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Research Article

The new Dysfunctional Personality Model of the Anxiety Matrix (DPM-AM): "Neurotic Personality Disorder" (NPD)

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Abstract

Background and objectives: According to the PICI model, second edition, the personality disorders of the neurotic area are six (anxious, phobic, obsessive, somatic, avoidant, and manic) and the diagnosis of the psychopathological disorder is determined on the basis of the persistence of certain dysfunctional traits present in the personality framework. However, on the basis of clinical experience and through the application of IPM/PICI, Deca, PDM, PHEM, and PPP-DNA models (including PF-SPEM and NDAM), it was found that all the disorders of the neurotic area had in common the anxiety traits and that the symptoms of the six different disorders were often present in comorbidity. This assumption led to the hypothesis that there was a different and better way to group them into a single, all-encompassing category: "neurotic personality disorder". This research aims to demonstrate whether or not the use of this hypothetical new nosographic construct is useful.

Materials and methods: Individual clinical interview, consisting of the amnestic collection and administration of the PICI-2TA (Perrotta Integrative Clinical Interviews, version 2-TA), PAD-Q (Perrotta Affective Dependency Questionnaire), PSM-1 (Perrotta Sexual Matrix) and PDM-Q (Perrotta Defence Mechanisms Questionnaire), to each group of population.

Result: Of the selected sample of 326 subjects, 318 were eligible because they met the inclusive criteria. The three male groups, subdivided by age (18-36, 37-54, 55-72), completely resolved their neurotic symptoms in 86.7% (13/15), 87.5% (7/8) and 60% (3/5), for a partial total of 78.1% (23/28), while the remaining 21.9% (5/28) declared to have benefited from the PPP-DNA protocol with an attenuation of at least 50% of their neurotic symptoms. The three female groups, subdivided according to age (18-36, 37-54, 55-72), completely resolved their neurotic symptoms in 93.3% (154/165), 95% (57/60), and 92.3% (60/65), for a partial total of 93.5% (271/290), while the remaining 6.5% (19/290) declared to have benefited from the PPP-DNA protocol with at least a 50% attenuation of their neurotic symptoms.

Conclusion: The PPP-DNA protocol is effective for 85.8% (with a greater prevalence of effectiveness in the female population) in the resolution of neurotic symptoms of anxious, phobic, somatic, avoidant, obsessive, and manic nature, both with the previous wording and with the new nosographic hypothesis "neurotic personality disorder", as it does not represent a new psychopathological construct but only a different way of grouping disorders of cluster A (neurotic) to avoid that the absorptions do not take into account important dysfunctional traits that are instead at the base of those disorders and therefore does not affect in any case the exact diagnosis of the dysfunctional personality profile.

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Background and objectives

Psychiatric disorders, precisely because of their particular nature, have always posed several difficulties from the diagnostic point of view, since, unlike most pathologies, they are not classifiable through variations of material components such as biochemical laboratory parameters or instrumental examinations. To overcome this obvious problem, since the middle of the last century, there has been an attempt to apply a schematic and nosographic approach in the classification of psychiatric disorders, so as to allow the realization of a simpler and more objective diagnosis, although this has clearly shown all its limitations since the phonological complexity of the individual is represented by a series of variants difficult to order. Currently, in psychiatry there are various methods of classification, generally recognized by the scientific and academic community: the most used and appreciated are the Diagnostic and Statistical Manual of Mental Disorders (DSM) written by the American Psychiatric Association and the International Classification of Diseases (ICD) issued by the World Health Organization, in addition to the attempt made through the Psychodynamic Diagnostic Manual (PDM) of the International Psychoanalytical Association [1-5].

Recent research, with a small sample of the population (65 people), on the application of the strategic model to patients suffering from neurotic disorders [6], has demonstrated the effectiveness of 74.36% within the tenth session and with complete regression of symptoms, while for the remaining 25.64% symptoms were relieved by more than 50%, identifying their resistance to change in adverse conditions however identifiable; however, in the totality (100%) of the selected population sample, a very curious feature emerged that aroused attention and the need for further investigation, namely that they all presented (albeit in different proportions and distribution) dysfunctional personality traits of anxious personality disorder, according to the classification contained in the PICI-2 [7-13]. In fact, even during the drafting of the PICI model the writer had posed the problem of reclassifying the disorders of the neurotic area according to a more synthetic and organizational logic, but he preferred to adhere at first to the structure closer to the DSM-V and PDM-II.

Here, therefore, emerges a different need, for greater awareness, to find out if the starting hypothesis can find a foundation or not (that is, if the neurotic area is represented by a single personality disorder, the "*neurotic personality disorder*", or it is convenient to keep distinct the single nosographic figures currently used in the literature). The current nosography related to PICI-2 provides a classification of the neurotic area distributed for 6 different personality disorders: Anxious, Phobic, Avoidant, Somatic, Obsessive, and Manic. Structuring them into a single personality disorder, of the neurotic type, would facilitate the nosographic, giving greater rigor to the continuous clinical findings that report an underlying anxious picture in each of the disorders of the neurotic area, namely the phobic, the somatic, the avoidant, the obsessive, and the manic.

If we were to adhere therefore to the starting hypothesis of grafting the new nosographic figure of "neurotic personality disorder" as an Omni comprehensive construct of the disorders of the neurotic area we would have to imagine a representation of this kind:

