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Research Article

The new Dysfunctional Personality Model of the Dramatic Matrix (DPM-DM) and the Psychotic Matrix (DPM-PM): "Dramatic Personality Disorder" (DPD) and "Psychotic Personality Disorder" (PPD)

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Abstract

According to the PICI model, there are six personality disorders in the neurotic area (anxious, phobic, obsessive, somatic, avoidant, and manic), and the diagnosis of psychopathological disorder is determined based on the persistence of certain dysfunctional traits present in the personality framework. Based on clinical experience and through the application of the IPM/PICI, Deca, PDM, PHEM and PPP-DNA models, it was found that all disorders in the neurotic area had anxiety traits in common and that symptoms of the six different disorders were often present in comorbidity. This assumption led to the hypothesis of a different and better way to group them into one all-encompassing category: "Neurotic Personality Disorder" (NPD). Based on this construct, it is suggested to perform the same nosographic operations for the other personality disorders, grouping 7 personality disorders (bipolar, depressive, borderline, histrionic, narcissistic, antisocial, psychopathic) from the psychopathological area related to Cluster B of DSM-5-TR and PICI-3 into "Dramatic Personality Disorder" (DPD) and 4 other personality disorders (delusional, paranoid, dissociative, schizophrenic spectrum) from the psychopathological area related to Cluster A of DSM-5-TR and Cluster C of PICI-3 into "Psychotic Personality Disorder" (PPD). This paper aims to suggest their use to facilitate psychopathological framing.

Keywords: neurotic personality disorder; anxiety; Panic; mania; obsession; compulsion; avoidance; phobia; dramatic personality disorder; bipolar; depressive; borderline; histrionic; narcissistic; antisocial; psychopathic; psychotic personality disorder; delirium; hallucination; paranoia; dissociation; pici-3

1.Introduction

The heterogeneous and intangible nature of psychiatric symptomatology has always generated problems of diagnostic certainty, in the absence of the use of biochemical laboratory parameters or instrumental examinations. To solve this clinical dilemma, already since the end of the first half of the last century, an attempt has been made to apply a rigid, nosographic approach in the classification of psychiatric disorders, so that a more objective diagnosis can be made, despite the limitations brought about by the rigidity of the method of investigation. Although diagnostic techniques have been perfected over the decades, including the use of validated psychometric instruments, several critical issues persist today that deserve attention. Currently, in psychiatry there are several classification methods, generally recognized by the scientific community, and the most widely used are the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) compiled by the American Psychiatric Association and the International Classification of Diseases (ICD-11) issued by the World Health Organization, in addition to the attempt made through the Psychodynamic Diagnostic Manual (PDM-II) of the International Psychoanalytical Association, with a clear psychoanalytic matrix. [1-5]

Based on the need for greater awareness of psychopathological diagnosis and based on 5 basic principles, underlying the "Integrated Psychodynamic Model" (IPM) and the "Perrotta Integrative Clinical Interviews" (PICI) [6-13], now in the third version (PICI-3) [14], the "Decagonal Model" (Deca-Model) [15-16], the "Perrotta Defense Mechanisms (PDM)" [17-18], now in second revised versioon [19], and

the "Perrotta Human Emotions Model" (PHEM) [20], now in second version [21], a new construct was identified that could reorganize the nosographic interpretation of neurotic area disorders, based on the "Perrotta Psychotherapeutic Protocol for Disorders of the Neurotic Area" (PPP-DNA). This new construct, crystallized in the "Dysfunctional Personality Theory of the Neurotic Matrix" (DPT-NM) and then in the corresponding model ("Dysfunctional Personality Model of the Neurotic Matrix", DPM-NM) was called "Neurotic Personality Disorder" (NPD) [22], with the characteristics of being able to distinguish between 6 specificities (Anxious, Phobic, Avoidant, Somatic, Obsessive and Manic) and several sub typicalities.

This construct, for the same needs, can also be extended to disorders not included in the neurotic area.

2. Dysfunctional Personality Model of the Dramatic Matrix (DPM-DM) and the Dramatic Matrix (DPD)

As with the neurotic model [22], a new restructuring of the individual types afferent to the dramatic area personality disorder is provided for the dramatic model (according to the DSM-5-TR) [23-103]. Based on the construct, below is the outline of the dysfunctional personality model that justifies the nosographic innovation of the matrix of "Dramatic Personality Disorder" (DPD) [**Table 1**].

