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Review Article

“Perrotta Integrative Clinical Interview (PICI-1)”: Psychodiagnostic evidence and clinical profiles in relation to the MMPI-II

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Abstract

Purpose: In order to study in depth the paraphiliac universe of the patient, avoiding diagnostic errors in terms of sexuality, sexual fantasies and disorders codified by the DSM-V, this research work focused on the importance of the exact identification of relevant sexual behaviours, in order to facilitate the relationship with the patient and the therapeutic pathway.

Methods: Once the population sample had been selected, which met the required requirements (age between 18 and 65 years, confirmed psychopathological diagnosis, absence of degenerative neurological pathologies and ability to understand and want to participate in the research), the first practical phase of the research was carried out with the execution of the clinical interview, asking the participants to omit any information (at this stage) about the previous psychopathological diagnosis suffered, so as not to induce the writer into any conditioning. The second and third phases of the research concluded with the initialling and interpretation, in the telematic presence with the interviewed subject, of the PICI-1 clinical interview (TA version). The fourth and fifth phases of the research concluded with the initialling and interpretation, in the telematic presence with the interviewed subject, of the MMPI-II, detecting in particular the clinical and content scales, with a value higher than 65 points (correct). The last phase of the research, the sixth, ended with an informative comparison between the results of the MMPI-II test and those of the PICI-1TA clinical interview.

Results: With a population sample of 472 participants (240 males and 232 females), performing first a clinical interview, then the PICI-1TA and finally the MMPI-II, a comparison of 98.73% of the results was valid, while the remaining 1.27% seems to be attributable to circumstances that can be identified, such as the interpretative limits of the theoretical model of the MMPI-II, a psychodiagnostic error during the previous diagnosis and the psychopathological evolution of the previously identified disorder. For reasons of theoretical differences in the models, it is not possible to carry out the same analysis for the PICI-1 children's version (C), as the reference nosography also changes with respect to the DSM-V.

Conclusions: With this research, despite the insufficiently representative sample, the effectiveness, efficiency and psychodiagnostic reliability of the Perrotta Integrative Clinical Interview (PICI-1), version for adolescents and adults (TA), was demonstrated in relation to the evidence obtained by comparing the data with the Minnesota Multiphasic Personality Inventory (MMPI-II). In particular, some aspects not identified by the MMPI-II emerged in the PICI-1, extremely useful to better profile the patient and proceed in a more systematic way to the specific clinical treatment.

Contents of the manuscript

Research objectives and Methods

The present research is aimed at detecting the psychodiagnostic evidence of the “Perrotta Integrative Clinical Interview” (PICI-1) [1] in relation to the results obtained using

the standardized test called “Minnesota Multiphasic Personality Inventory” (MMPI-II), in the light of the conclusions found in the drafting of PICI-1 as follows: <<Finally, the work concludes with the listing of the new psychopathological personality disorders classes [...] and with the listing, for each class, of the nine dysfunctional personality traits, according to four areas of domain (neurotic, latent, psychotic, mixed or residual), also



