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Research Article

Perrotta Integrative Clinical Interviews (PICI-2): Innovations to the first model, the study on the new modality of personological investigation, trait diagnosis and state diagnosis, and the analysis of functional and dysfunctional personality traits. An integrated study of the dynamic, behavioural, cognitive and constructivist models in psychopathological diagnosis. Research

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Abstract

Purpose: As a result of clinical findings it is necessary to make some changes to the previous model, the first version. The second version of the PICI model (Perrotta Integrative Clinical Interviews) improves the previous version by introducing some interpretative corrections, especially with regard to dysfunctional hyperactivation, unitary diagnosis, symptomatological persistence, categorical absorption, trait diagnosis and state diagnosis, egosyntony and egodystonia, reducing the items from 150 to 128 for the PICI-2C questionnaire and from 195 to 173 for the PICI-2TA questionnaire. The second version of the PICI is also enriched by a third questionnaire, PICI-2FT, always administered by the therapist after the clinical interview, with 18 items, capable of investigating functional personality traits and thus completing in a more descriptive way the personality picture of the patient in its functional and structural totality.

Methods: Clinical interview, administration of the PICI-2TA and MMPI-II.

Results: With a population sample of 718 participants (310 males and 408 females), performing first a clinical interview, then the PICI-2TA and finally the MMPI-II, a comparison of 99.7% of the results was valid, while the remaining 0.3% 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: This research demonstrated the efficacy, efficiency and psychodiagnostic reliability of the "Perrotta Integrative Clinical Interviews" (PICI-2), version for adolescents and adults (TA), in relation to the evidence obtained by comparing the data with the Minnesota Multiphasic Personality Inventory (MMPI-II). In particular, in the PICI-2 some aspects not identified by the MMPI-II emerged, extremely useful to better profile the patient and proceed in a more systematic way to the specific clinical treatment. It is important to remember that the administration of the PICI-2 photographs the historical moment of the patient and not the previous one; therefore, it may happen that some results are conditioned or distorted by the positive or negative historical moment that the patient is living; it is the duty of the therapist to frame in a clear and exhaustive way the anamnestic universe of the patient in order to understand possible overactivations or omissions of activation following a moment of stability of the patient, which in reality hide the real extent of his clinical manifestation. psychopathological tendency, net of external reinforcements such as the family and the social context.

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Introduction to the PICI model and the concept of psychopathological diagnosis

The first version of the PICI model [1-4] started from the structural and functional concept of “personality” [5-7], understood as <<the totalitarian ‘structural representation’ of its individual parts (Character, Person, Ego and its two functions Self and Superego, Id, Shadow and Past), capable of interacting with the interior and exterior according to defence mechanisms that may be adaptive (in the absence of psychopathologies) or maladaptive (in the presence of psychopathologies) and the ‘functional representation’ of the sum of the functional and dysfunctional traits of the person, such as to create a stable, precise and lasting model of a specific psychic organisation (so-called functioning)>>, taking up and readjusting the definitions of S. Freud, Jung, Eysenck, Adler, Rogers, Kohut, Allport, Cloninger and Murray [8-19]. This position is also confirmed and strengthened in the following second version.

In fact, starting from the first psychodynamic models, the PICI (both in the first and second version) emphasises the fundamental importance of the identification of “personality traits” (from a structural point of view) and of personality functioning (from a functional and constructivist point of view); this leads to a modification of the psychodynamic paradigm following the theoretical integrations of the new model described, which is thus more responsive to clinical and practical needs. The tripartite Freudian model (Ego, Super-Ego and Id) becomes binary (Ego and Id), while the Super-Ego (together with the Self) become functions of the Ego; the Ego and the Id thus remain the conscious and unconscious components of the person, while the Super-Ego represents the function of filtering through defence mechanisms the instinctual impulses of the Id and the Self represents the borderline between conscious and unconscious. The Id, finally, is in turn endowed with two functions: that of maintaining and preserving removed memories (chamber function), drives (Shadow) and guarding ancestral energies (Past). In the PICI-1 the single dysfunctional traits were identified (in two separate interviews, 1C and 1TA, the first for children and the second for adolescents and adults), while in the PICI-2 a third interview aimed at identifying only functional personality traits was also introduced.

In the light of this model, “psychopathologies” [20] are conceived in a less rigid and more functional manner: they are, in essence, the product of the structural and functional alterations of the instances contained in the proposed model, in response to the external (educational and social) environment, but in different terms from the classic and/or modern psychodynamic model (according to the functional dichotomy of hypertrophic Ego – hypotrophic Id or hypotrophic Ego – hypertrophic Id); the central role is therefore no longer the hypotrophic or hypertrophic structure of the Ego or the Id, but the more or less correct functioning of the “functions of the Ego” (Self and Super-Ego), insofar as physically the Ego and the Id remain structurally unchanged, according to the following three psychopathological hypotheses:

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

Thus adapting the definition of “psychopathology” in clinical terms, according to the PICI model, both in its first and second versions, the PICI exploits the methodology of the DSM-V [21] with additions from the PDM-II [22] to create a new nosographic framework starting from dysfunctional personality traits, classifying the disorders into three distinct clusters (18 for children, 24 for adolescents and adults and 12 common disorders in comorbidity). All disorders of the mind become definitively “personality”, and are considered real “creative adaptations of the psyche”, whose structure and functioning are rigidly modelled on the basis of the main traumatic event, according to the internal response and external stimuli, reinforcing themselves positively or negatively on the basis of them; therefore, the more the patient possesses a series of homogeneous traits (and reinforces them over time), the more striking the personality diagnosis will be [23-26]. However, it is important to emphasise the value of a diagnosis according to a nosographic scheme: <<Framing the patient’s symptomatology in a specific nosographic framework is useful to photograph him and recognise the habitual toxic patterns and tendencies of his personality; however, this does not mean containing his personality in a rigid way or crystallising it forever, since the personality is plastic (just like our brain) and is modelled according to new awarenesses reached and corrective emotional experiences. The more rigid a personality is, the more its capacity to model itself is free. In certain conditions, where psychopathology seriously compromises the



functions of reality, such as judgement and awareness, this condition is evident and one cannot ignore the objectivity of the symptoms manifested. In this, the strategic approach is too extreme. Therefore, if on the one hand it is always useful to frame his personality structure (structural component) according to the present symptomatology with the use of shared nosographies thanks to scientific evidences, on the other hand it is fundamental to put the accent on the functional aspect of his personality (functional component) and therefore to work on his resources, on the attempted solutions, on the reproduced vicious circles, on his emotional literacy and awareness, always bearing in mind that a personality functioning cannot be clustered as it is the sum of all the functional and dysfunctional traits of the patient and therefore each patient is a universe of personality in itself that can also change over time as a result of the experiences lived, whether positive (and functional) or negative (and dysfunctional)>> [20].