Primary Disorder	***Type or Specifications (of traits)***	***Sub-types***	***Description***
Dramatic Personality Disorder	*Bipolar* [104]	Manic-depressive (or type I)	The subject has been suffering for more than 6 months from a manic-depressive condition, characterized by the alternation of medium-long cycles of manic and depressi-ve moods, capable of negatively impacting one or more complex spheres of his or her existence (personal, social, affective, work,...), with symptoms that do not sponta-neously regress and that worsen the quality of life.
		Manic-dysthymic (or type II)	The subject has been suffering for more than 6 months from a manic-dysthymic condition, characterized by alternating medium-long cycles of manic and dysthymic, capable of negatively impacting one or more complex spheres of his or her existence (personal, social, affective, work,...), with symptoms that do not spontaneously regress and that worsen the quality of life.
		Depressive-Hypomanic (or type III)	The subject has been suffering for more than 6 months from a hypomanic-depressive condition, characterized by alternating medium-long cycles of hypomanicity and depression, capable of negatively impacting one or more complex spheres of his or her existence (personal, social, affective, work,...), with symptoms that do not sponta-neously regress and that worsen the quality of life.
		Hypomanic - dysthymic (or type IV)	The subject has been suffering for more than 6 months from a hypomanic-dysthymic condition, characterized by alternating medium-long cycles of hypomanicity and dysthymia, capable of negatively impacting one or more complex spheres of his or her existence (personal, social, affective, work,...), with symptoms that do not sponta-neously regress and that worsen the quality of life.
		Mixed form (or type V)	The subject has been suffering for more than 6 months from a hypomanic-depressive condition, characterized by alternating medium-to-long cycles of mixed forms of manic/hypomanicity and depression/dysthymia, capable of negatively impacting one or more complex spheres of his or her existence (personal, social, affective, work,...), with symptoms that do not spontaneously regress and worsen the quality of life.
	Depressive [105-106]	Sub-clinical (or type I)	The person has been suffering from a potentially clinically interesting condition for less than 30 days, in which he or she manifests depressive symptoms but in a milder or less impactful form than depressive disorders (e.g., premen-strual dysphoria, occasional seasonal dysphoria, adjust-ment deficit, brief depressive episode of less than 30 days). This condition is capable of negatively impacting one or more complex spheres of his or her existence (personal, social, emotional, work,...), with

			symptoms that do not spontaneously regress and worsen the quality of life.
		Reactive (or type II)	The subject has been suffering for less than 12 months from a reactive or situational condition that results in depressive symptoms of clinical interest and stems from an adjustment disorder that has been active and unpro-cessed for at least 30 days (e.g., events during pregnancy, separation stressors or hypercontrol in postpartum, prolonged seasonal dysphoria, persistent bereavement with depressive symptoms for less than 1 year, mala-djustment to the traumatic event). This condition is capa-ble of negatively impacting one or more complex spheres of his or her existence (personal, social, emotional, work,...), with symptoms that do not spontaneously regress and worsen the quality of life.
		Dysthymic (or type III)	The subject has been suffering for less than 2 months from a dysthymic condition resulting in depressive symptoms of clinical interest. This condition is capable of negatively impacting one or more complex spheres of his or her existence (personal, social, affective, work,...), with symptoms that do not spontaneously regress and worsen the quality of life.
		Chronic or Major (or type IV)	The subject has been suffering for more than 2 months from a dysthymic condition resulting in depressive symptoms of clinical interest. This condition is capable of negatively impacting one or more complex spheres of his or her existence (personal, social, affective, work,...), with symptoms that do not spontaneously regress and worsen the quality of life.
		Mixed “typical” form (or type V)	They are conditions of clinical interest, with a specificity different from the pure forms of depressive conditions and depressive disorder. They have a wide negative impact on the patient's life, such that their functioning is impaired to a large extent and they cause psychophysical distress and malaise.
		Mixed “atypical” form (or type VI)	These are conditions of clinical interest, where the patient manifests depressive symptoms, without fully meeting all criteria or only the structural criterion, but at a more severe level than the subclinical form. They have an extensive negative impact on the patient's life, such that his or her functioning is impaired to a large extent and he or she perceives psychophysical distress and discomfort.
	Borderline [104, 107]	Unstable-impulsive (or type I)	The subject has been suffering for more than 6 months from a clinically relevant condition characterized by emotional instability, impulsivity, and irrational fear of being abandoned, forgotten, or betrayed (in the absence of psychotic symptoms). This condition involves one or more complex spheres of his or her existence (personal, family, social, work) and the symptoms do not sponta-neously regress, worsening the quality of life.
		Aggressive-explosive (or type II)	The person has been suffering for more than 6 months from a clinically relevant condition characterized by unwarranted fear for self or others (in the absence of psychotic symptoms) and marked explosive aggression, under circumstances that are not objectively justifiable. This condition involves one or more complex spheres of his or her existence (personal, family, social, work) and the symptoms do not spontaneously regress, worsening the quality of life.
		Emotional-humoral (or type III)	The person has been suffering from a clinically relevant condition for more than 6 months, characterized by a marked mood sensitivity that tends toward emotional fragility and need for attention, under circumstances that are not objectively justifiable. This condition involves one or more complex spheres

