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First revision of the Psychodiagnostic Investigation Model (PIM-1R) and elaboration proposal of a clinical interview for the analysis of personality disorders (Perrotta Integrative Clinical Interview or PICI-1) for adults, teenagers and children

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ABSTRACT

Starting from the general concept of personality, as elaborated in the previous research (which is substantially the first part of the work), the psychodiagnostic investigation model (now renamed PIM-1R) has been revised, elaborating a first version of the clinical interview 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 on Psychodiagnostic Investigation Model (PIM)

The general concept of «personality»

Starting from the general concept of «personality», in a previous research work of the writer [1], I proceeded to analyze the main theories (historical, dynamic, analytical, hierarchical, neurobiological, structural -of the single traits-, structural-psychanalytical- and basic) [2-3] to redefine in the most systematic way possible the definition object of the treatment.

It was thus concluded that the «personality» was, from a functional point of view, «the stable and lasting organization of a person›s character, temperament and cognitive functions»; from a structural point of view, on the other hand, the personality was the totalitarian representation of the model then proposed (what the Gestaltics would label with the assumption that «the whole is more than the sum of the individual parts»). The personality is therefore the totalitarian whole of the single parts but able to interact with the outside, where instead of the «personality traits» are nothing more than the social expression of the personality (the external expression of a precise inner trajectory) [1].

To arrive at this conclusive definition [2] I realized that one had necessarily to go through the modification of the «traditional psychodynamic model», already enriched and modeled based on modern and post-modern theories (the ego, the self, object relations, attachment and defense mechanisms).

Integrated Psychodynamic Model - IPM

On this assumption, the writer has therefore proceeded with a detailed analysis of the psychodynamic models referred to the subject under examination, to make three main corrections that would act as systematic ordinators for the creation of a new spherical model (called 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».

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.

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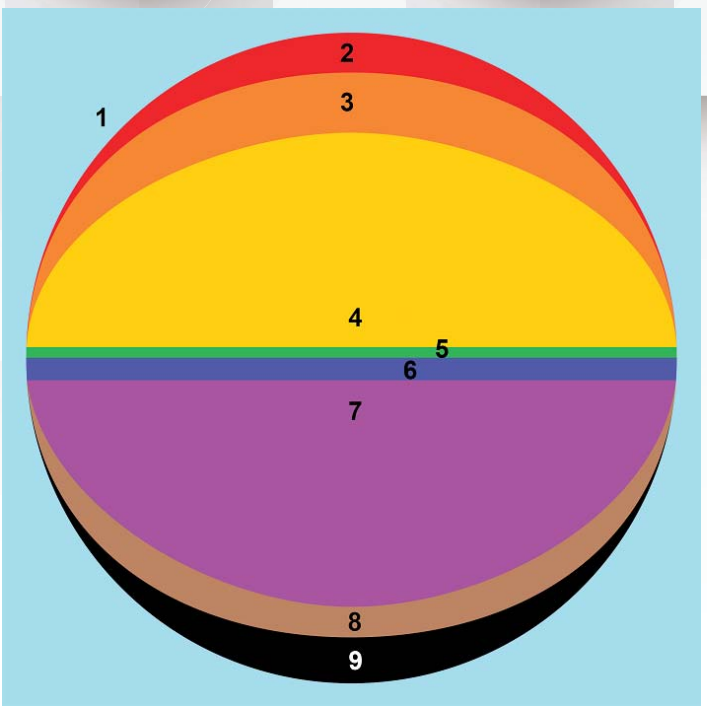

Table n. 1: «IPM Model» by G. Perrotta (2020) In this *new theoretical model*:

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

2) the *Id* is the main instance par excellence; it is the operative system of endowment from birth. During the first year of life it gives part of itself to the conscious plan, to make it develop. It is in continuous contact with the deepest parts and acts as an anti-chamber containing the «Shadows» (the real container of the drive and destructive energies, governed by the dominion of the egoistic and individule principle of pleasure) that are nourished by the «Past» (of collective memories and ancestral memories of forbidden access to the conscious).

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

The new functional classification of psychopathological disorders based on IPM

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).

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]

The new model of psychopathological investigation based on IPM

Continuing to trace this line of investigation, a new *model of psychopathological investigation* [5-6] was therefore proposed that would take into account different rules of style, reported here with some revisions functional to the insertion and adaptation of the model also for disorders in children:

1) *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.