In the first edition, therefore, two 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 [3]; compared by results with the MMPI-II, in a study with a sample of 472 subjects, the diagnostic reliability was demonstrated to be 98.73% with respect to the diagnoses obtained using the Minnesota test, even with a greater indication of the dysfunctional traits to be treated in psychotherapy [27]. In the second edition, however, the two clinical interviews for the identification of dysfunctional personality traits (PICI-2C / PICI-2TA) were revised and made more streamlined (128 items for the C and 173 items for the TA), especially on interpretive profiles (as indicated in the second paragraph of this research) with the addition of a third clinical interview aimed exclusively at identifying functional personality traits (PICI-2FT), with 18 items on a scale 0-4 [4].

Changes to PICI-1 and the new version PICI-2

During the studies and research on the selected population sample [27], the writer realised that some corrections had to be introduced to the PICI model of the first version, in order to better favour the interpretative profiles that reworked the answers to the questionnaires. In a subsequent study [28], these adaptations produced a better interpretative result, favouring the drafting and publication of the second version of the PICI model.

In particular [28], on the basis of specific clinical observations, evident in the proposed cases, the following corrections to the basic PICI-1 model have been suggested:

- 1) **At the diagnostic level:** The diagnosis takes into account the first two highest levels of dysfunctional traits (with reference to the values obtained by PICI-1), considering the next three lower levels (i.e. tertiary) exclusively as elements of psychotherapeutic interest. In the hypothesis of dysfunctional hyperactivation, when the results show an incidence on at least five different nosographic categories with at least five dysfunctional traits in each category, the diagnosis should be re-evaluated at the end of the psychotherapeutic course,

for possible improvements according to corrective emotional experiences;

- 2) **On the unitary diagnosis:** The diagnosis takes into account, in its final formulation, the primary disorder (P, main diagnosis), the co-primary disorders (M, mixed diagnosis), the comorbidities (C), the secondary disorders (S), and the tertiary traits (T), the latter being useful only in psychotherapy (for the hypotheses of support, treatment and therapy);
- 3) **On the symptomatic persistence of symptoms and on the plasticity of the personality:** Awareness can help change, as long as it is real, concrete and current and the dysfunctional traits complained of have not been present for a long time (in any case more than 1 year), according to the subjective perception of the patient, because the longer they persist, the more the personality is modelled on them, creating anchors, resistance and persistence;
- 4) **On absorptions:** The anxiety disorder absorbs the somatic disorder, the phobic disorder and the manic disorder, the latter becoming specific traits of the (main) anxiety disorder; the psychotic disorders absorb all the other neurotic disorders.
- 5) The administration of the PICI-2 photographs the historical moment of the patient and not the previous one; therefore, it may happen that certain findings are conditioned or distorted by the positive or negative historical moment that the patient is living. It is important for the therapist [29] to frame in a clear and exhaustive way the patient's anamnestic universe, in order to take a picture also of the moments preceding the administration of the PICI-2 and to understand possible overactivations or omissions of activation following a moment of stability of the patient, which actually hide the real extent of his clinical manifestation.

Trait diagnosis and state diagnosis. Egosyntonia and egodystonia and the normative rules of PICI-2

The PICI-2 is modelled on the normative rules of the first edition [4,30], focusing its strength on the following principles:

1. **The "personological diagnosis":** The psychopathological diagnosis is always "personological" and always refers to a habitual, stable, persistent and pervasive maladaptive pattern of experiences and behaviours that deviate from the social culture to which the individual belongs, with manifestations in at least two areas between cognitive and affective experience, interpersonal functioning and impulse control. The "personological diagnosis", in its complexity, can be made from the age of twelve, while for patients below this threshold the diagnosis is always of "psychopathological presumption of personality", deserving however of clinical treatment if the number of dysfunctional traits and/or behaviours found cause significant anomalies such as to merit intervention; this is because before the age of twelve the personality is in a formative phase and is therefore less rigid and more subject



to corrective emotional experiences, provided that the socio-environmental and family context responds positively to the needs of the child. In these cases, one will speak not of personality disorders but simply of “specific disorders” (insofar as the requirement of stability is lacking, in a personality that is not yet perfectly structured) and they will follow a precise nosographic categorisation that tends to differ from real 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 suggested nosographic list; this is because the time factor and the negative experiences accumulated and not re-elaborated make the personality structure increasingly rigid and not very subject to change, all the more so if the disorder is then serious and pervasive in its reality level. In children, the personological diagnosis is always relative, because the young age allows more easily to modify the dysfunctional behavior and therefore to correct the psychopathological tendency, net of external reinforcements such as the family and the social context.

2. **The binomial “egosyntony-hegodystonia”:** In the clinic we refer to the concept of “egosyntony” when talking about personality disorders, understanding it as an image conforming to one’s own perception; in other words, personality disorders are egosyntonic because the patient does not realise that certain behaviours implemented are dysfunctional and feed the vicious circles that contribute to the rigidity and pervasiveness in several of the patient’s vital “dimensions”: a) “personal” (i.e., the relationship with his inner psychological parts); b) “familial” (i.e., the relationship with his family of origin); c) “affective” (i.e., the relationship of friendship and meaningful emotional bonding); d) “emotional” (i.e., the relationship with the family created as a result of the sentimental and filial relationship); e) “sentimental” (i.e. the bond of deep feeling towards a person and their offspring); f) “work” (i.e. work relationships); g) “social” (i.e. the socio-environmental relationships where the person lives, domiciles or resides); h) “intimate-sexual” (i.e. the physical and carnal relationships entertained); j) “psychophysical well-being” (i.e. the area of relationships with one’s body and mind). From here, in the clinic, the concept of “egodystonia” is distinguished, when the patient realises and feels disturbed by such pervasiveness. The PICI bypasses this atavistic duality in that it considers all psychic disturbances to be the expression of a precise personality, starting precisely from personality traits, and no longer splits up “egosyntonia” and “egodystonia”, except to explain the patient’s level of awareness (or insight) before, during and after the course of therapy. In fact, according to this perspective, the patient can also be egodystonic with respect to his symptoms but still be affected by a clinical form of personality disorder, as he is aware of the condition but not fully aware of the consequences of his behaviours and emotions. The PICI abolishes this duality, relegating it exclusively to an interpretative concept useful to describe in a more meaningful way the patient’s capacity to be aware, in a psychotherapeutic key.