leaving room for the psychopathological conditions common to all twenty-seven personality disorders and any medical and socio-environmental conditions relevant to the diagnosis. This research work aims to lay the foundations for a structured investigation aimed at supporting the approval of the suggested model (more adherent and compatible with the best definition of “personality”). In the light of the integrative psychodynamic model and the first model of psychodiagnostic investigation, the present work has focused on the revision of these models (with the separation for patients under twelve years of age and those above this threshold), to refine these useful and functional tools to help the therapist in the clinical diagnosis, essential in a clinical interview and anamnestic study (personal and family), achieving the goal set at the beginning of the project: to reorganize the diagnostic profiles of psychopathologies based on nosographic and functional knowledge, integrating them, to achieve a better awareness of the knowledge shared until now by the scientific community on psychodiagnostic. In particular, based on a sample of one hundred units for adolescents, one hundred units for adults and one hundred units for children, in compliance with the self-imposed rules indicated in the previous paragraphs, the proposed and revised model (PICI-1) is compatible with the current more widespread psychodiagnostic systems (mentioned in the research) and is even more detailed than the MMPI-II, as it focuses more on personality traits to provide a broader overview, necessary to build a personalized psychotherapeutic plan targeted and adapted to the patient, taking into account both nosographic and psychodynamic profiles and functional, cognitive and strategic ones. From a parallelism with the diagnoses made based on MMPI-II, the diagnoses obtained using PICI models are identical and more useful in practice (in psychotherapy); precisely for this reason, the proposed interviews do not need results about the validity and reliability of the instruments, as they adhere perfectly to the results of the MMPI-II and the nosography of the DSM-V (integrated with the psychodynamic profiles of the PDM-II), with specific variants that do not change the diagnosis at all but enrich it with technical details useful in psychotherapy. Again along the same lines, the limits only concern the descriptive content of the individual traits specific to each psychopathological disorder, which could be more enriched and varied in the future. However, it should be borne in mind that by modifying the basic theoretical paradigm (the psychodynamic model), even the structure at the basis of the psychodiagnostic model cannot be compared with the current models in use; therefore, the basic idea is that of a clinical interview administered directly by the therapist, who before that moment proceeded to the clinical evaluation based on anamnestic and documentary evidence, with the testimonial evidence of the closest family members. On this basis, the implant appears to be solid and robust and functional to the set goal [2].

This research has been structured according to the following phases:

1. “Clinical interview” on the basis of a previous certified psychopathological diagnosis, to ascertain the persistence of the symptomatology suffered.

2. Marking of the answers, by the examiner, of the clinical interview “PICI-1” on the basis of the symptoms declared during the clinical interview.
3. Processing of the result after the completion of the second point.
4. Administration of the “MMPI-II test”, taking care that it has not already been administered in a previous time period of at least six months.
5. Processing of the result following the completion of the fourth point.
6. Comparison between the results of the “PICI-1” and the “MMPI-II test”.

The method applied is therefore the administration of the “PICI-1” and the “MMPI-II test”, following a clinical interview, in order to better define the psychopathological profile of the interviewee and compare the results obtained to detect any psychodiagnostic criticalities in the “PICI-1”.

Introduction and background

Giving an unambiguous definition of “personality” is very complicated. The term, as we know it today, has been established since the 1930s, particularly in the United States, by scholars including Allport and Murray, who raised the issue. Previously, to indicate similar concepts it was preferred to refer to “character” (which, however, implied a greater emphasis on moral and social characteristics) or “temperament” (which in turn implied a greater emphasis on the relationship between psychological and biological characteristics). With this new term “personality” we wanted to particularly emphasize the passage from a nomothetic psychology (aimed at studying general laws valid for all men) to an idiographic psychology (aimed at studying the individual and the causes that make each different from the others). The difficulties related to a general definition of personality are more than legitimate, as it is difficult to frame in a structured and unified way all the theories of personality that have been proposed so far [3].

Trying to sketch the main theories of personality in the most linear and detailed way, the main theories can be listed as follows [4-13].

1. Hippocrates’ *historical or biological theory*, which defines four “personal types”, based on the basic mood present in the body (melancholic, choleric, phlegmatic and sanguine), while Cicero defines it as the appearance and dignity of a human being or that part that is played in life. These concepts will then be taken up by Pavlov in his reflexological and behavioral theorization and by Sheldon with the intent to identify the links between biological and behavioral structures (starting from the soft, solid, or fragile physical constitution).

2. *Dynamic theory* of S. Freud. Sigmund Freud’s theory of personality has undergone variations as it progressed in its theoretical development. According to Freud, the human personality is the product of the struggle between destructive impulses and the pursuit of pleasure. Without setting social



limits aside as a regulatory authority. The construction of the personality is therefore a product: the result of the way that each person uses to manage their internal conflicts and demands from outside. The personality will indicate how each person acts socially and how they deal with their conflicts: internal and external.