Primary Disorder	*Specifications (of traits)*	*Types*	*Topics*
Neurotic Personality Disorder	Anxious	Monothematic	The subject has been suffering for more than 6 months from a specific anxiety symptom (i.e., the primary cause that produced it is identified) that does not regress spontaneously and worsens quality of life
		Polythematic	The subject is affected by more than 6 months of a series of specific anxious symptoms (i.e. we identify the primary causes that have produced them), involving one or more complex spheres of his existence (for example: if the social dimension is affected it will be social anxiety if the clinical dimension is affected it will be an anxiety of disease or mild hypochondria) that do not regress spontaneously and that worsen the quality of life without extending to all spheres of life of the subject
		Generalized	The subject is affected for more than 6 months by the anxiety disorder of polythematic type but with extension to all spheres of life of the subject, producing a marked worsening quality of life. When the onset of symptoms is explosive, unmanageable, and ingravescent will speak of generalized anxiety disorder from panic, while if it depends on a specific traumatic event will speak of post-traumatic stress disorder
	Phobic	Monothematic	The subject has been suffering for more than 6 months from a specific phobic symptom (i.e., the primary cause that produced it is identified) that does not regress spontaneously and worsens the quality of life
		Polythematic	The subject has been suffering for more than 6 months from a series of specific phobic symptoms (i.e. the primary causes that produced them are identified) that do not regress spontaneously, involving one or more complex spheres of their existence (for example: if the social dimension is affected it will be a social phobia if the clinical dimension is affected it will be a phobia of disease or complex hypochondria)
	Avoidant	Monothematic	The subject has been suffering for more than 6 months from a specific avoidant symptom (i.e., the primary cause that produced it is identified) that does not regress spontaneously and worsens quality of life
		Polythematic	The subject has been suffering for more than 6 months from a series of specific avoidant symptoms (i.e. the primary causes that produced them are identified) that do not regress spontaneously, that involve one or more complex spheres of their existence (for example: if the social dimension is affected it will be a social avoidance if the clinical dimension is affected it will be a hypochondriac avoidance) and that worsens the quality of life

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	Somatic		The subject has been suffering for more than 6 months from a series of somatic specific/conversion symptoms (i.e., the primary causes that produced them are identified) or nonspecific/somatoform symptoms (i.e., the primary causes that produced them are not identified), which do not regress spontaneously, and which worsen the quality of life, in the absence of specific anxiety (because it would fall in the anxious personality disorder), phobia (because it would fall in the phobic disorder, as happens in hypochondria) or fictitious behaviors more or less voluntary (because it falls in the sphere of cluster B sand/or C, as happens in Munchausen Syndrome)
	Obsessive	Monothematic	The subject has been suffering for more than 6 months from a specific obsessive symptom (i.e. the primary cause that produced it is identified) that does not regress spontaneously and worsens the quality of life
		Polythematic	The subject has been suffering for more than 6 months from a series of specific obsessive symptoms (i.e. the primary causes that produced them are identified) that do not regress spontaneously, and that involve one or more complex spheres of their existence
		Compulsive	The subject is affected by more than 6 months of a series of specific obsessive symptoms (i.e. we identify the primary causes that have produced them) that do not regress spontaneously and that precede compensatory ritualistic behaviors (compulsions), able to negatively affect one or more complex spheres of their existence (eg body dysmorphism, compulsive accumulation, pyromania and compulsive self-injury type scratching other than the injurious forms present in the personality profiles of clusters B or C)
	Manic	Pure (type 1)	The subject has been suffering for more than 6 months from a condition of classical manic hyperactivation determined by the reduced need for sleep, increased talkativeness, flight of ideas, and excessive self-esteem in the absence of symptoms typical of cluster B; symptoms that do not regress spontaneously, involving one or more complex spheres of their existence and worsening the quality of life
		Hypomanic (type 2)	The subject has been suffering for more than 6 months from a condition of manic hypertension in an attenuated form (or hypomaniacality), which does not regress spontaneously, involving one or more complex spheres of his existence and worsening the quality of life, albeit in a lesser form than the classic form

Again, the research cited [6], in order to demonstrate the effectiveness and efficiency of the proposed model, relied on 5 *fundamental principles*, basic theoretical assumptions that built the thinking itself:

1. The *Integrated Psychodynamic Model* (*IPM*) and the *Perrotta Integrative Clinical Interviews* (*PICI-2*) [7-13]. Starting from the general concept of personality, according to the models known in the literature, the emphasis is on the importance of personality traits (under the structural profile) and personality functioning (under the functional profile). As a result, the modern psychodynamic paradigm is modified by the theoretical integrations of the new model described, which is more responsive to clinical needs. The entire model, including the individual internal and external parts, describes the personality of the individual, from the most external to the most internal levels. The central points of this research are:

a) The definition of "*personality*", intended (under the functional profile) as the stable and durable organization of the proposed model, or the totalitarian representation of the model - what the Gestaltists would label with the assumption that "the whole is more than the sum of its parts" - (under the structural profile). It is therefore the totalitarian whole of the single parts described, able to interact with the outside, according to precise adaptive mechanisms (in the absence of psychopathologies) and/or maladaptive ones (in the presence of psychopathological traits). The "personality traits", then, are nothing but the expression of the personality in its individual internal facets.

b) The "*psychopathologies*" are the product of structural and functional alterations of the instances contained in the model itself, in response to the external environment, but not in classical psychodynamic terms (hypertrophic Ego - hypotrophic ID / hypotrophic Ego - hypertrophic ID); in this new model attention is paid only to the "functions of the ego" (hypervigilant, unstable or shattered, if they are pathological), as physically the ego and the id remain structurally unchanged but change their functional components or what in psychodynamics are called "superego" and "self".

c) The new model provides a "*new classification of disorders*" (PIM), integrating the knowledge of the DSM-V with the PDM-II, establishing that the diagnosis is always personological, based on dysfunctional traits, classifying disorders into 3 clusters (18 for children, 24 for adolescents and adults and 12 commons). Personality disorders thus become "creative adaptations of the mind" that, by structure and functioning, are shaped on the basis of the main traumatic event, according to the internal response to external stimuli, reinforcing themselves positively or negatively according to them. Thus, 2 clinical interviews were created in the first edition, 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. Compared to the result with the MMPI-II, in research with a sample of 472 subjects, diagnostic reliability was demonstrated at 98.73% compared to the diagnoses obtained using the Minnesota test, even with a greater indication of the dysfunctional traits to be treated in psychotherapy. In the second edition, the 2 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 for interpretive profiles, with the addition of a third clinical interview aimed at identifying functional personality traits (PICI-2FT), with 18 items on an L0-4 scale; subjected to the selected population sample of 718 participants, male and female, again in relation to the MMPI-II, guaranteed reliability of 99.7%, improving the performance of the first edition (2/718 participants were found to be different for clinical reasons highlighted in the research).