3. **The binomial “trait diagnosis - status diagnosis”:** “Personality disorder” is a *maladaptive (or dysfunctional) model*

of long-term thinking and behaviour that differs significantly from the social norms and expectations of one’s environment. This condition is the result of the summation of several dysfunctional personality traits that are homogeneous in terms of functioning, capable of modelling the personality according to a precise nosographic description. The 2C and 2TA versions of the PICI describe the individual dysfunctional traits for each psychopathological personality disorder, identifying them in detail; however, having one or two dysfunctional personality traits is not equivalent to receiving a diagnosis of a personality disorder (nor does it indicate a specific pathological condition), since the centrality of the diagnosis concerns the number of homogeneous dysfunctional traits possessed, according to the following classification:

- a. The absence of personality traits is equivalent to a diagnosis of “sanity”.
- b. A single dysfunctional trait is equivalent to a diagnosis of “*dysfunctional trait*”, which indicates exclusively the tendency of the patient to possess that single trait in the event of hyperactivation (understood as an external circumstance capable of reactivating or bringing to the surface one or more dysfunctional traits present in his personality picture). If this trait has been present for less than three months or has resolved by the end of the third month, one speaks only of “*dysfunctional behaviour*”.
- c. Two homogeneous dysfunctional traits (i.e. of the same nosographic category) are equivalent to a diagnosis of “*dysfunctional inclination*”, which indicates the patient’s tendency to possess those traits in case of hyperactivation. In the previous version of the PICI, dysfunctional inclination was diagnosed with three dysfunctional traits.
- d. Three homogeneous dysfunctional traits are equivalent to a diagnosis of “*dysfunctional attitude*”, which indicates the patient’s overwhelming tendency to possess those aspects in case of hyperactivation. In the previous version of the PICI, dysfunctional attitude was diagnosed with two dysfunctional traits.
- e. Four homogeneous dysfunctional traits are equivalent to a diagnosis of “*dysfunctional predisposition*”, which indicates the patient’s strong tendency to possess those aspects in case of hyperactivation.
- f. With at least five homogeneous dysfunctional traits one has the diagnosis of “*personality disorder*”, which indicates, in the case of hyperactivation, the dysfunctional habit, stability, persistence and pervasiveness of the specific psychopathological representation, according to a scale of severity 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 seriously compromised, with nine traits). In the hypothesis of a person under the age of



twelve, one speaks only of a “*specific disorder*”, as the personality is not yet definitively structured. Only in this hypothesis is it possible to speak of “*state diagnosis*”, while in cases b), c), d) and e) one will speak of “*trait diagnosis*”.

4. The “unitary diagnosis”: On the basis of the model, the final diagnosis is structured according to the scalar identification, from the highest to the lowest, of the psychopathological condition that presents more homogeneous dysfunctional traits. In particular:

- a. **Primary disorder (P, primary diagnosis):** Represented by the disorder with the highest score (e.g. 9 anxiety traits).
- b. **Co-primary disorder (Mp, mixed primary diagnosis):** This is represented by the disorder with the highest score, with an equal score with another disorder higher than all the others (e.g. 9 anxious traits and 9 obsessive traits).
- c. **Secondary disorders (S):** Represented by the disorder with the second highest score (e.g. 9 anxiety traits and 8 phobic traits).
- d. **Co-secondary disorders (Mc, mixed secondary diagnosis):** Represented by the disorder with the second highest score, with the same score with another disorder (e.g. 9 anxious traits, 8 phobic traits and 8 obsessive traits).
- e. **Tertiary traits (T):** Represented by the disorder with the third, fourth and fifth highest score, provided that there are at least 5 dysfunctional traits (e.g. 9 anxious traits, 8 phobic traits, 7 obsessive traits, 6 somatic traits, 5 manic traits).
- f. **Co-tertiary traits (Tt):** It is represented by the disorder with the third, fourth and fifth highest score, with the same score with another disorder, provided that there are always at least 5 dysfunctional traits (e.g. 9 anxious traits, 8 phobic traits, 7 obsessive traits, 7 depressive traits, ... the two 7 are the co-tertiary traits).
- g. **Comorbidity (C):** It is represented by all those conditions of comorbidity with common psychopathologies. Twelve psychopathological conditions are common to all disorders, which however pertain to the personological sphere: neurodevelopmental disorders; brief or acute psychotic disorder; catatonic disorder; selective mutism; nutritional disorders; evacuation disorders; sleep-wake disorders; gender identity disorders; paraphiliac disorders; sexual dysfunction disorders in adolescents and adults, in the absence of an organic basis; drug and/or behavioural addiction disorders; suicidal tendency.

5. “Psychopathological hyperactivation”: Possessing one or more dysfunctional personality traits does not in itself lead to a rigid diagnosis; this is because the nosographic framework does not take account of external variable elements (a trauma, a bereavement, suffering) capable of accentuating

them. Hyper-arousal should therefore always be analysed and monitored in relation to the symptomatological picture narrated by the patient and studied according to a transversal logic of dysfunctional activation, since the human mind is plastic and subject to positive or negative modifications on the basis of experience and corrective emotional experiences or negative reinforcements. It may happen, however, that certain hyperactivations are so strong as to decompensate the patient in a radical or destabilising way (so-called “decompensatory hyperactivations”); in this case one will see a particularly marked outcome of the PICI questionnaires (2C / 2TA), that is, at least five homogeneous dysfunctional traits will be detected in at least five different nosographic categories. In this case, the therapist will have to proceed with the planned therapeutic course and repeat the administration of the questionnaire at the end of the cycle of clinical sessions, in order to verify the effects of the health intervention.

6. “The apparent link of interconnection between anxious personality disorder and phobic, somatic and avoidant personality disorders”: Both in the 2C and in the 2TA questionnaire, from a nosographic point of view, these categories share several traits, to such an extent that they are often activated at the same time, albeit with a different degree of impact on the patient’s personality picture. In the first draft of the PICI theoretical model, the need was seen to evaluate the incorporation of all these categories under the larger category of “anxiety spectrum disorders” which, as in the hypothesis of schizophrenic spectrum disorders or autistic spectrum disorders, found its location first in the dysfunctional concept of anxiety and then diversification into different types. This theoretical hypothesis, however, clashed with the first factual and empirical evidence that not infrequently reported different and divergent values, depending on the concrete case. This analysis has allowed us to diversify the origin of these disorders although they share a common core of anxious nature; in fact, if the anxiety disorder is characterized by a chronicity of the patient’s actions as a function of the fear of not being up to situations and relationships (in its various forms, such as generalization, social anxiety, panic and post-traumatic), in other disorders the picture changes direction: in the phobic disorder, fear is concretized in a material object, which from thought leads to action according to the phobic pattern; in the somatic disorder, fear is concretized in the idea of a physical discomfort that he cannot control or cannot manage, in the absence of objective medical findings; in the avoidant disorder, the fear is realized in the final act, in the reaction to the same that leads to avoidance to “avoid” the direct confrontation, due to an irrational belief arising from a traumatic event experienced by the patient or through a third person (therefore induced). Therefore, although it may happen to find activated one or more profiles, in reality, under the nosographic profile, they appear different for concrete manifestation and therefore it seems more correct to exclude the hypothesis of “anxiety spectrum disorder”, which could however be used for the different forms already mentioned of anxious personality disorder. The obsessive-compulsive personality disorder has instead its own clear and distinct nosographic compared to the anxious personality disorder, even if it shares at the base of



the disorder the usual common core of anxious nature (which draws its strength from fear, managed in a dysfunctional way). Again, the dependent personality disorder presents as for the obsessive disorder its own clear and distinct nosography, for the same descriptive reasons mentioned above; not by chance, in fact, the position in the 2C questionnaire is different from that of the 2TA questionnaire, as it presents in the first hypothesis elements much closer to evolutions from cluster B than from cluster A.