			of his or her existence (personal, family, social, work) and the symptoms do not sponta-neously regress, worsening the quality of life.
		Deflected (or type IV)	The subject has been suffering from a clinically relevant condition for more than 6 months, characterized by a marked mood sensitivity that tends toward emotional fragility, and a need for protection from the surrounding world, with a negative and deflected mood most of the time, in the absence of clinically relevant depressive symptoms. This condition involves one or more complex spheres of his or her existence (personal, family, social, work) and the symptoms do not spontaneously regress, worsening the quality of life.
		Fragmented (or type V)	The subject has had a clinically relevant condition for more than 6 months, characterized by marked mood sensitivity tending toward emotional fragmentation, in the absence of clinically relevant psychotic symptoms. The perceptual plane is distorted but without psychotic episodes. This condition involves one or more complex spheres of his or her existence (personal, family, social, work) and the symptoms do not spontaneously regress, worsening the quality of life.
		Mixed (or type VI)	The subject has been suffering for more than 6 months from a clinically relevant condition, characterized by a multitude of borderline features in the various typifi-cations, but without remaining marked on a specific one, for at least 5 years. Single brief episodes do not fall into the present category but are representations of overacti-vations in any case not exceeding 15-30 days. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the symp-toms do not regress spontaneously, worsening the quality of life.
	Histrionic [108]	Concentrator (or type I)	The subject has been suffering for more than 6 months from a clinically relevant condition characterized by the need to centralize attention on oneself, in the absence of psychotic symptoms (delusions) and the absence of narcissistic behavior (manipulation to the detriment of others for one's advantage). Reasons for need may vary according to personality profile and may depend on caretaking needs, more or less conscious simulations. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the symp-toms do not spontaneously regress, worsening the quality of life.
		Manipulative (or type II)	The subject has been suffering for more than 6 months from a clinically relevant condition characterized by the use of manipulation and lying, in the absence of psychotic symptoms (delusions) and in the absence of narcissistic behavior (manipulation to the detriment of others for one's advantage). This condition involves one or more complex spheres of his or her existence (personal, family, social, work) and the symptoms do not spontaneously regress, worsening the quality of life.
		Fascinator (or type III)	The subject has been suffering for more than 6 months from a clinically relevant condition characterized by the need to use one's oratorical, communicative, and intelle-ctual arts to charm, in the absence of psychotic symptoms (delusions) and the absence of narcissistic behavior (ma-nipulation to the detriment of others for one's advantage). This condition involves one or more complex spheres of his or her existence (personal, family, social, work) and the symptoms do not spontaneously regress, worsening the quality of life.