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d) Framing the patient's symptomatology in a specific nosographic framework (structural component) is useful to recognize the habitual toxic patterns and tendencies of his personality; however, it is essential to place the emphasis on the functional aspect of his personality (functional component) and therefore work on his resources, on attempted solutions, on vicious circles reproduced, on emotional literacy and awareness, always taking into account that you can not simply cluster a personality functioning as it is the sum of all functional and dysfunctional traits of the patient and therefore each patient is a universe of personality in itself that over time can also change as a result of experiences, whether positive (and functional) or negative (and dysfunctional).

e) The administration of the PICI, in the present time, photographs the historical moment of the patient and not the previous one; therefore, certain findings may be conditioned or distorted by the positive or negative historical moment that the patient is living. The therapist needs to frame the patient's anamnestic universe in a clear and exhaustive way, to photograph also the moments preceding the administration of the PICI, in order to understand possible overactivations or omissions of activation following a moment of stability of the patient that, in reality, hides the real extent of his clinical manifestation. If, however, the diagnosis in adolescents and even more so in adults tends to be stable and absolute, especially in those who present certain dysfunctional behaviors for a longer time, in children, the personological diagnosis is always relative, as the young age allows more easily to modify the dysfunctional behavior and thus correct the psychopathological tendency, net of external reinforcements such as family and social context. It is suggested that the questionnaire be administered together with the patient, helping him/her to sign the questionnaire, in order to avoid omissions, manipulations or lack of awareness on the part of the patient; however, it is useful to have the patient sign the questionnaire exclusively, with the therapist's final approval at the end of the administration, in the hypothesis that one wants to gauge the patient's degree of awareness and collaboration.

2. *Decagonal Model* (*Deca-Model*) [14,15]. Starting from the strategic model, this research focuses on its critical aspects, to propose a dynamic and structured model, called the "decagonal model" to be applied in clinical practice and organized by actions (what), purpose (why), time/place (when/where) and modality (how). Framing the patient's symptomatology in a specific nosographic framework (structural component) is, therefore, useful to photograph him and recognize the habitual toxic patterns and tendencies of his personality, but the strategic operations to be implemented are to focus on the functional aspect of his personality (functional component), working on his resources, on the solutions attempted, on the vicious circles reproduced, on emotional literacy and awareness. On the basis of the classical models of strategic psychotherapy we have come to structure a specific model called "decagonal", consisting of ten steps: 1) reception of the client; 2) reception of the subjective narrative; 3) complete drafting of the personal and family history; 4) stipulation of the therapeutic contract; 5) delineation of the patient's psychological functioning; 6) identification of the patient's psychological functioning; 7) deconstruction of the dysfunctional components; 8) restructuring of the deconstructed components; 9) closure of the therapeutic path; 10) follow-up.

3. *Perrotta Defense Mechanisms (PDM)* [16,17]. Starting from the models of human psychological defense mechanisms by Perry-Vaillant, Gleser-Ihilevich, Bond, Haan, Plutchik, Carver, and Johnson-Gold, we came to propose a new model [91] that could respond in a more functional and structured way, taking into account the new personological rearrangement of the PICI and the new theory on human emotions PHEM. The new model consists of 24 different defense mechanisms, adaptive or maladaptive on the basis of subjective experience, capable of generating 87 subtypes (24 functional and 59 dysfunctional). On the basis of this new theorization, a specific questionnaire (PDM-Q) has been prepared in 24 questions on a scale of L0-5, able to investigate the patient's own defense mechanisms. The paradigm at the base of the questionnaire is therefore to work directly on the emotional states and on the emotional-behavioral reactions of the patient, in order to identify the individual mechanisms and their degree of the functioning or habitual dysfunction.

4. *Perrotta Human Emotions Model (PHEM)* [18,19]. It is a theoretical model that is based on the assumption that the "emotional states" (or emotions) are the basic modalities that our mind knows (and "installed" by default) thanks to which we are able to adapt to internal and external circumstances, while the "emotional-behavioral reactions" (or sentiments) are subjective emotional experiences lived by the person thanks to the interaction of basic emotions with anxiety, and/or with the combination of two or more basic emotions. In total, there are 2 emotional states (or basic emotions) that give rise to 150 first (14/150), second (42/150), and third-level (94/150) emotional-behavioral reactions (or sentiments), based on certain well-identified criteria. Referring to the PICI-2 model and the role of anxiety as an activator and/or neutral natural enhancer (and not as a basic emotion), the origin of all psychopathologies is to be found in the dysfunctional management of one or both basic emotions (anguish and pleasure) and not in anxiety itself: in fact, working in psychotherapy on basic emotions allows to unlock the anxiety and consequently the vicious circle that feeds the psychopathological condition. The paradigm at the base of PHEM is therefore to work directly on the emotional alphabet of the person and on the analysis of their emotions, to intervene indirectly on the anxiety that feeds and enhances the toxic, maladaptive, dysfunctional, and pathological pattern.

5. *Perrotta Psychotherapeutic Protocol for Disorders of the Neurotic Area (PPP-DNA)* [6] It is a protocol that insinuates itself into the seventh and eighth process (deconstruction and reconstruction of functioning) of the "Deca Model", according to an excellent

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constructivist and strategic approach. This protocol acts as a power "injector", able to orient the patient, according to a strategic language, towards the deconstruction of his dysfunctional processes and the consequent restructuring of the same. The PPP-DNA consists of 5 maneuvers (so-called "FGR" or "Five Golden Rules"), to be performed in the order indicated in a maximum number of ten sessions: a) identification of the problem that you want to solve; b) relaxation; c) analysis of your emotional state, concerning the problem; d) identification of solutions; e) cognitive-behavioral reorganization. For details see the text of the research. The basic assumption is two theoretical models, the first functional and the second dysfunctional:

a) the Perrotta Functional Senso-Perceptual-Emotional Model (PF-SPEM), consists of the following described 6-step scheme:

1) "Sensory phase", in which the subject, through the 5 senses, receives from the external environment the information that will then be processed during the perceptive phases.