7. **“The apparent link of interconnectedness between bipolar disorder and borderline personality disorder”**: The topic should certainly be separated with respect to the two questionnaires. With regard to the questionnaire 2C, the distinctive problem does not arise because the associated nosography lacks the category “borderline” as this disorder is the more or less direct evolution of one of the disorders present in the framework 2C, or disruptive mood dysregulation, maladaptive separation, oppositional-provocative, explosive-intermittent, uninhibited social commitment and attachment (although then we often witness the evolution towards other pathological forms, almost all related to the cluster B). A different discussion should be made instead for the 2TA questionnaire that presents a separate nosography precisely because of its intrinsic characteristics, although they have in common several aspects, such as affective and emotional instability; however, the differences are obvious: in the bipolar patient, there is a marked tendency to emotional and affective instability that is more rigid and enriched by irrational beliefs taken to the extreme, between depressive and manic episodes that represent the two main modes of the patient (albeit with four different hypotheses that make the picture closer to one or the other); in the borderline patient, there is a greater and more pronounced tendency to impulsivity and aggressiveness, with emotional and affective fluctuations more sudden and fast, and depressive and manic episodes shorter and more circumscribed in time and space. It is therefore more than correct, in the opinion of the writer, to separate the two interpretative hypotheses, precisely because of their peculiar characteristics of the behavioral and emotional-affective picture.

8. **“The interconnection link between narcissistic personality disorder and sadistic, masochistic and/or sadomasochistic personality disorders”**: The topic should definitely be split with respect to the two questionnaires. With regard to questionnaire 2C, the problem does not arise insofar as these categories are missing and in children they are clearly blurred and still in the phase of definition. A different discussion should be made for the 2TA questionnaire. In the first draft of the questionnaire, the starting hypothesis was to group them under a single category called “Narcissistic Spectrum Personality Disorder”, then subdivided into narcissistic overt disorder, narcissistic covert disorder, narcissistic sadistic disorder, narcissistic masochistic disorder, narcissistic sadomasochistic disorder and narcissistic mixed disorder. The factual and empirical findings, however, produced discordant results; in fact: if on the one hand the nosography respected the central feature of the original disorder, on the other hand it did not take into account

that almost all the forms found fell into the mixed disorder, as the traits were activated in several categories and rarely there was a genuine diagnosis of one of the other categories (not mixed). In the second hypothesis of drafting the questionnaire it was then decided to re-evaluate the “Narcissistic Spectrum Personality Disorder” by including only the overt and covert forms, considering the other categories as by-products of these two, in essence typological qualifications and nothing more. Even this hypothesis, however, was wrecked because not infrequently there were diagnoses of other disorders with a marked presence of sadistic, masochistic or sadomasochistic traits. The last choice, mandatory and necessary, was therefore to consider these categories as individual and separate, even if the core is always the narcissistic prevalence. This decision was reinforced by the following reasons, later confirmed during subsequent studies and research on representative population samples: A) Overt narcissism consists of the egocentricity of the subject who consciously believes himself or herself to be superior, in the absence of objective and validly considered feedback. B) Covert narcissism consists in the egocentricity of the subject who draws for himself a representation of an insecure and unfit person, while realizing his potential and his expressed action. The role of victim and of insecure and unfit become part of his personality structure, as they find intolerable to be guilty of their condition and therefore must consider third parties external to them as causes of their suffering and problems. However, they differ from a genuine victimistic, insecure and maladaptive approach to life by the fact that they can't stand the idea that someone is better than them and they can't stand the idea that someone might point it out to them, while in the second hypothesis it is the same person who confirms their role as “inferior” to others. Subtle forms of covert narcissism are also detectable in subjects who, although aware of their own means (intelligence, beauty, opportunity) consciously prefer the role of “inferior” to receive attention and reassurance. C) The sadist has a very obvious egocentricity, such as to make it seem a narcissistic disorder; in fact, although they share the same core, in the sadist there is the need to destroy the other, enjoy the suffering of others because in him there is the need to absorb the object (psychological) and disintegrate it. D) The masochist has an egocentricity apparently less evident, and not infrequently takes on the appearance more of a dependent disorder or of another nature; in reality, sharing as in the sadist the same core (narcissistic nature), in the masochist there is the need to destroy oneself, annihilate oneself, enjoy one's own suffering because certain irrational beliefs have led the patient to live pleasure through suffering, always in order to disintegrate it. The peculiarity of masochistic disorder, however, is to be found in the means to achieve pleasure through suffering: humiliation or pain. Therefore: if the masochist prefers humiliation as an operative tool of his masochistic conduct, then the patient will be more oriented to masochistic conducts per se, thus concretizing the diagnosis of “masochistic personality disorder” in its individual nosography and separate from the narcissistic disorder; on the other hand, if the masochist prefers pain as a means of implementation of his masochistic conduct, then



the patient will be more oriented to narcissistic conducts (more covert type), thus orienting the diagnosis on “narcissistic personality disorder” or combined between narcissistic disorder and masochistic or sadomasochistic disorder, on the basis of individual dysfunctional traits found in practice. In fact, it often happens that, during the initialing of the PICI-2TA, narcissistic traits are underestimated, underestimated or submerged compared to masochistic traits, so as to suspect at first sight a prevalence of masochism; in reality, the analysis must be in this case oriented precisely on the mode of exercise of masochism, and therefore humiliation or pain, to focus more adequately the final diagnosis and not incur in the risk of identifying a single category for the sole fact of presenting more distinctive dysfunctional traits.

9. **“The interconnection link between schizophrenic personality disorder and personality disorders of the psychotic sphere”:** With regard to the 2TA questionnaire, the following should be pointed out. In the first draft of the questionnaire, the starting hypothesis was to group them under a single category called “Psychotic Personality Spectrum Disorder,” then subdivided into schizophrenic disorder, schizoid disorder, schizotypal disorder, schizoaffective disorder, paranoid disorder, delusional disorder, and dissociative disorder. On the one hand, the nosography respected the central feature of the original disorder (the psychotic matrix). On the other hand, it did not take into account that the diagnosis of schizophrenic disorder is based on symptoms common to the psychotic sphere, but differs from it in terms of the severity of the symptoms, which must necessarily include both delusions and hallucinations. For these reasons it was decided to abandon the idea of the “psychotic spectrum” and to separate the individual categories. In the second hypothesis of drafting the questionnaire, it was then decided to re-evaluate the schizoid, schizoaffective and schizotypal hypotheses in the context of schizophrenic disorder, but this hypothesis also foundered for the reasons mentioned above with respect to schizophrenic disorder. The last choice, mandatory and necessary, was therefore to consider these categories as individual and separate, even if the central core is always the psychotic prevalence. This decision was reinforced by the following reasons, later confirmed during subsequent studies and research on representative population samples: A) In schizophrenic disorder there is the presence of delusions, hallucinations, speech and behavior, inappropriate affectivity, dysphoric mood (depression, anxiety, anger), and negative symptoms (apathy, affective flattening, ideational poverty, impairment of interpersonal and social relationships). B) In schizoid disorder, there is a need for isolation, disinterest in social relationships, and limited use of emotional language, with impairment of interpersonal relationships. C) In schizotypal disorder there is the presence of strong distress at the idea of relating to people or situations in an intimate and personal way, alterations in thinking and eccentric behavior other than the histrionic hypothesis. D) In schizoaffective disorder there is the presence of schizophrenic symptoms such as delusions and hallucinations, but in a softer and less resistant version, along with frequent mood swings more typical of bipolar