2) *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.

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3) *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).

4) *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: -

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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
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

5) *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.

6) *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).

7) *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.

2. First proposed revision of the Psychodiagnostic Investigation Model (PIM-1R)

For a better adherence to the DSM-V and the PDM-II, 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).

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

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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;

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*».

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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 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;

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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 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;

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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;

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;

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

18) *Schizophrenic 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 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 evolves

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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;

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

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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*

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;

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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;

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:

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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, 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;

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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)

18) *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).

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

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

a) Age limits and previous clinical conditions. The clinical interview must respect the reference age (PICI-1C for patients aged between four and twelve years old, PICI-1TA for patients aged twelve years and over). The reference age may be waived at the discretion of the therapist›s clinical evaluation of a psychophysical and neurobiological nature if there is sufficient evidence of mild mental retardation or significant immaturity. Moderate or severe retardation or other pathology of neurodevelopment that significantly impairs cognitive abilities and functions are not preclusive to the administration of interviews;

b) Modalities of administration. The two clinical interviews are administered during or after the clinical and anamnestic interview, both personal and family, and are completed exclusively by the therapist, with or without the patient›s involvement, and serve to frame the patient more systematically, both concerning specific disorders and to individual dysfunctional personality traits. It is preferable to administer the interviews in a single solution.

c) Structure of clinical interviews. The children›s version contains one hundred and fifty items, while the adolescents› and adults› version contains one hundred and ninety-five items; in both cases, the items contain only one correct answer «Yes/No» and the answers «Maybe», «Don›t know», abstention from answering and partial answers («More or less», «Almost», «In short») are not allowed. Several items may refer to the same dysfunctional trait; therefore, a positive answer to even one item of the same dysfunctional trait is sufficient to consider that specific trait present.

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

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

3.1. 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?		
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?		

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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?		
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?		

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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?		

3.2. 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
35	4.8

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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
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
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

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138	28.1
139	28.1
140	28.2
141	28.3
142	28.4
143	28.5
144	28.6
145	28.7
146	28.8
147	28.9
148	28.11
149	28.11
150	28.12