2) "Primary perceptive phase or registration phase", in which the subject starts, through cognitive and neurobiological processes, to internally process the information captured by the 5 senses, according to a logic of sensory stimulation, synthetic-analytical elaboration, and perceptual rules of the Gestalt school. In this first phase, the external information is received and recorded in a serial way through memorization.

3) "Secondary perceptual or emotional phase", in which processing takes place through interpretation, i.e. according to one's own emotional language. Here, the information stored in short-term memory is processed on the basis of its emotional component (emotions and feelings).

4) "Tertiary or reactive perceptual phase", in which anxiety modulates the functional process of the emotional component to activate the ego's defense mechanisms.

5) "Quaternary or defensive perceptual phase", in which the Ego (through the "Super-Ego" function) activates defense mechanisms in reaction to the arrival of processed information.

6) "Restitutive or reactive or behavioral phase", in which there is the behavioral manifestation then externalized by the subject.

Sensation → Primary perception (mnemonic) → Secondary perception (emotional) → Tertiary perception (reactive or anxious) → Quaternary perception (defensive) → Emotional-behavioral reaction

b) il Neurotic Disease Area Model (NDAM) which consists of the following 6-step scheme [6]:

1) "Emotional phase", in which the processing takes place through the interpretation of the recorded information, i.e. according to one's own emotional language. Here, the information stored in short-term memory is processed on the basis of its own emotional component (emotions and feelings) which, if not structured in a functional way, can give rise to dysfunctional mechanisms at the basis of future psychopathologies (e.g. I hear a dog barking in the street by hearing and I geolocate it by sight but has suffered as child aggression with a bite on the leg, I can not dominate the anxiety that could happen again).

2) "Reactive phase", in which anxiety becomes a natural energetic activator of the system to amplify the dysfunctional process if the emotional component does not process the information correctly (eg anxiety of being bitten is so conditioning that it enhances anxiety leading to the subject to experience negative feelings such as fear, frustration, and terror, thus failing to rationalize and find solutions to the problem).

3) "Defensive phase", in which the Ego (through the "Super-Ego" function) activates defense mechanisms in reaction to a danger presumably considered as such, on the basis of the wrong emotional interpretation (e.g. in prenda to the anxiety and to the negative feelings that derive from it, such as fear, frustration, and terror, also the defense mechanisms of the Ego are conditioned by the excessive level of circulating anxiety).

4) "Restitutive or balancing phase", in which the ego (through the "Self" function) makes concrete efforts to restore the balance through "compensatory" mechanisms, such as avoidance (typical in phobias), compulsion (typical in obsessions), agitation (typical in manic states), hysterical attack (typical in anxiety disorders and even more in a panic) and fixation (typical in somatization); However, these mechanisms, if consolidated over time become pathological because they become the only valve for venting inner emotional tension (eg. in prey to anxiety and the negative feelings that arise, such as fear, frustration, and terror, the subject lives the avoidance or paralysis in prey to the potentially dangerous element).

5) "Restorative phase", in which the Ego, always through the Self uses specific emotional-reactive aggravating factors (such as phobias, obsessions, somatization, mania, and panic) in order to collapse the system and then "restart" it; however, these aggravating factors, if consolidated over time become pathological because they become the only way to vent the inner emotional tension (eg. in prey to anxiety and the negative feelings that arise from it, such as fear, frustration and terror, the subject lives the avoidance or paralysis in the grip of the potentially dangerous element whenever he will be in the presence

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of that specific negative stimulus, creating, in fact, a behavioral reinforcement that over time will lead him to shape his personality in the function of the specific psychopathological morbidity). Therefore: phobias, obsessions, manias, panic, and somatizations are all expressions of a dysfunctional alteration of one's basic emotionality, for the neurotic area, which on the subjective assumption, the person will generate one or rather the other disorder according to their experiences, inclinations and pathological predispositions.

6) "Confirmatory or repetitive phase", in which the subject tends to constantly repeat both the compensatory mechanism and the emotional-reactive aggravation, even if dysfunctional, at the base of the pathological condition diagnosed.

Anxiety → Negative emotional-behavioral reactions → Compensatory mechanisms (avoidance, compulsion, agitation, hysteria, and fixation) → Emotional-reactive aggravators (phobias, obsessions, mania, somatization, and panic) Repetitive confirmation of the toxic pattern

Materials and methods

Based on the first research [6] and always using the same theoretical models, the present research uses the individual clinical interview, consisting of the amnestic collection and administration of the PICI-2TA (Perrotta Integrative Clinical Interviews, version 2-TA) [7-13], PAD-Q (Perrotta Affective Dependency Questionnaire) [20-22], PSM-1 (Perrotta Sexual Matrix) [23] and PDM-Q (Perrotta Defence Mechanisms Questionnaire) [19], to each group of population.

This research, as in the previous one [6], addresses the topic of anxiety, phobic and obsessive disorders [24-35], for the 6 personality disorders of the neurotic area (anxious, somatic, phobic, obsessive, avoidant, and manic), according to the PICI-2 models, in order to confirm the starting hypothesis and the structuring in a complex form of the neurotic personality disorder.

The phases of the research were divided as follows

1. Selection of the population sample, based on the following inclusion criteria:

a) age between 18 years and 72 years;

b) residence or domicile on Italian territory for at least 5 years, regardless of nationality and/or citizenship;

c) well-defined male or female gender, regardless of sexual orientation;

d) absence of diagnosis of personality disorder type B and C of the PICI-2TA classifications or personality traits of those specific diagnoses (B/C types) in the number equal to or greater than four;

e) an affirmative answer to the following question: "Do you believe you suffer from a neurotic disorder, markedly anxious disorder?"

2. Individual clinical interview, consisting of anamnestic collection and administration of the PICI-2TA (Perrotta Integrative Clinical Interviews, version 2-TA), PAD-Q (Perrotta Affective Dependency Questionnaire), PSM-1 (Perrotta Sexual Matrix), and PDM-Q (Perrotta Defence Mechanisms Questionnaire), to each population group.