forms. Distinct for obvious characteristics are instead the delusional disorder, the paranoid disorder and the dissociative disorder, even if the main symptoms of these disorders are recognizable in the previous categories, based on their specific gravity. As a matter of organizational simplicity, it is preferred to keep distinct all the categories analyzed, although it does not seem unlikely to assume a different nosographic based on a specific psychotic triad: 1) psychopathic personality disorder (which, by type and classification, presents symptoms afferent to both cluster b and cluster c); 2) typical psychotic spectrum disorder (which would include delusional disorder, paranoid disorder and dissociative disorder); 3) schizophrenic spectrum disorder (which would include schizophrenic disorder, schizoid disorder, schizotypal disorder and schizoaffective disorder). This hypothesis, however, would present critical organizational and diagnostic issues that would merit further investigation.

10. **“Absorptions”:** Certain nosographic categories, by structure and type, are absorbed by other nosographic categories. Absorption occurs only if the number of traits of the absorbing pathology is equal to or greater than the number of traits of the absorbed pathology (for example, normally bipolar disorder absorbs manic disorder, but if the latter has a greater number of traits, the diagnosis will be manic disorder with bipolar traits). Absorption does not obscure the absorbed traits but simply incorporates them; therefore, for the purposes of psychotherapy, it is necessary for the therapist to consider the absorbed traits as well. Below in detail:

PICI-2C	
Absorbent (that which absorbs)	Absorbed (what is absorbed)
Anxiety disorder	-
Phobic disorder	-
Avoidant Disorder	-
Obsessive Disorder	-
Somatic disorder	-
Maniacal Disorder	Anxiety disorder
Bipolar disorder	Anxiety disorder; Maniacal Disorder; Depressive Disorder
Disruptive mood dysregulation disorder	Anxiety disorder
Maladaptive Separation Disorder	Anxiety disorder
Oppositional Defiant Disorder	Anxiety disorder; Disruptive mood dysregulation disorder
Explosive-intermittent disorder	Anxiety disorder; Disruptive mood dysregulation disorder; Oppositional Defiant Disorder
Uninhibited social engagement disorder	Anxiety disorder
Attachment Disorder	Maladaptive Separation Disorder
Dependent disorder	Maladaptive Separation Disorder
Depressive Disorder	Anxiety disorder
Egoistic disorder	Anxiety disorder
Libidinal Disorder	Anxiety disorder
Psychotic disorder	Anxiety disorder


PICI-2TA

Absorbent (that which absorbs)	Absorbed (what is absorbed)
Anxiety Personality Disorder	-
Phobic Personality Disorder	-
Avoidant Personality Disorder	-
Obsessive Personality Disorder	-
Somatic Personality Disorder	-
Maniacal Personality Disorder	Anxiety Personality Disorder
Bipolar Personality Disorder	Anxiety Personality Disorder; Maniacal Personality Disorder; Depressive personality disorder
Emotional Personality Disorder	Anxiety Personality Disorder
Dependent Personality Disorder	Anxiety Personality Disorder
Depressive personality disorder	Anxiety Personality Disorder
Borderline Personality Disorder	Anxiety Personality Disorder; Maniacal Personality Disorder; Emotional Personality Disorder
Histrionic personality disorder	Anxiety Personality Disorder
Narcissistic overt personality disorder	Anxiety Personality Disorder
Narcissistic covert personality disorder	Anxiety Personality Disorder
Antisocial Personality Disorder	Anxiety Personality Disorder; Emotional Personality Disorder
Sadistic Personality Disorder	Anxiety Personality Disorder
Masochistic personality disorder	Anxiety Personality Disorder
Psychopathic Personality Disorder	Anxiety Personality Disorder
Schizophrenic personality disorder	Anxiety Personality Disorder; All other psychotic disorders
Schizoid personality disorder	Anxiety Personality Disorder
Schizotypal personality disorder	Anxiety Personality Disorder
Schizoaffective Personality Disorder	Anxiety Personality Disorder; Depressive personality disorder
Delusional Personality Disorder	Anxiety Personality Disorder
Paranoid Personality Disorder	Anxiety Personality Disorder
Dissociative personality disorder	Anxiety Personality Disorder

The “new nosographic classification”: The PICI-2, like the previous version, redesigns a new nosographic classification [31-92] on the basis of the following distinction:

a) For PICI-2C (children and pre-adolescents):

a1) “Neurotic domain area” (Cluster A)

- “Anxiety disorder” (with generalised, social, panic and post-traumatic variants), as distinct from the attenuated forms of episodic anxiety and complex multiple anxiety;
- “Phobic disorder” (with specific, multiple and social variants);
- “Avoidant disorder”;
- “Obsessive disorder” (with the complex or mixed, compulsive, accumulative, pyromaniac, kleptomaniac and injurious variants), as distinct from the simple form;

- “Somatic disorder”;
- “Manic disorder”, distinguished from form I (severe / complex) or form II (moderate / hypomanic).

a2) “Latent domain area” (Cluster B)

“Bipolar disorder”, distinguished into form I (overt depressive-manic), form II (moderate / depressive-hypomanic), form III (predominantly depressive with hypomanic episodes) and form IV (cyclothymic, with manic or hypomanic episodes);

- “Disruptive mood dysregulation disorder”;
- “Maladaptive separation disorder”;
- “Oppositional-provocative disorder”;
- “Explosive-intermittent disorder”;
- “Uninhibited social engagement disorder”;
- “Attachment disorder”, divided into inhibited type and uninhibited type;
- “Dependent disorder”;
- “Depressive personality disorder” (with minor, major, persistent grief and cyclothymic variants);
- “Egoistic disorder”;
- “Libidinal disorder”.

a3) “Psychotic domain area” (Cluster C)

- “Psychopathic personality disorder”.

a4) “Residual domain area” (Cluster D):

- “Mixed personality disorder”;
- “Comorbidity conditions”;
- “Concomitant or triggering medical and/or socio-environmental conditions”.

b) For PICI-2TA (adolescents and adults):

b1) “Neurotic domain area” (Cluster A)

- “Anxious personality disorder” (with generalised, social, panic and post-traumatic variants), as distinct from the attenuated forms of episodic anxiety and complex multiple anxiety;
- “Phobic personality disorder” (with specific, multiple and social variants);
- “Avoidant personality disorder”;
- “Obsessive personality disorder” (with complex or mixed, compulsive, accumulative, pyromaniac, kleptomaniac and injurious variants), as distinct from the simple form;



- “Somatic personality disorder”;
- “Manic personality disorder”, distinguished from form I (severe / complex) or form II (moderate / hypomanic).

b2) “Latent domain area” (Cluster B)