3. Jung's *analytical theory*. Jung sees in the personality of the individual the product and the synthesis of his ancestral history. He emphasizes the racial origins of man. Man was already born with many predispositions transmitted by his ancestors and these guide him in his conduct. Thus there is a collective and racially preformed personality that is modified and elaborated by the experiences he receives.

4. Eysenck's *hierarchical theory*. Eysenck was the first to define the personality of the individual according to a general concept, labeling it as the stable and lasting organization of a person's character, temperament, intellect, and physique; an organization that determines his full adaptation to the environment.

5. Allport's *trait theory*. Resuming the concept of traits, Allport believed that each individual was a unique combination of "personality traits", and for this reason, it was impossible to identify two identical personalities. He hypothesized the first division into common traits and personal traits: the former are those that can be identifiable for a group of people or category (e.g., boxers defined as "aggressive"); the latter are specific to each individual, and cannot be defined in a single word.

6. Cloninger's *neurobiological theory*. The author formulated the "TCI" theory, i.e. a psychodynamic theory that defines personality substantially based on the functioning of four important neurotransmitters, and their receptors, that determine dominant behaviors and responses to the environment.

7. Murray's *Theory of Needs*. Then taken up again from Maslow's studies, who theorized the hierarchical pyramid of needs, Murray maintains that personality is a hypothetical psychic structure that governs the organism and constantly mediates with the environment, exercising its processes based on the motivations behind the unconscious needs of the individual (twelve, how to feed and reproduce) and conscious needs concerning the environment (twenty-seven, how to defend oneself, preserve, recognize, acquire, build, be autonomous, avoid and be successful), creating adaptive behavior patterns from time to time (always concerning one's own needs).

8. Kernberg's *structural psychoanalytic theory*. Kernberg defined his theoretical approach as the Psychology of the Ego and Object Relationships, in which the three psychoanalytical models of reference converge. Kernberg, starting from the limits found in Freud's drive theory, i.e. the inability to give adequate explanations to the complexity of human motivation, referring to Mahler's theory, focused on the separation-individuation process, and Jacobson's theory, with the

definition of the representational world, i.e. images or past experiences from which cognitive maps of the external world are derived, formulated a new theory on personality disorders. Kernberg's work is based on the belief that the psychopathology of personality is determined by psychic structures resulting from emotional experiences with primary significant objects. Mental structures are relatively stable configurations of psychic processes resulting from different internalized objective relationships. The structural organization stabilizes the psychic apparatus, determining a mediation between etiological factors and the direct manifestations of illness and behavior.

9. Zucherman's *basic theory*. For Zuckerman, at the center of the personality there would be a basic trait, the sensation seeking, describable as a continuous need for new experiences and sensations, which determines the propensity to take physical and social risks: individual differences in the expression of this trait would correspond to the expression of a fundamental dimension of personality.

Starting from the general concept of "personality", according to the main models known in the literature, the writer stressed the importance of personality traits (from a structural point of view) and personality functions (from a functional and strategic point of view). The result is a change in the modern psychodynamic paradigm following theoretical integrations, in a new model called *IPM (integrated psychodynamic model)*, more responsive to clinical needs; in particular, the changes made concern both structure and functioning:

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

2) The whole model, including the individual internal and external parts, describes the personality of the individual, from the most external levels to the most internal ones. The "personality" is therefore, from a functional point of view, the stable and durable organisation of the proposed model; from a structural point of view, on the other hand, the personality becomes the totalitarian representation of the model (what the Gestaltics would label with the assumption that "the whole is more than the sum of the individual parts"). It is therefore the totalitarian whole of the single parts 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 the expression of the personality in its single parts (the social expression of internal trajectories).

Still in this theoretical model, the "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 EGO - Hypotrophic EX / Hypotrophic EGO - Hypertrophic EX); in this model, instead, attention will be paid exclusively to the “functions of the Ego”, since physically the Ego and the Ex remain structurally unchanged. Therefore, three distinct relevant psychodiagnostic hypotheses can be verified:

1) 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 “hyper-vigilant”. The ES 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 provided by the model) [14].