3. Post-administration data processing in relation to data obtained from clinical interviews and administration of all instruments used.

4. Selection of the population sample meeting the inclusion criteria of the research.

5. First clinical session.

6. Subsequent clinical sessions, in the maximum number of 10, could answer the final question subject of the study hypothesis: "Does the application of the PPP-DNA guarantee the alleviation or resolution of the neurotic symptomatology declared by the patient, within the tenth session?".

7. The final phase of the research: Results and conclusions.

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 Video call Whatsapp, both for the clinical interview and for the administration.

The present research work was carried out from July 2021 to January 2022 (7 months).

All participants were guaranteed anonymity and the ethical, moral, and clinical contents of the 1964 Declaration of Helsinki were respected.

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The main limitations of the research are: the instruments used to investigate personality (PICI-2, PAD-Q, PSM-1, PDM-Q) are not yet standardized psychometric instruments but proposed, despite the excellent results obtained and already published in international scientific journals.

This research has no funders and has no conflicts of interest.

In particular:

1. In the first phase of the research, the sample of the population that requested total participation (July 2021 - September 2021) was 326 individuals, 56 male, and 270 female, in relation to the request for collaboration in the research and who could answer the following clinical question: "Do you believe you suffer from a neurotic disorder, markedly anxious, in the absence of psychopathological diagnosis of the borderline or psychotic area?".

2. In the second phase of the research (September 2021), individual clinical interviews were conducted, consisting of anamnestic collection and administration of the PICI-2TA (Perrotta Integrative Clinical Interviews, version 2-TA), PAD-Q (Perrotta Affective Dependency Questionnaire), PSM-1 (Perrotta Sexual Matrix), and PDM-Q (Perrotta Defence Mechanisms Questionnaire), to each population group, in order to exclude all persons presenting at least 4 dysfunctional traits of the exclusionary disorders (clusters B and C of the PICI-2TA).

3. Post-administration data processing in relation to data obtained from clinical interviews and administration of all instruments used (October 2021).

4. Selection of the population sample meeting the research inclusion criteria (November 2021). The population sample finally selected is as follows: Of 326 people initially called, 318 people were found to be eligible for the research, of which 28 were male (15 aged 18-36 years, 8 aged 37-54 years, and 5 aged 55-72 years) and 290 were female (165 aged 18-36 years, 60 aged 37-54 years and 65 aged 55-72 years) [Table 1].

5. The clinical sessions, in the maximum number of 10, could answer the final question object of the study hypothesis (November 2021 - December 2021): "Does the application of the PPP-DNA guarantee the alleviation or resolution of the neurotic symptomatology declared by the patient, within the tenth session?". The PPP-DNA protocol was applied throughout the cycle of sessions.

Final Phase of Research: Results and Conclusions (December 2021 - January 2022).

Table 1: General population sample.

Gender of the sample population	*Bunds of age*	*Quantity per selected population sample*
Male	18-36	15
Male	37-54	8
Male	55-72	5
Female	18-36	165
Female	37-54	60
Female	55-72	65

Results

On the basis of the interviews carried out, the administration of the PICI-2 questionnaires (to highlight the dysfunctional personality picture), PAD-Q (to highlight any profiles linked to affective dependence), PSM-1 (to highlight any dysfunctional sexual conduct and more compatible with a cluster B and C of the PICI-2TA) and PDM-Q (to highlight the defense mechanisms usually used), and the application of the PPP-DNA protocol, in a strategic key according to the "Deca Model", the present research work, on a sample of 318 patients divided into 6 sub-samples, has shown the following [Table 2]:

1. In the male group, aged 18-36 years, there are 15 people, of whom 13 (86.7%) reacted to the complete resolution of the neurotic symptoms described between the fifth and tenth session, while only 2 (13.3%) said they felt their neurotic symptoms attenuated by at least 5 points out of 10 (>50%). These resistances to the complete resolution of symptoms are attributable to two main factors: unfavorable socio-environmental, work, and family conditions and the duration of neurotic symptoms for more than 2 years.

2. In the male group, aged 37-54 years, there are 8 people, of whom 7 (87.5%) reacted to the complete resolution of the neurotic symptomatology described between the fifth and tenth session, while only 1 (12.5%) stated that he felt his neurotic symptoms

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Table 2: PICI-2 Population sample.

Gender of the sample population	Bunds of age	Quantity per selected population sample	% Resolution or alleviation(> 50%) of symptoms in the number of sessions scheduled			
			No. Sessions	***No. / % Resolution***	***No. / % Alleviation***	***No. / % Failures***
Male	18-36	15	5	3(20%)	0(0%)	0(0%)
			6	3(20%)	0(0%)	0(0%)
			7	2(13%)	0(0%)	0(0%)
			8	2(13.3%)	0(0%)	0(0%)
			9	2(13.3%)	0(0%)	0(0%)
			10	1(6.8%)	2(13.3%)	0(0%)
Male	37-54	8	*No. Sessions*	*No. / % Resolution*	*No. / % Alleviation*	*No. / % Failures*
			5	1(12.5%)	0(0%)	0(0%)
			6	1(12.5%)	0(0%)	0(0%)
			7	1(12.5%)	0(0%)	0(0%)
			8	1(12.5%)	0(0%)	0(0%)
			9	1(12.5%)	0(0%)	0(0%)
			10	2(25%)	1(12.5%)	0(0%)
Male	55-72	5	*No. Sessions*	*No. / % Resolution*	*No. / % Alleviation*	*No. / % Failures*
			5	0(0%)	0(0%)	0(0%)
			6	0(0%)	0(0%)	0(0%)
			7	0(0%)	0(0%)	0(0%)
			8	0(0%)	0(0%)	0(0%)
			9	1(20%)	0(0%)	0(0%)
			10	2(40%)	2(40%)	0(0%)
Female	18-36	165	*No. Sessions*	*No. / % Resolution*	*No. / % Alleviation*	*No. / % Failures*
			5	12(7.3%)	0(0%)	0(0%)
			6	23(13.9%)	0(0%)	0(0%)
			7	31(18.7%)	0(0%)	0(0%)
			8	25(15.2%)	0(0%)	0(0%)
			9	44(26.6%)	0(0%)	0(0%)
			10	19(11.5%)	11(6.8%)	0(0%)
Female	37-54	60	*No. Sessions*	*No. / % Resolution*	*No. / % Alleviation*	*No. / % Failures*
			5	8(13.3%)	0(0%)	0(0%)
			6	9(15%)	0(0%)	0(0%)
			7	6(10%)	0(0%)	0(0%)
			8	10(16.7%)	0(0%)	0(0%)
			9	9(15%)	0(0%)	0(0%)
			10	15(25%)	3(5%)	0(0%)
Female	55-72	65	*No. Sessions*	*No. / % Resolution*	*No. / % Alleviation*	*No. / % Failures*
			5	8(12.3%)	0(0%)	0(0%)
			6	9(13.9%)	0(0%)	0(0%)
			7	6(9.2%)	0(0%)	0(0%)
			8	11(17%)	0(0%)	0(0%)
			9	9(13.9%)	0(0%)	0(0%)
			10	17(26.2%)	5(7.5%)	0(0%)