- “Bipolar personality disorder”, distinguished into form I (overt depressive-manic), form II (moderate / depressive-hypomanic), form III (predominantly depressive with hypomanic episodes) and form IV (cyclothymic, with manic or hypomanic episodes);
- “Emotional-behavioural personality disorder”;
- “Dependent personality disorder”;
- “Depressive personality disorder” (with minor, major, persistent grief, cyclothymic and acute or chronic post-partum variants);
- “Borderline personality disorder”;
- “Histrionic personality disorder”;
- “Dependent personality disorder”;
- “Narcissistic personality disorder”, distinguished into overt and covert;
- “Sadistic personality disorder”;
- “Masochistic (or self-destructive) personality disorder”.

b3) “Psychotic domain area” (Cluster C)

- “Psychopathic personality disorder”;
- “Schizophrenic personality disorder” (if the symptomatology is less than 6 months, this is referred to as “schizophreniform disorder”);
- “Schizoid personality disorder”;
- “Schizotypal personality disorder”;
- “Schizoaffective personality disorder”;
- “Delusional personality disorder”;
- “Paranoid personality disorder”;
- “Dissociative personality disorder”;

b4) “Residual domain area” (Cluster D)

- “Mixed personality disorder”;
- “Comorbidity conditions”;
- “Concomitant or triggering medical and/or socio-environmental conditions”.

12) “**Rules for carrying out questionnaires**”: On the basis of the revised model, two distinct clinical interviews are structured below, which follow the following rules of style:

a) **Age limits and previous clinical conditions**: The clinical interview must respect the reference age (PICI-2C for patients between 3 and 12 years of age, PICI-2TA for patients 12 years of age or older). The reference age may be waived at the discretion of the therapist’s clinical psychophysical and neurobiological assessment if there is sufficient data to believe that mild mental retardation or significant immaturity is present. Moderate or severe retardation or other neurodevelopmental pathology that significantly impairs cognitive abilities and functions are not preclusive to the administration of the interviews;

b) **Method of administration**: The two clinical interviews are administered during or after the clinical and anamnestic interview, both personal and family, and are compiled exclusively by the therapist, with or without the patient’s involvement, and serve to frame the patient in a more systematic manner, both with reference to specific disorders and to individual dysfunctional personality traits. It is advisable to administer the questionnaires after at least 3-5 meetings, in order to promote a better knowledge of the patient’s symptomatological universe. It is also possible to administer the questionnaires by having the patient sign them, provided that the therapist carries out a subsequent check on the answers and that this operation is functional exclusively to verify the reliability, sincerity and awareness of the patient about his condition and his state of health.

c) **Structures of the clinical interviews**: The second version for children contains 128 items, while the one for adolescents and adults contains 173 items (in contrast to the first version which contained 195 items for adults and adolescents and 150 items for children); in both cases, the items have only one correct answer “Yes/NO” and the answers “Maybe”, “I don’t know”, abstention from the answer and partial answers (“More or less”, “Almost”, “In short”) are not admitted. Several items can refer to the same dysfunctional trait; therefore, a positive response to even one item of the same dysfunctional trait is sufficient to consider that specific trait present.

d) **Relevance of the answers**: Only the positive answers to the items define the presence of the 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 the anamnestic data, with the family findings and with the implications deriving from the socio-educational context of reference, especially with reference to the patient under twelve years of age.

The clinical research

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-2" 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-2" and the "MMPI-II test".

The method applied is therefore the administration of the "PICI-2" 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-2".

The selected population sample is 718 participants, divided as follows: 310 males and 418 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-2 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 March 2020 to June 2021 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	26
Male	21-25	20
Male	26-30	54
Male	31-35	23
Male	36-40	53
Male	41-45	41
Male	46-50	26
Male	51-55	30
Male	56-60	16
Male	61-65	21

Female	16-20	23
Female	21-25	44
Female	26-30	40
Female	31-35	53
Female	36-40	54
Female	41-45	42
Female	46-50	52
Female	51-55	32
Female	56-60	42
Female	61-65	26

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-2 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-2TA 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-2TA) 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-2TA 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-2TA 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-2, for 99.7%, which



enriches what is reported in the previous clinical documentation with further information (the single traits).

- 5) The remaining 0.3% of the population sample, different from the initial diagnosis and equal to no. 2 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.
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.

The present research work, although with an important but certainly not representative sample of the population, has shown a reliability of 99.7% of the PICI-2TA 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 0.3%, in the writer's opinion, is due to reasons external to the reliability, effectiveness and efficiency of the PICI-2TA 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 sufficiently representative and the result of 99.7% 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-2 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-2TA only (adolescents and adults). The use of the third interview (PICI-2FT) did not appear necessary here and will be evaluated elsewhere with other findings.
- 3) PICI-2 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-2 is a free psychodiagnostic tool, this research has no financial backer and does not present any conflicts of interest. The standards set forth in the 1964 Declaration of Helsinki have been met.

The clinical interview for identifying functional traits: PICI-2FT

Referring again to the studies on personality contained in the first and second chapters of this work, this last chapter is devoted to the drafting of the PICI-2FT questionnaire to investigate functional personality traits.

In fact, by analysing the models proposed by the main scholars, including S. Freud, Jung, Eisenck, Cattell, Allport and Costa, it emerges, in the opinion of the writer, the need to construct a new model that takes into account the following correctives:

- 1) *First corrective.* In all the proposed models we find as specific functional personality traits designations of traits which by nature, structure and function are dysfunctional, such as impulsiveness, tension, psychoticism, immaturity, neuroticism and diffidence; in some cases real functions, such as intelligence, are labelled as "traits", and in other cases statuses such as maturity. These models suffer from the cultural influence of the time and therefore need to be revised. As a first corrective, it is proposed that the list of functional traits be entirely reconstructed, taking care not to confuse functional traits with dysfunctional traits or even with functions or statuses of another nature.
- 2) *Second corrective.* In order to classify individual functional traits in a more organised manner, it is proposed to use a 0-4 scaling with a single digit indication of a specific trait. The PICI-2FT will be drawn up exclusively by the therapist during the clinical interview, in order to evaluate the patient's self-perception and the correspondence with the data obtained from the clinical interview and from the possible results of the meetings held; in this way, the therapist will have a more complete overview, also to identify more quickly the possible resources to be used to favour the patient's corrective emotional experiences. After having initialled the number corresponding to the trait/characteristic that one feels one possesses, one will report the data in the corresponding table/chart, starting from the first main trait to arrive at the eighteenth: the traits that will result between the first, second or fifth column will be traits to be carefully evaluated in the clinic because they are



potentially able to favour the eventual decompensation of the patient in terms of psychic organisation, even if in themselves they are functional and may not be relevant from a psychopathological point of view (everything will depend on the type of functioning of the patient). The traits eventually identified by the questionnaire are never fixed and stable, but are always changeable, according to the circumstances; possible repetitions or fixations could represent in that person simply a greater representation of that characteristic, which however does not represent in itself something fixed.