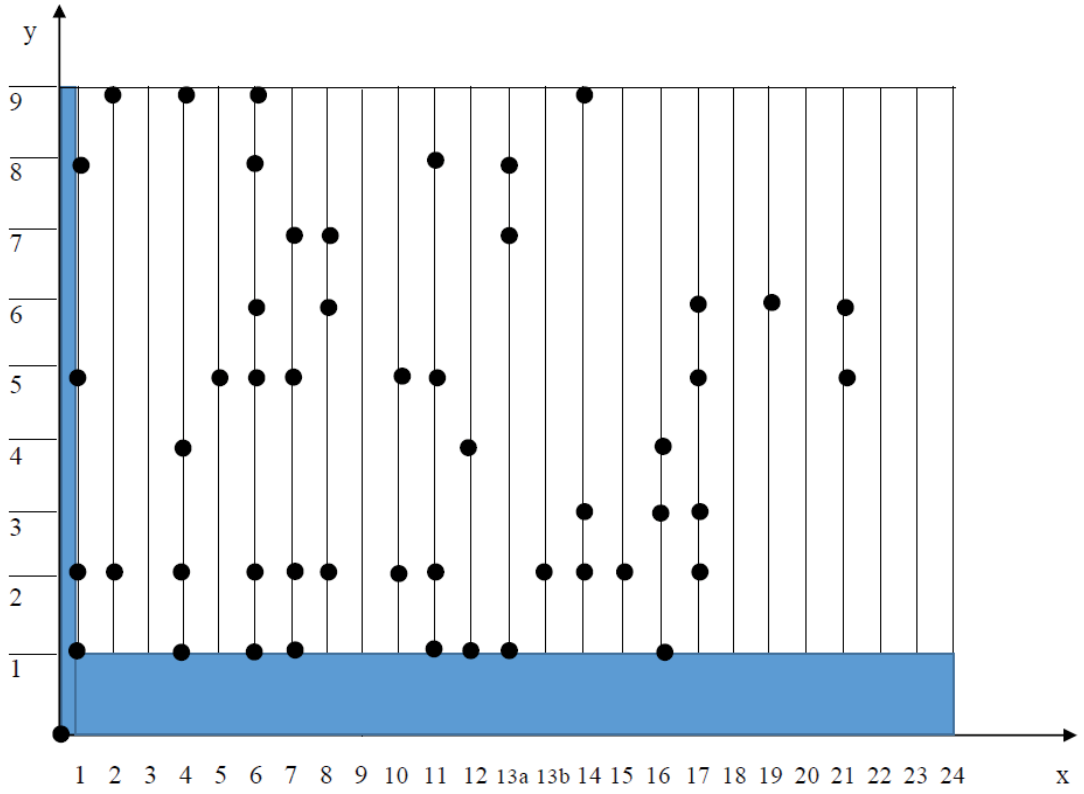

Table n. 2: Graphic element for PICI-1C. In "X" we find the new single psychopathological categories, while in "Y" we find the single dysfunctional traits that characterize the single disorder.

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).

3.3. 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?		
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?		

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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?		

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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?		
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?		

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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		

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

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

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89	12.5
90	12.6
91	12.7
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
104	13b.2
105	13b.3
106	13b.4
107	13b.5
108	14.1, 15.8, 17.8
109	14.3, 17.3
110	15.1
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
120	16.5
121	16.6
122	16.7
123	16.9
124	17.1
125	17.4
126	17.4
127	17.7
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
139	19.2

140	19.3
141	19.3
142	19.6
143	19.7
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
162	23.3
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
184	28.1
185	28.2
186	28.3
187	28.4
188	28.5
189	28.6
190	28.7

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191	28.8
192	28.9
193	28.10
194	28.11
195	28.12

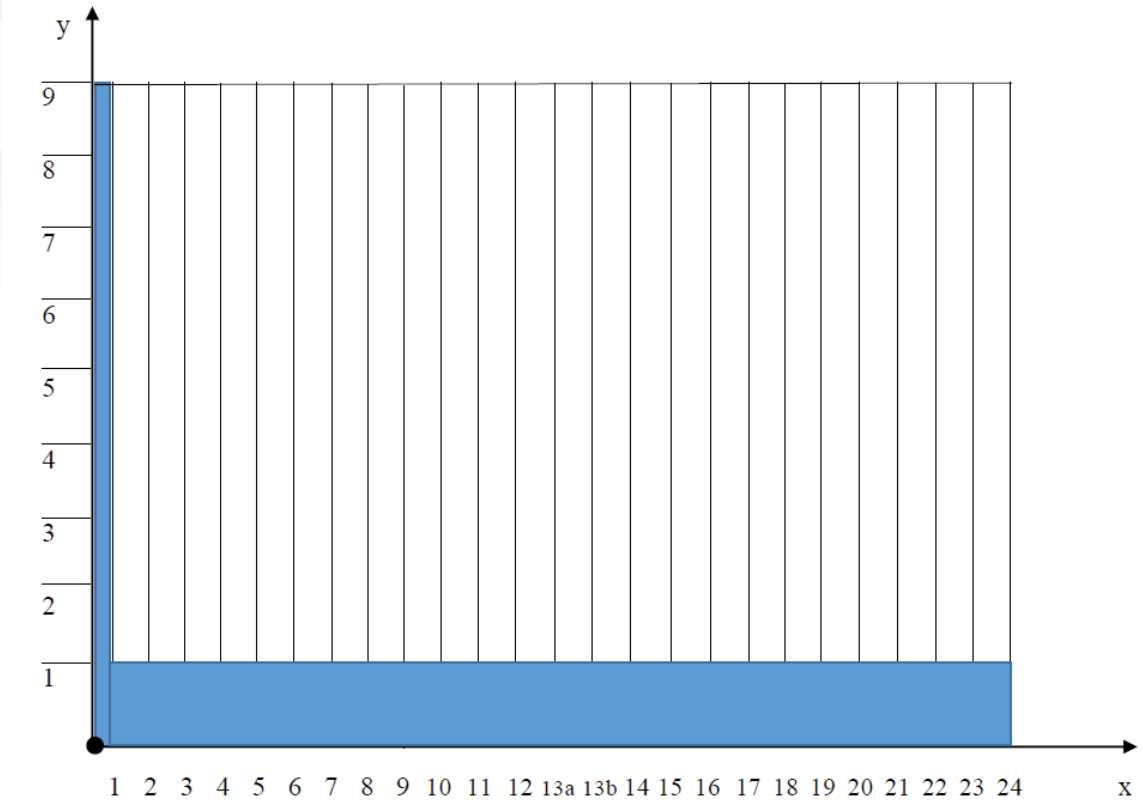

Table n. 3: Graphic element for PICI-1TA. In "X" we find the new single psychopathological categories, while in "Y" we find the single dysfunctional traits that characterize the single disorder

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).