attenuated by at least 5 points out of 10 (>50%). These resistances to the complete resolution of symptoms are attributable to two main factors: unfavorable work and family conditions and the duration of neurotic symptoms for more than 2 years.

3. In the male group, aged 55-72 years, there are 5 people, of whom 3 (60%) reacted to the complete resolution of neurotic

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symptomatology described between the ninth and tenth sessions, while only 2 (40%) said they felt their neurotic symptoms attenuated by at least 5 points out of 10 (>50%). These resistances to the complete resolution of symptoms are attributable to two main factors: the unfavorable personal and family condition and the duration of neurotic symptoms for more than 2 years.

4. In the female group, aged 18-36 years, there are 165 people, of whom 154 (93.3%) reacted to the complete resolution of the neurotic symptomatology described between the fifth and ninth sessions, while only 11 (6.7%) stated that they felt their neurotic symptoms attenuated by at least 5 points out of 10 (>50%). These resistances to the complete resolution of symptoms are attributable to two main factors: unfavorable socio-environmental, work, and family conditions and the duration of neurotic symptoms for more than 2 years.

5. In the female group, aged 37-54 years, there are 60 people, of whom 57 (95%) reacted to the complete resolution of neurotic symptomatology described between the fifth and ninth session, while only 3 (5%) said they felt their neurotic symptoms attenuated by at least 5 points out of 10 (> 50%). These resistances to the complete resolution of symptoms are attributable to two main factors: unfavorable work and family conditions and the duration of neurotic symptoms for more than 2 years.

6. In the female group, aged 55-72 years, there are 65 people, of whom 60 (92.3%) reacted to the complete resolution of neurotic symptoms described between the fifth and ninth sessions, while only 5 (7.7%) said they felt that their neurotic symptoms attenuated by at least 5 points out of 10 (>50%). These resistances to the complete resolution of symptoms are attributable to two main factors: the unfavorable personal and family condition and the duration of neurotic symptoms for more than 2 years.

Discussion and limitations

According to the current model of the PICI, in its second version, the diagnosis of neurotic disorders is made by identifying one or more traits, which, if more than five for the same type, identify the disorder and its possible comorbidities, taking into account possible absorptions, as occurs especially in the case of anxiety personality disorder, which is automatically absorbed in the hypothesis of parity or inferiority of traits with manic disorder and all the other disorders of cluster B (borderline area) and C (psychotic area).

However, when the new nosographic category "neurotic personality disorder" is introduced, two main issues need to be clarified:

1. The relationship with other neurotic disorders. Unlike anxiety disorder, which is part of the neurotic structure and is to all intents and purposes a disorder that characterizes dysfunctional personality and can be absorbed by others (as is the case with manic disorder and disorders of clusters B and C), the neurotic disorder is synonymous with cluster A, since it is nosographically complex and encompasses several traits that are heterogeneous to each other (e.g., phobic and obsessive). Therefore, a neurotic personality disorder cannot and should not be considered a disorder on par with the others belonging to cluster A, but should be considered in itself as a synonym of cluster A, characterized than by the individual dysfunctional personality traits that may have been identified.

2. Relations with clusters B and C and possible absorption. If the neurotic personality disorder is not so much one of the disorders of cluster A but is itself cluster A, it can easily be related to all the other disorders of clusters B and C, remaining at the same level and without undergoing any absorption.

Taking up then the data obtained from the new research, and adhering to the starting hypothesis, it emerges that having anxiety absorbed by the manic disorder and by all the other disorders of cluster B and C creates a disparity of content since in clinical reality the anxious traits are those that paradoxically feed the whole psychopathological scaffolding in subjects with neurotic prevalence, and therefore by adhering to the diagnosis of the new nosography the problem is overcome, since the macro category "neurotic personality disorder" is preserved from possible absorption and remains in comorbidity with the other pictures of clusters b and c, remaining always differentiated in the diagnosis on the basis of traits and typologies.

Let's take three examples, starting from the previous diagnosis

a) A has 6 anxious, phobic, obsessive, 5 avoidants, and 4 manic traits. Diagnosis: Anxious-phobic-obsessive disorder, with avoidant and manic traits.

b) A has 6 anxious, phobic, obsessive, 5 avoidants, and 4 borderline traits. Diagnosis: Anxious-phobic-obsessive disorder, with avoidant and borderline traits.

c) A has 6 anxious, phobic, obsessive, and borderline traits, 5 avoidant, and 4 depressive traits. Diagnosis: Borderline-phobic-obsessive disorder, with avoidant and depressive traits (by absorbing the anxious disorder).