The eighteen main functional traits for all ages are identified below, along with their functional (secondary) subtraits:

1. **Existential orientation:** This is the trait that delineates the person's approach to life and to his/her own existence, according to the following scale:

1. **Anxious:** The subject lives his/her existence in an anxious way, but not to the point of perceiving this state as dysfunctional; it is at most a protective and defensive mode, even if very extreme and extremely close to dysfunctional forms of anxiety.
2. **Nervous:** The subject lives his existence in a tense way, worried (even if not in a dysfunctional way) about the outcome of a given event; it is also a protective and defensive modality, even if very close to the dysfunctional forms always of anxious nature.
3. **Centred:** The subject lives his/her existence in a centred way, able to face daily anxieties and tensions in a balanced way.
4. **Serene:** The subject lives his/her existence in a serene way, able to face daily anxieties and tensions in a relaxed and positive way.
5. **Peaceful:** The subject lives his existence in a peaceful way, able to face daily anxieties and tensions in an ideal way, even if this modality could hide an avoiding tendency to be analysed in a more specific way.

2. **Courage:** This is the trait that delineates the patient's representative way of acting, according to the following scale:

0. **Fearful:** The subject lives his modality in a fearful way, unable to face the daily circumstances because pervaded by anxiety.
1. **Slightly Spooky:** The subject lives his modality in a fearful way, unable to face daily circumstances because pervaded by worry.
2. **Vigilant:** The subject lives his/her modality in a vigilant way, able to face daily circumstances in a balanced way.
3. **Exaggerated:** The subject experiences his or her modality in an exaggerated but not extreme manner, able to cope with daily circumstances even though he or she may run unnecessary risks.

4. **Excessive:** The subject lives his/her modality in an excessive and extreme way, he/she is able to cope with daily circumstances but often incurs unnecessary and harmful risks.

3. **Intrapreneurship:** This is the trait that delineates the patient's representative mode of action, according to the following scale:

0. **Shameless:** The subject experiences his/her modality in an excessively enterprising manner, unable to weigh up the consequences of his/her actions due to defence mechanisms or over-activation, which however still do not fully represent the hypothesis of loss of control or impulsiveness.
1. **Spontaneous:** The subject experiences their mode in a spontaneous and open manner, without asking themselves any questions about the consequences or simply not giving it the right weight, out of lightness.
2. **Clear:** The subject experiences his/her modality in a clear and direct way, correctly representing the consequences of his/her actions.
3. **Sincere:** The subject experiences his/her modality in a sincere and straightforward manner, accurately representing the consequences of his/her actions.
4. **Free:** The subject lives his/her modality free from superstructures, representing the consequences of his/her actions but overestimating his/her own interpretations.

4. **Self-control:** This trait outlines the ability to self-regulate and manage one's impulses, according to the following scale:

0. **Hypercontrolling:** the subject lives his/her mode in an excessively rigid way, with a form of hypercontrol that does not yet represent a totally dysfunctional mode.
1. **Framed:** The subject lives his/her modality in a framed and methodical way.
2. **Confident:** The subject lives his modality in a secure and representative way, with a tendency to a cumbersome way of thinking.
3. **Loose:** The subject lives his/her own modality in a free way, elastically representing the possible alternatives.
4. **Hypocontrolling:** The subject lives his modality in an excessively elastic way, without control or with a minimum form of control.

5. **Sensitivity:** This is the trait that delineates the sensitivity level of the subject, according to the following scale:

0. **Disinterested:** The subject experiences his or her mode in a cold and disinterested way, almost insensitive as if it did not concern him or her personally (so-called cold egoism).
1. **Phlegmatic:** The subject experiences his/her modality in



a detached and phlegmatic way, out of self-defence or selfish tendency.

2. **Controlled:** The subject lives his modality in a fair and balanced way, with a tendency towards rationalisation.
3. **Sensitive:** The subject lives his/her modality in a sensitive and empathic way.
4. **Hypersensitive:** The subject lives their modality in an excessively sensitive way, gets involved and often finds themselves sucked in and lacking in emotional strength, complaining of their discomfort and excessive self-giving.

6. **Expression in action:** This is the trait that delineates the person's expressive approach to life, according to the following scale:

0. **Introverted:** The subject lives his/her own modality in a closed and deeply protective way.
1. **Shy:** The subject lives his/her modality in a shy and internalised way.
2. **Reserved:** The subject lives his/her modality in a reserved way but externalized in the shareable social aspects.
3. **Open:** The subject lives his/her modality in an open way and externalized in the shared social aspects.
4. **Extroverted:** The subject lives his/her way openly, extroverted and externalized in all aspects, even the most intimate and private ones.

7. **Awareness:** This is the trait that outlines the level of awareness of the subject with respect to his/her actions and experience, according to the following scale:

0. **Unconscious:** The subject experiences his/her modality in an unconscious way, overwhelmed by his/her defence mechanisms and self-deceptions.
1. **Voluntary:** The subject lives his/her modality in a semi-conscious way, knowing that certain dynamics are caused by his/her actions but accepting the risk and consequences of his/her self-deceptions as plausible.
2. **Conscious:** The subject lives his/her mode consciously and wonders about the consequences of his/her actions.
3. **Informed:** The subject experiences his/her modality in a conscious and informed way, wondering about the consequences of his/her actions, but also about possible valid alternatives.
4. **Aware:** The subject experiences his/her modality in a fully conscious way.

8. **Comparison of the Ego and the Id:** This is the trait that delineates the internal relations between the reality principle and the pleasure principle, between the conscious and the unconscious, according to the following scale:

0. **Instinctive:** the subject experiences his mode instinctively.

1. **Emotional:** The subject experiences his modality emotionally.
2. **Measured:** The subject lives his/her modality in a measured way, allowing him/herself to be instinctive in emotional situations and rational in factual situations.
3. **Reflective:** The subject lives his modality in a reflective manner, attentive to his own inner needs but paying particular attention to social rules and behaviour.
4. **Rational:** The subject lives his/her modality in a rational way, giving more space to the conscious component.

9. **Emotionality:** This is the trait that delineates the emotional world of the person in a dynamic relationship with third parties, according to the following scale:

0. **Subordinate:** the subject experiences his or her own mode in a subordinate, almost servile way, giving greater priority to the needs of others.
1. **Interdependent:** The subject lives his/her modality in an interdependent way, giving greater priority to the needs of others even if he/she does not submit to them or excessively limit his/her needs.
2. **Individualistic:** The individual lives his/her modality in an individualistic way, giving priority to his/her own and others' needs according to circumstances while maintaining his/her uniqueness.
3. **Autonomous:** The subject lives his/her mode in an autonomous way, giving priority to his/her own and others' needs, with a greater preference for his/her own needs.
4. **Independent:** The subject lives his/her mode independently, giving greater priority to his/her own needs.

10. **Energy:** This is the trait that outlines the person's approach to the external conduct of life, according to the following scale:

0. **Passive:** The subject lives his/her modality in a passive way, suffering from events and circumstances, almost as if attracting the worst.
1. **Tiepid:** The subject lives his modality in a lukewarm way, avoiding to face the choices that could expose him, without however manifesting the avoidant symptomatology of the disorder.
2. **Harmonious:** The subject lives his modality in a harmonious and balanced way, between active and passive, according to the factual circumstances.
3. **Energetic:** The subject experiences his/her modality in an energetic manner, without excess, but with decisiveness.