		Seductive (or type IV)	The person has been suffering for more than 6 months from a clinically relevant condition, characterized by a need to use his or her body and sense for personal advan-tage, in the absence of psychotic symptoms (delusions) and the absence of narcissistic behavior (manipulation to the detriment of others for one's advantage). This condi-tion involves one or more complex spheres of his or her existence (personal, family, social, work) and the symp-toms do not spontaneously regress, worsening the quality of life.
		Mixed form (or type V)	The subject has been suffering for more than 6 months from a clinically relevant condition, characterized by a variety of histrionic symptoms that cannot be attributed exclusively to one type, but always in the absence of psychotic symptoms (delusions) and narcissistic behavior (manipulation to the detriment of others for one's advan-tage). This condition involves one or more complex sphe-res of his existence (personal, family, social, work) and the symptoms do not spontaneously regress, worsening the quality of life.
	Narcissistic [109-110]	Infantilism (or type I)	The person exhibits childish attitudes and behaviors, relative to age and context, consisting of poor intellectual and emotional maturity. This condition involves one or more complex spheres of his or her existence (personal, family, social, work), leading to a deterioration in the quality of life.
		Selfishness (or type II)	The person exhibits selfish attitudes and behaviors, in comparison with social expectation, age and reference context, consisting of over-characterization of his own needs compared to those of the people around him. This condition involves one or more complex spheres of his existence (personal, family, social, work), leading to a worsening of the quality of life.
		Egocentrism (or type III)	The subject exhibits egocentric attitudes and behaviors, concerning social expectation, age and context of reference, consisting of over-characterization of his own needs for those of the people around him, to their detriment (to selfishness that is realized without the need to take advantage of others' subjective positions). This condition involves one or more complex spheres of his existence (personal, family, social, work), leading to a worsening of the quality of life.
		Narcissism-Overt (or type IV)	The subject has had a clinically relevant condition for more than 6 months and he presents egocentric attitudes and behaviors, concerning social expectation, age and context of reference, consisting of the use of active manipulation, the need to establish superficial and fun-ctional ties to obtain personal goals, to the detriment of others, needs for admiration and power, high self-esteem often unmotivated, arrogance and sense of superiority. This condition involves one or more complex spheres of his or her existence (personal, family, social, work), leading to a deterioration in the quality of life.
		Narcissism-Covert (or type V)	The subject has had a clinically relevant condition for more than 6 months and he presents egocentric attitudes and behaviors, concerning social expectation, age and context of reference, consisting of the use of passive-aggressive manipulation, the need to establish bonds of control and dependence, even fictitious ones, need for attention and reassurance, low self-esteem often unmoti-vated or feigned only to attract attention, use of grievance and guilt to obtain one's advantages. This condition involves one or more complex spheres of his or her existence (personal, family, social, work), leading to a worsening quality of life.

		Narcissism- Mixed (or type VI)	The subject presents egocentric attitudes and behaviors, concerning social expectation, age and reference context, consisting of both overt and covert narcissistic modes, without a specific predominance or exclusively related to situational overactivations. This condition involves one or more complex spheres of his or her existence (personal, family, social, work), leading to a worsening quality of life.
	Antisocial [111-112]	Deviant (or type I)	The subject manifests conduct in violation of social norms, which exposes him or her to the judgment of the relevant community. He tends to maintain a generally expected profile, even if he is considered by his environ-ment to be a rebel or a compliant person, without, howe-ver, violating any legal norms or of low value to the criminal system. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the consequences make the quality of life worse.
		Criminal (or type III)	The individual manifests conduct in violation of legal norms, which exposes him or her to the judgment of the relevant community and criminal sanctions of a punitive nature (economic and/or imprisonment of one's personal freedom). He fails to maintain a generally expected profile and is considered a criminal by his environment. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the conse-quences make the quality of life worse.
	Psychopathic [111-112]		The subject has been affected for more than 6 months by a constellation of specific affective, interpersonal, and behavioral characteristics, such as superficial charm, lack of empathy, the grandiosity of self, arrogance and haugh-tiness, need for continuous stimulation, pathological lying, manipulation use of violence, antisociality, beha-vioral dyscontrol, low tolerance of frustration with aggres-sive behavior in the face of criticism and failure, asso-ciated with high irritability and anger dysregulation, pro-miscuous sexual behavior, and early behavioral problems: all of which recall the instability of the borderline, the criminal behaviors of the antisocial, the fascination of the histrionic and the grandiosity of the narcissist, via the mood swings of the bipolar and the deflections of the depressed. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the consequences make the quality of life worse.
	Mixed form		The subject presents a constellation of symptoms remi-niscent of two or more types of disorders, but without having a specific characterization. Mixed forms are cha-racterized by being the result of two distinct profiles, unlike psychopathy, which has a multitude of symptoms but the predominance is antisociality and grandiosity, in essence, a narcissistic-antisocial condition with the pre-sence of borderline, bipolar and histrionic features. The multiplicity of symptoms may also involve the neurotic and/or psychotic spectrum.

Table 1: Dramatic Personality Disorder (DPD).