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Let us take three examples, with the new nosographic diagnosis of the neurotic area

a) A is a carrier of 6 anxious, phobic, obsessive, 5 avoidants, and 4 manic traits. Diagnosis: neurotic disorder markedly anxious, phobic, and obsessive, with avoidant and manic traits.

b) A has 6 anxious, phobic, obsessive, 5 avoidants, and 4 borderline traits. Neurotic disorder markedly anxious, phobic, and obsessive, with avoidant and borderline traits.

c) A has 6 anxious, phobic, obsessive, borderline, 5 avoidants, and 4 depressive features. Diagnosis: neurotic-borderline disorder markedly anxious-phobic-obsessive, with avoidant and depressive features.

In the first diagnostic hypothesis, there is labeling that grafts both the cluster A and cluster B pictures on the same level, thus allowing the absorption of the anxious features that are instead the main characteristic of a subject diagnosed as cluster A (neurotic). In the second hypothesis, on the contrary, the difference is maintained by indicating the expression "neurotic" more markedly. Thus, there is a different classification that better preserves the general picture of the patient.

Conclusion

The present research has demonstrated the validity of the PPP-DNA clinical protocol applied to neurotic disorders, both with the current nosography of PICI-2 and with the new nosographic hypothesis of "neurotic personality disorder", which represents a synonym of cluster A, being a complex diagnostic figure, but always characterized by the single dysfunctional traits eventually identified. Adherence to the new nosography does not, however, change the diagnosis of the traits made by the PICI-2, since in both cases the study is based on the presence of the single dysfunctional traits; it is only a question of better systematic organization in the diagnostic phase which, in this way, preserves and underlines the neurotic nature of a profile that would otherwise be relegated to the background despite the fact that dysfunctional anxiety is at the origin of the problem suffered. Adhering to one view or the other is not, therefore, a structural or functional error, but a different way of outlining the personality picture, which remains and will remain a trait-based diagnosis.

With a larger sample than in the first research [6], the result previously obtained was therefore confirmed. The study showed that the proposed protocol (PPP-DNA), for neurotic disorders, was effective in the total population sample of 85.8%, for the fractionated male population sample of 78.1%, and the fractionated female population sample of 93.5%, with a resistance to change identified in adverse conditions of family, environmental, socio-cultural and temporal type (of the duration of neurotic symptomatology), however able to promote an attenuation of the suffered symptomatology of at least 50%, noting the causes in the unfavorable work and family conditions and the duration of neurotic symptoms for more than 2 years, and continuing the psychotherapeutic course in a strategic and/or cognitive-behavioral key [36-40].

Although the sample is not representative, and this is the only limitation, the results obtained are extremely positive and give hope for an application on a sample much more appropriate and representative.

References

1. Perrotta G (2019) Psicologia clinica. I ed., Luxco Ed.
2. Perrotta G (2019) Psicologia dinamica. I ed., Luxco Ed.
3. APA (2013) DSM-V, Diagnostic and Statistical Manual of Mental Disorders, Fifth Ed.
4 PDM Task Force (2017) Psychodynamic Diagnostic Manual. Silver Spring, II ed., MD: Alliance of Psychoanalytic Organizations. **Link:** https://bit.ly/3ISQNDe
5. WHO Task Force (2018) ICD-11 - Mortality and Morbidity Statistics. Icd.who.int.
6. Perrotta G (2021) "Perrotta Psychotherapeutic Protocol for Disorder of the Neurotic Area (PPP-DNA)": proposal of protocol, profiles and clinical applications. Open J Trauma 5: 010-018. **Link:** https://bit.ly/38hqY31
7. Perrotta G (2020) The structural and functional concepts of personality: The new Integrative Psychodynamic Model (IPM), the new Psychodiagnostic Investigation Model (PIM) and the two clinical interviews for the analysis of personality disorders (Perrotta Integrative Clinical Interview or PICI) for adults and teenagers (1TA version) and children (1C version), Psychiatry Peertechz, E-book. **Link:** https://bit.ly/2SqQevV
8. Perrotta G (2020) *First revision of the Psychodiagnostic Investigation Model (PIM-1R) and elaboration proposal of a clinical interview for the analysis of personality disorders (Perrotta Integrative Clinical Interview or PICI-1) for adults. Teenagers and Children* Psychiatry Peertechz, E-book. **Link:** https://bit.ly/2MQe3dY
9. Perrotta G (2020) "Perrotta Integrative Clinical Interview (PICI-1)": Psychodiagnostic evidence and clinical profiles in relation to the MMPI-II. Ann Psychiatry Treatm 4: 062-069. **Link:** https://bit.ly/3tSdXVL
10. Perrotta G (2021) "Perrotta Integrative Clinical Interview" (PICI) for adults and teenagers (1TA version) and children (1C version): new theoretical models and practical integrations between the clinical and psychodynamic approach. Ann Psychiatry Treatm 5: 001-014. **Link:** https://bit.ly/3IUik7f

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11. Perrotta G (2021) Perrotta Integrative Clinical Interview (PICI-1): a new revision proposal for PICI-1TA. Two single cases. Glob J Medical Clin Case Rep 8: 041-049. **Link:** https://bit.ly/3Ny54sv

12. Perrotta G (2021) 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. Ann Psychiatry Treatm 5: 067-083. **Link:** https://bit.ly/3tSFarq

13. Perrotta G (2021) Perrotta Integrative Clinical Interviews (PICI-2), III ed., LK ed.

14. Perrotta G (2020) The strategic clinical model in psychotherapy: theoretical and practical profiles. J Addi Adol Behav 3: 5. **Link:** https://bit.ly/3aPMx9X

15. Perrotta G (2021) Strategic psychotherapy and the "decagonal model" in clinical practice. Ann Psychiatry Treatm 5: 028-035. **Link:** https://bit.ly/3tRwr98

16. Perrotta G (2020) *Human mechanisms of psychological defence: definition, historical and psychodynamic contexts, classifications and clinical profiles.* Int J Neurorehabilitation Eng 7: 1. **Link:** https://bit.ly/2L0I5dJ

