality type (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 4:

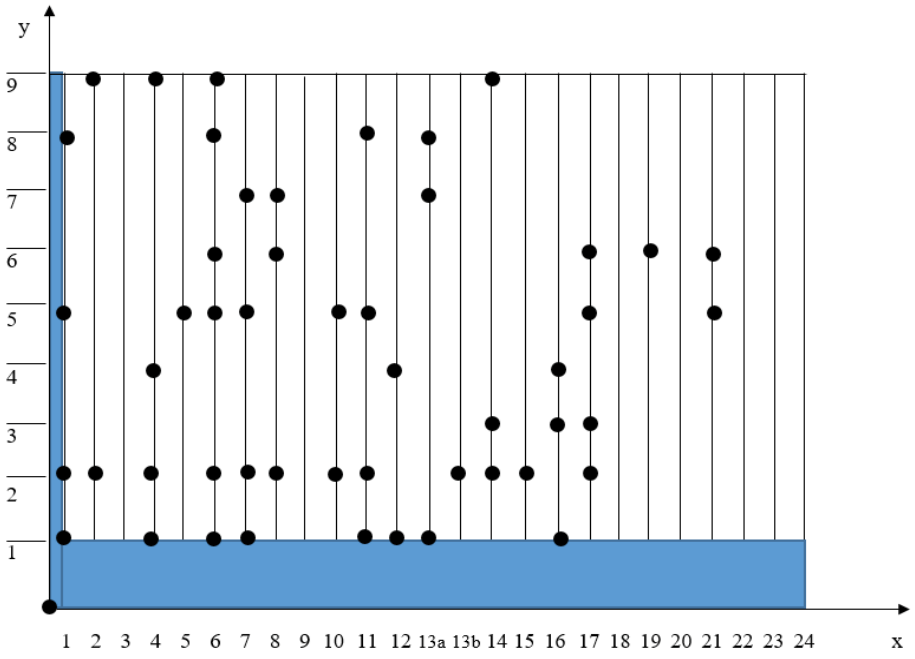

Figure 4: Graphic element of the proposed clinical case.

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;

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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.

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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 ordinators 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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Giulio Perrotta*

Giulio Perrotta, Director, Department of Criminal and Investigative Psychology UNIFEDER, Italy, Tel: +39 349 21 08 872; E-mail: info@giulioperrotta.com

The structural and functional concepts of personality: The new Integrative Psychodynamic Model (IPM), the new Psychodiagnostic Investigation Model (PIM) and the two clinical interviews for the analysis of personality disorders (Perrotta Integrative Clinical Interview or PICI) for adults and teenagers (1TA version) and children (1C version)

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