3. *Dysfunctional Personality Model of the Psychotic Matrix (DPM-PM) and the Psychotic Matrix (PPD)*

As with the neurotic model [22], a new restructuring of the individual types afferent to the psychotic area personality disorder is provided for the psychotic model (according to the DSM-5-TR) [113-127]. Based on the construct, below is the outline of the dysfunctional personality model that justifies the nosographic innovation of the matrix of "Psychotic Personality Disorder" (PPD) [**Table 2**]. For all types of the psychotic spectrum the specifiers are applicable [**Table 3**].

Primary Disorder	*Type or Specifications (of traits)*	*Sub-types*	*Description*
Psychotic Personality Disorder [128-130]	*Delusional*	-	The subject has been suffering for more than 1 month from a clinically relevant condition characterized by one or more false or erroneous beliefs held firmly, in the presence of a real stimulus and concerning facts existing in real life, even though there are ele-ments that disconfirm one's interpretation of reality. When the delirium becomes structured in a resistant form and occurs in the absence of any real external stimulus, coloring itself with myste-rious, magical, bizarre, extravagant scenarios devoid of any con-crete or realistic foothold (in the absence of hallucinations), and thus is not the mere exaggeration of a real or otherwise realistic fact, it assumes the designation of "paranoia". The content of the delirium may take a variety of forms and contents (e.g., somatic delirium, religious delirium, nihilistic delirium, persecutory deli-rium, love delirium, sexual delirium, megalomania, delirium of guilt or sin) but never must have a bizarre and/or extravagant orientation (e.g., paranormal phenomena and/or extrasensory powers), in the absence or presence of altered perceptual states. In no case should there be any hallucination phenomena (understood as false perception in the absence of a real stimulus), Otherwise, the schizophrenic spectrum hypothesis should be considered. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the symptoms do not sponta-neously regress, worsening the quality of life. The duration of less than 1 month, and it is not recurrent, defines the diagnosis of a "delusional episode or psychotic slip of the delusional type".
	Dissociative	Internal	The subject has been suffering for more than 1 month from a clinically relevant condition characterized by one or more disso-ciative episodes, related to experiences of depersonalization (understood as perceptions of disconnection from one's body or mental processes, as if one were observing one's life from the outside). The subject feels detached from body, mind, feelings and/or sensations. The subject may also report feeling out of reality or like an automaton, with no control over what he or she does or says, and may feel emotionally or physically numb. In these cases, the subject may describe himself as an outside observer of his own life, or as a "dead man walking". If he or she presents bizarre and/or extravagant content one must refer to the schizophrenic spectrum in diagnosis. If it presents hallucinatory phenomena one must refer, in diagnosis, to complicated internal dissociative disorder. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the symptoms do not regress spontaneously, worsening the quality of life. The duration of less than 1 month, and it is not recurrent, defines the diagnosis of a "depersonalizing dissociative episode or psychotic slip of the in-ternal dissociative type", complicated or not if there is the presence of hallucinations and there are no extremes for the diagnosis of schizophrenic spectrum.
		External	The subject has been suffering for more than 1 month from a clinically relevant condition characterized by one or more disso-ciative episodes, related to experiences of derealization (under-stood as perceptions of detachment from the surrounding environ-ment, including people and things, with a marked feeling of un-reality). If it presents bizarre and/or extravagant content, one must refer to the schizophrenic spectrum in diagnosis. If it presents hallucinatory phenomena one must refer, in diagnosis, to com-plicated external dissociative disorder. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the symptoms do not regress spontaneously, worsening the quality of life. The duration of less than 1 month, and it is not recurrent,