17. Perrotta G (2021) "Perrotta Human Defense Mechanisms Questionnaire" (PDM-Q): The new psychodiagnostic tool to identify human psychological defense mechanisms and their clinical implications. Arch Depress Anxiety 7: 029-033. **Link:** https://bit.ly/35oOvOi

18. Perrotta G (2021) The "Human Emotions" and the "Perrotta Human Emotions Model" (PHEM): The new theoretical model. Historical, neurobiological and clinical profiles. Arch Depress Anxiety 7: 020-027. **Link:** https://bit.ly/3qRxWSF

19. Perrotta G (2021) "Perrotta Human Defense Mechanisms Questionnaire" (PDM-Q): The new psychodiagnostic tool to identify human psychological defense mechanisms and their clinical implications. Arch Depress Anxiety 7: 029-033. **Link:** https://bit.ly/3u30Ykx

20. Perrotta G (2020) Affective Dependence: from pathological affectivity to personality disorders. Definitions, clinical contexts, neurobiological profiles and clinical treatments. Health Sci 1: 1-7. **Link:** https://bit.ly/3qQBcO5

21. Perrotta G (2021) Perrotta Affective Dependence Questionnaire (PAD-Q): Psychodiagnostic evidence and clinical profiles. Int J Sex Reprod Health Care 4: 080-084. **Link:** https://bit.ly/3LtagMh

22. Perrotta G (2021) The diagnosis of personality traits in "affective dependency": when the toxic bond is an expression of a personality disorder. Research. Int J Sex Reprod Health Care 4: 085-090. **Link:** https://bit.ly/35tbo3k

23. Perrotta G (2021) Perrotta Individual Sexual Matrix Questionnaire (PSM-1). The new clinical questionnaire to investigate the main areas of the individual sexual matrix. Int J Sex Reprod Health Care 4: 013-021. **Link:** https://bit.ly/3oTua9o

24. Perrotta G (2019) Anxiety disorders: definitions, contexts, neural correlates and strategic therapy. J Neur Neurosci 6: 046. **Link:** https://bit.ly/2WSmiaT

25. Perrotta G (2019) Obsessive-Compulsive Disorder: definition, contexts, neural correlates and clinical strategies. Cientific Journal of Neurology 1: 08-16. **Link:** https://bit.ly/3pxNbNu

26. Perrotta G (2019) Tic disorder: definition, clinical contexts, differential diagnosis, neural correlates and therapeutic approaches. J Neurosci Rehab 2019: 1-6. **Link:** https://bit.ly/3wQSNcF

27. Perrotta G (2019) Neural correlates in eating disorders: Definition, contexts and clinical strategies. J Pub Health Catalog 2: 137-148. **Link:** https://bit.ly/3mWmf8s

28. Perrotta G (2019) Post-traumatic stress disorder: Definition, contexts, neural correlations and cognitive-behavioral therapy. J Pub Health Catalog 2: 40-47. **Link:** https://bit.ly/3rvaCc6

29. Perrotta G (2019) Sleep-wake disorders: Definition, contexts and neural correlations. J Neurol Psychol 7: 09. **Link:** https://bit.ly/3hoBiGO

30. Perrotta G (2019) Depressive disorders: Definitions, contexts, differential diagnosis, neural correlates and clinical strategies. Arch Depress Anxiety 5: 009-033. **Link:** https://bit.ly/2KADvDm

31. Perrotta G (2019) Panic disorder: definitions, contexts, neural correlates and clinical strategies. Current Trends in Clinical & Medical Sciences 1. **Link:** https://bit.ly/38IG6D5

32. Perrotta G (2021) Maladaptive stress: Theoretical, neurobiological and clinical profiles. Arch Depress Anxiety 7: 001-007. **Link:** https://bit.ly/3sDs39Y

33. Perrotta G (2019) Behavioral addiction disorder: definition, classifications, clinical contexts, neural correlates and clinical strategies. J Addi Adol Beh 2. **Link:** https://bit.ly/3rAT9ip

34. Perrotta G (2019) Delusions, paranoia and hallucinations: definitions, differences, clinical contexts and therapeutic approaches. Cientific Journal of Neurology (CJNE) 1: 22-28. **Link:** https://bit.ly/3ht2nKz

35. Perrotta G (2020) Suicidal risk: definition, contexts, differential diagnosis, neural correlates and clinical strategies. J Neuroscience Neurological Surgery 6: 114. **Link:** **Link:** https://bit.ly/3aMqcu5

36. Perrotta G (2020) Psychological trauma: definition, clinical contexts, neural correlations and therapeutic approaches. Curr Res Psychiatry Brain Disord: CRPBD-100006. **Link:** https://bit.ly/37UD3bz

37. Perrotta G (2019) The reality plan and the subjective construction of one's perception: the strategic theoretical model among sensations, perceptions, defence mechanisms, needs, personal constructs, beliefs system, social influences and systematic errors. J Clinical Research and Reports 1. **Link:** https://bit.ly/3b34baH

Citation: Perrotta G (2022) The new Dysfunctional Personality Model of the Anxiety Matrix (DPM-AM): "Neurotic Personality Disorder" (NPD). Ann Psychiatry Treatm 6(1): 001-012. DOI: https://dx.doi.org/10.17352/apt.000038

38. Perrotta G (2020) Dysfunctional attachment and psychopathological outcomes in childhood and adulthood. Open J Trauma 4: 012-021. **Link:** https://bit.ly/2Mi2ThB

39. Perrotta G (2020) The strategic clinical model in psychotherapy: theoretical and practical profiles. J Addi Adol Behav 3: 5. **Link:** https://bit.ly/3aPMx9X

40. Perrotta G (2020) Accepting "change" in psychotherapy: from consciousness to awareness. Journal of Addiction Research and Adolescent Behaviour 3. **Link:** https://bit.ly/36Vw80Q

Citation: Perrotta G (2022) The new Dysfunctional Personality Model of the Anxiety Matrix (DPM-AM): "Neurotic Personality Disorder" (NPD). Ann Psychiatry Treatm 6(1): 001-012. DOI: https://dx.doi.org/10.17352/apt.000038