2) 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 “fragile”. As a result, the EX 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 (or at the limit, cluster B, according to the new classification provided by the model).

3) 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 EX consequently has a full and complete possibility to let the enhanced energy filter at a conscious level. In this hypothesis we are witnessing the onset of psychopathological conditions classified as psychotic (cluster C, according to the new classification provided by the model) [15].

The theoretical model, as constructed, is applied to clinical practice by redrawing from a psychopathological point of view a *new classification of disorders (PIM)*, integrating the rules contained in the DSM-V [16] and PDM-II [17], establishing that:

- 1) Psychopathological diagnosis is always personological.
- 2) The new psychopathological classification consists of three clusters (eighteen disorders in children, twenty-four personality disorders in adolescents and adults, and the twelve possible disorders common to all ages of development).
- 3) The diagnosis is based on the identification of individual dysfunctional personality traits and their incidence in terms of structure and function, in terms of quantity and psychopathological quality, according to a precise “progressive scale”: I) “dysfunctional behaviour” (one trait); II) “pathological attitude” (two traits); III) “pathological inclination” (three traits); IV) “pathological predisposition”

(four traits); V) “real personality disorder” (from five to nine traits).

4) Psychopathological disorders, in the light of the new model, are always “creative adaptations” which, by structure and function, are modelled on the basis of the traumatic event suffered, on the basis of internal responses to external environmental stimuli and vice versa, strengthening in positive or negative according to them.

On the basis of this new model, therefore, two different clinical interviews were created, one for children (PICI-1C) with 150 items, and one for adolescents and adults (PICI-1TA) with 195 items, both on a YES/NO scale, both given during this research to confirm their validity.

Setting and participants

The selected population sample is 472 participants, divided as follows: 240 males and 232 females. All subjects have a certified psychodiagnostic background; however, for reasons of opportunity, it was preferred to learn the previous diagnosis only after the administration and processing of the MMPI-II test results and the PICI-1 clinical interview results, so as not to run the risk of influencing interpretation.

The selected setting, taking into account the protracted pandemic period (already in progress since the beginning of the present research), is the online platform via Skype and Videocall Whatsapp, both for the clinical interview and for the administration.

The present research work was carried out from May 2020 to December 2020 and focused exclusively on the clinical interview for adolescents and adults, as the theoretical differences of the model referring to children does not allow a uniform comparison with the application of MMPI-II.

The selected population sample is divided as follows:

Gender of the Sample population	Bunds of age	Sample number
Male	16-20	18
Male	21-25	21
Male	26-30	35
Male	31-35	14
Male	36-40	45
Male	41-45	34
Male	46-50	24
Male	51-55	23
Male	56-60	14
Male	61-65	12
Female	16-20	14
Female	21-25	23
Female	26-30	27
Female	31-35	31
Female	36-40	31
Female	41-45	28



Female	46-50	43
Female	51-55	18
Female	56-60	10
Female	61-65	7

Results

Once the population sample had been selected, which met the required requirements (age between 18 and 65 years, confirmed psychopathological diagnosis, absence of degenerative neurological pathologies and ability to understand and want to participate in the research), the first practical phase of the research was carried out with the execution of the clinical interview, asking the participants to omit any information (at this stage) about the previous psychopathological diagnosis suffered, so as not to induce the writer into any conditioning.

The second and third phases of the research concluded with the initialling and interpretation, in the telematic presence with the interviewed subject, of the PICI-1 clinical interview (TA version).

The fourth and fifth phases of the research concluded with the initialling and interpretation, in the telematic presence with the interviewed subject, of the MMPI-II, detecting in particular the clinical and content scales, with a value higher than 65 points (correct).