4. 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:

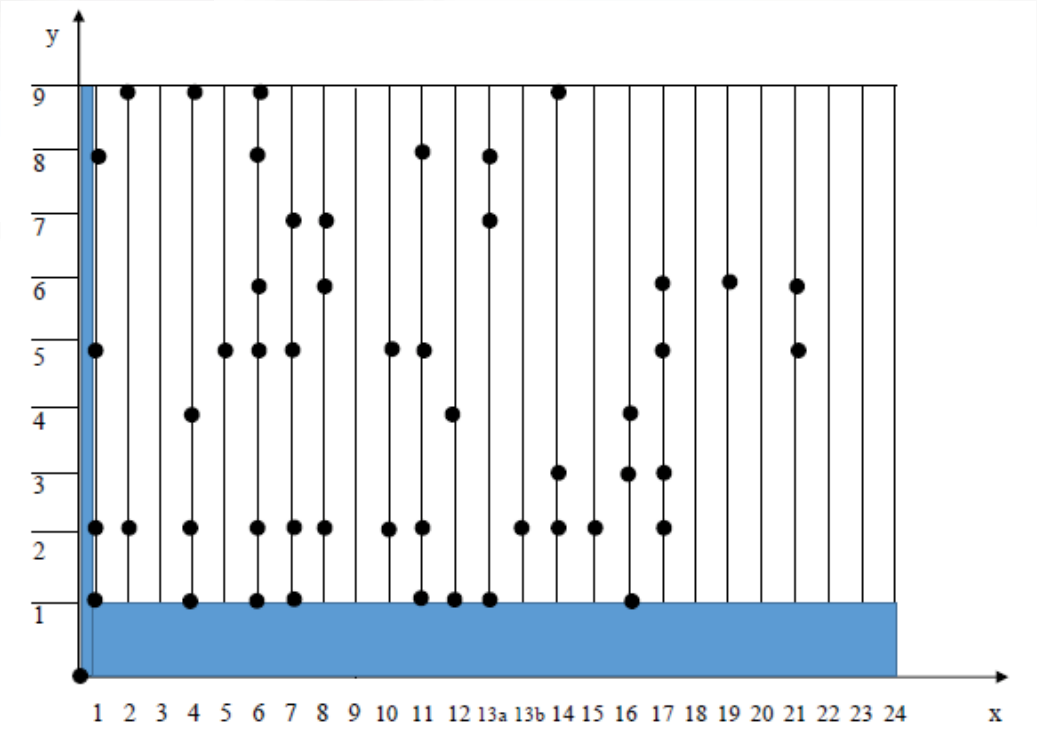

Table n. 2: Graphic element of the proposed clinical case

They turn out to be there:

1) four traits (1, 2, 5, 8) of the anxious personality disorder;

2) two traits (2, 9) of phobic personality disorder;

4) four traits (1, 2, 4, 9) of obsessive personality disorder;

5) one trait (5) of the somatic personality disorder;

6) six traits (1, 2, 5, 6, 8, 9) of the manic personality disorder;

7) four traits (1, 2, 5, 7) of bipolar personality disorder;

8) three traits (2, 6, 7) of the emotional-behavioral personality disorder;

10) two traits (2, 5) of depressive personality disorder;

11) four traits (1, 2, 5, 8) of borderline personality disorder;

12) two traits (1, 4) of histrionic personality disorder;

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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.

5. Research elements and conclusive profiles

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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First revision of the Psychodiagnostic Investigation Model (PIM-1R) and elaboration proposal of a clinical interview for the analysis of personality disorders (Perrotta Integrative Clinical Interview or PICI-1) for adults, teenagers and children

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