4. **Active:** The subject lives their modality in an active way, without often falling into excesses, sometimes manic.

11. **Stability (or Ego Strength):** This is the trait that delineates the strength of the Ego, according to the following scale:

0. **Unstable:** the subject experiences his mode in an unstable and indecisive way, fearful and frightened.

1. **Precarious:** The subject lives his modality in a precarious way, avoiding to choose for fear of being wrong.

2. **Balanced:** The subject lives his/her modality in a balanced way.

3. **Constant:** The subject lives his/her modality in a constant way, with a tendency towards functional operational mania.

4. **Stable:** The subject lives their modality in a stable and secure manner, with a tendency towards operational functional obsession, unless other unconscious elements indicate dysfunctionality.

12. **Security:** This is the trait that outlines the person's approach to the internal conduct of life, according to the following scale:

0. **Insecure:** the subject lives his mode in an insecure way, full of uncertainties and often with thoughts tending to obsessiveness.

1. **Uncertain:** The subject lives his/her modality in an uncertain way, but tends to react.

2. **Proportionate:** The subject experiences his/her modality in a proportionate and reasoned way.

3. **Reliable:** The subject lives his/her modality in a reliable way, becoming the reference point for other people.

4. **Secure:** The subject lives his/her modality in a secure way, full of certainty and often risking going far beyond his/her possibilities or potential.

13. **Relational function:** This is the trait that delineates the emotional world of the person in emotional relationship with third parties, according to the following scale:

0. **Superficial:** The subject lives his/her own modality in a superficial way, underestimating and taking for granted people and relational dynamics.

1. **Fickle:** The subject lives his/her own modality in a fickle way, although realising the mistakes he/she makes, he/she continuously falls back into the same dynamics due to the fragility of his/her self-esteem.

2. **Diligent:** The subject lives his modality in a diligent way, giving the right weight to people and circumstances.

3. **Concrete:** The subject lives his modality in a concrete way, giving the right weight but risking putting himself in second place.

4. **Solid:** The person lives his or her mode in a solid way, often giving more value to the other person and putting his or her own needs in second place, risking a dependent or masochistic relationship.

14. **Dexterity:** This is the trait that outlines the use of reason for one's own ends, cunning and astuteness in relationships, according to the following scale:

0. **Reckless:** The subject lives his or her mode in a careless manner, risking through his or her own fault to be a victim of abuse.

1. **Naïve:** The subject lives his/her own modality in a naïve and too utopian way, seeing the other person as basically good and available regardless of events.

2. **Attentive:** The subject lives his/her modality in an attentive way, paying attention to factual circumstances and people, based on their actions and not only on words.

3. **Astute:** The subject lives their modality in an astute way, anticipating moves and often appearing doubtful and defensive.

4. **Shrewd:** The subject lives their modality in a shrewd way, where shrewdness can become suspiciousness and mistrust.

15. **Sociability:** This is the trait that delineates the person's sociable and environmental approach to others and to life, according to the following scale:

0. **Assertive:** the person experiences his or her mode in an assertive and helpful manner, is constructive and raises legitimate questions, even risking putting him or herself in the background.

1. **Accommodating:** The subject lives his/her own modality in an accommodating way, meeting the needs of others without putting him/herself in the background.

2. **Reasonable:** The subject lives his/her modality in a reasonable way, between his/her own needs and those of others, including social rules.

3. **Adequate:** The subject lives his/her mode in an adequate way, paying more attention to social rules and customs.

4. **Conformist:** The subject lives his/her modality in a conformist way, often paying attention to social rules and customs to the detriment of personal needs and requirements and those of those around him/her.

16. **Altruism:** This is the trait that outlines the person's openness in relations with third parties, according to the following scale:

0. **Generous:** the subject lives his/her own modality in a generous way, giving top priority to third parties and their needs, even at the cost of compressing him/herself.

1. **Good:** The subject lives his/her modality in a good way, giving fair priority to third parties.



2. **Available:** The subject lives his/her mode in a helpful way, giving the right priority to third parties without affecting his/her personal spheres.
3. **Defensive:** The subject lives his/her modality in a defensive way, giving low priority to third parties, justifying him/herself with cognitive distortions.
4. **Selfish:** The subject lives his/her modality in a selfish way, giving top priority to him/herself and his/her own needs, often at the involuntary expense (underestimation) of others' needs.

17. **Openness:** This is the trait that delineates the openness of the person in internal relations with him/herself, according to the following scale:

0. **Resilient:** The person experiences their mode in a resilient way, overcoming adversity by finding adequate solutions.
1. **Disengaged:** The person lives his/her modality in a disengaged way, overcoming adversity with commitment but also with casualness.
2. **Agape:** The person lives their mode in an open manner, overcoming adversity with the help of others.
3. **Committed:** The subject experiences his/her modality in a committed way, finding it difficult to overcome adversity on his/her own.
4. **Closed:** The subject experiences his/her modality in a closed way, failing to overcome adversity adequately, even with the help of others.

18. **Passionality:** This is the trait that delineates the person's sentimental and physical approach to life and relationships with third parties, according to the following scale:

0. **Indifferent:** The subject lives his/her own modality in an indifferent way, apparently cold and detached he/she lives sexuality as if it were not important or in any case of third order.

1. **Detached:** The subject lives his modality in a detached way, almost fearful, living sexuality as a secondary element compared to other relational dynamics.

2. **Involving:** The subject lives his/her own modality in an involving way, giving the right weight both to sexuality and feelings, experiencing sexuality as a primary element but not superior to other relational dynamics.

3. **Passionate:** The subject lives his/her own modality in a passionate way, considering sexuality as necessary and often superior to other relational dynamics, however separable from feelings.

4. **Fiery:** The subject lives his modality in a fiery and physical way, considering sexuality as fundamental and superior to other relational dynamics, however always separable from feelings.

(Appendix PICI-2FT (App. PICI-2FT))

The clinical interview for identifying dysfunctional traits in children: PICI-2C

(Appendix PICI-2C (App. PICI-2C))

The clinical interview for the identification of dysfunctional traits in adolescents and adults: PICI-2TA

(Appendix PICI-2TA (App. PICI-2TA))

Conclusions

It appears evident, in light of the previous research on PICI-1TA, that the requirements and expectations of reliability and consistency of the instrument used have been met here as well, improving the value previously obtained (from 97.7% to 99.7%) demonstrating the overcoming of said objective limits. Finally, it is important to remember that the administration of the PICI-2 photographs the historical moment of the patient and not the previous one; therefore, it may happen that certain findings are conditioned or distorted by the positive or negative historical moment that the patient is living. It is important for the therapist to frame in a clear and exhaustive way the patient's anamnestic universe, in order to take a picture also of the moments preceding the administration of the PICI-2 and to understand possible overactivations or omissions of activation following a moment of stability of the patient, which actually hide the real extent of his clinical manifestation.

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