The last phase of the research, the sixth, ended with an informative comparison between the results of the MMPI-II test and those of the PICI-1TA clinical interview, noting the following:

- 1) The MMPI-II distinguishes between specific disorders and personality disorders, while the PICI-1TA identifies each disorder in the personological sphere, defining in a more systematic way and completing the psychodiagnostic picture, giving (the PICI-1TA) more information with reference to the personality picture and therefore to the points of interest that the therapist should focus on during psychotherapy.
- 2) The relevance of the results emerging from PICI-1TA fully absorbs the results of the clinical and content scales of MMPI-II, paying particular attention to personality traits that better define and enrich the personological diagnosis.
- 3) The results of PICI-1TA fill the gaps in MMPI-II with reference to the different modes of expression of the personalities that are not mentioned in DSM-V and that are present in PDM-II.
- 4) The initial diagnosis of the population sample is confirmed and reinforced in PICI-I, for 98.73%, which enriches what is reported in the previous clinical documentation with further information (the single traits).
- 5) The remaining 1.27% of the population sample, different from the initial diagnosis and equal to no. 6 participants, is distributed as follows:

Gender of the person	Bunds of age	Past diagnosis	Pici-1ta diagnosis	Possible explanation
Male	16-20	Conduct Disorder	Borderline personality disorder	1) natural evolution of the conduct disorder; 2) interpretative limit of the theoretical models of MMPI-II.
Male	21-25	Major Depressive Disorder	Bipolar personality disorder	1) psychodiagnostic error of clinical history; 2) interpretative limit of the theoretical models of MMPI-II.
Female	16-20	Conduct Disorder	Borderline personality disorder	1) natural evolution of the conduct disorder; 2) interpretative limit of the theoretical models of MMPI-II.
Female	26-30	Major Depressive Disorder	Bipolar personality disorder	1) psychodiagnostic error of clinical history; 2) interpretative limit of the theoretical models of MMPI-II.
Female	31-35	Bipolar disorder	Borderline personality disorder	1) psychodiagnostic error of clinical history; 2) interpretative limit of the theoretical models of MMPI-II.
Female	51-55	Bipolar disorder	Covert narcissistic personality disorder	1) psychodiagnostic error of clinical history; 2) interpretative limit of the theoretical models of MMPI-II.

Conclusions, limits and possible conflicts of interest

The present research work, although with an important but certainly not representative sample of the population, has shown a reliability of 98.73% of the PICI-1TA interview with respect to the use of MMPI-II, also allowing us to focus attention on certain clinical signs (personality traits) that are extremely interesting, in relation to the establishment of a psychotherapy and a specific therapeutic plan (which is not the case if we use only MMPI-II).

The different percentage, equal to 1.27%, in the writer's opinion, is due to reasons external to the reliability, effectiveness and efficiency of the PICI-1TA instrument, since all the critical personality traits are in any case detected; the hypotheses of explanation for the presence of a different diagnosis are probably explained by the interpretative limits of the theoretical model of MMPI-II, or by a psychodiagnostic error during the previous diagnosis or by a psychopathological evolution of the previously identified disorder.

The limits of this research are

- 1) the use of a population sample that is not sufficiently representative, even if the result of 98.73% appears objectively very high in order not to take into consideration and positively



consider the result itself, and therefore its effectiveness, efficiency and reliability.

2) PICI-1 consists of two clinical interviews, based on the age of the interviewed subject; however, the one referring to the child and pre-adolescent age cannot be used in relation to MMPI-II because the theoretical assumption, the reference model and the nosography used are different [18-20]. The present research work is therefore aimed at studying the reliability of PICI-1TA only (adolescents and adults).

3) PICI-1 is a psychodiagnostic tool used by the therapist to organise psychotherapy aimed at individual needs [21-78], as it identifies individual dysfunctional personality traits, even if the diagnosis of DSM-V is based on the presence of specific clinically relevant symptoms; therefore, it is a tool that can be compiled and drafted only by the healthcare professional and not by the patient and only after a clinical interview aimed at diagnosis and therapy (which also includes a meeting with family members and direct subjects) [79,80].

As PICI-1 is a free psychodiagnostic tool, this research has no financial backer and does not present any conflicts of interest.

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