			defines the diagnosis of a "derealizing dissociative epi-sode or psychotic slip of the external dissociative type", compli-cated or not if there is the presence of hallucinations and there are no extremes for the diagnosis of schizophrenic spectrum.
		Mixed dissociative form	The subject has been suffering for more than 1 month from a clinically relevant condition characterized by a mixed form of the previously described symptoms related to internal and external dissociative disorders. This condition involves one or more com-plex spheres of his existence (personal, family, social, work) and the symptoms do not spontaneously regress, worsening the quality of life. A duration of less than 1 month defines the diagnosis of a "dissociative episode or psychotic slippage of dissociative type", complicated or not if there is the pre-sence of hallucinations and there are no extremes for the diagnosis of the schizophrenic spec-trum.
		Fragmentation of identity	The subject manifests a clinically relevant condition characterized by the presence of one or more personalities, with speech, tem-perament, and behavior patterns also different from those normally associated with the subject. Each personality may present specific functional and dysfunctional traits, and they should be studied individually. This condition involves one or more complex spheres of his or her existence (personal, family, social, work), and the symptoms do not regress spontaneously, worsening the quality of life. In this condition, there is no time limit for the manifestation of symptoms, and even a single event is assessable according to the pattern of psychotic personality disorder, dissociative type, and fragmentary subtype of identity.
	Schizophrenic spectrum	Schizoid	The subject has been manifesting for more than 1 month a cli-nically relevant condition characterized by a pervasive pattern of general detachment and disinterest in social relationships and a limited range of emotions in interpersonal relationships. Any delu-sional, paranoid, and/or dissociative content should be evaluated based on the complexity of the pathological form. The presence of hallucinations orients the diagnosis in pure subtype schizophrenic spectrum disorder. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the symptoms do not regress spontaneously, worsening the quality of life. Duration of less than 1 month defines the diagnosis of a "schizoid episode or schizoid-like psychotic slip".
		Schizotypical	The subject has been manifesting for more than 1 month a clinically relevant condition characterized by a pervasive pattern of intense distress and reduced capacity for close relationships, alterations in thinking and perceptions, and eccentric behavior. These patients often misinterpret daily episodes as having special meaning for them (ideas of reference). They may be superstitious or think they have special paranormal powers that enable them to perceive events before they happen or to read the minds of others. They may think that they have magical control over others, thin-king that they can cause other people to experience everyday events (e.g., feeding the dog), or that performing magical rituals can prevent harm (e.g., washing hands 3 times can prevent illness). Any delusional, paranoid, and/or dissociative content should be evaluated based on the complexity of the pathological form. The presence of hallucinations orients the diagnosis in pure subtype schizophrenic spectrum disorder. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the symptoms do not regress spontaneously, worsening the quality of life. The duration of less than 1 month defines the diagnosis of "schizotypal episode or psychotic slippage of schi-zotypal type".
		Schizoaffective	The subject has been manifesting for more than 1 month of a clinically relevant condition characterized by a pervasive pattern manifesting psychotic symptoms and marked humor of unipolar (manic/depressive) or bipolar type. The presence of hallucinations directs the diagnosis into pure

			subtype schizophrenic spectrum disorder. This condition involves one or more complex spheres of his existence (personal, family, social, work) and the symp-toms do not regress spontaneously, worsening the quality of life. The duration of less than 1 month defines the diagnosis of "schi-zoaffective episode or psychotic slip-page of schizoaffective type or mixed bipolar form complicated by psychotic symptoms".
		Pure (or Schizophrenia o Mixed form)	The subject has been manifesting for more than 1 month of a clinically relevant condition characterized by psychosis (loss of contact with reality), hallucinations (false perceptions), delu-sions/paranoia (false beliefs), disorganized language and behavior, flattening of affectivity (reduced emotional manifestations), cogni-tive deficits (impaired reasoning and problem-solving ability), and occupational and social malfunction. It represents the most severe form of psychotic disorder. This condition involves one or more complex spheres of existence (personal, family, social, occupa-tional) and symptoms do not spontaneously regress, worsening the quality of life. The duration of less than 1 month defines the diagnosis of an "episode of psychotic lability, with schizophrenic marking".
	Psychotic mixed form	-	The subject presents a constellation of symptoms reminiscent of two or more types of disorders, but without having a specific characterization. Mixed forms are characterized by being the result of two distinct profiles. The multiplicity of symptoms may also involve the neurotic and/or dramatic spectrum.

Table 2: Psychotic Personality Disorder (DPD).

Specifier	***Description***
Primary disorder	The symptomatology described by the patient or the patient's medical history is determined by the psychiatric illness and not by other secondary illnesses (e.g., dementia, cancer), drug use, or as a result of taking drugs that cause the symptoms.
Secondary disorder	The symptomatology described by the patient or the patient's medical history is not determined by the psychiatric illness but by other secondary illnesses (e.g., dementia, cancer), drug use, or as a result of taking drugs that cause the symptoms.
Short Episode	The psychotic episode, consisting mainly of one or more psychotic symptoms, has a total duration of less than or equal to 1 week, in continuous form.
Recurring Episodes	Psychotic episodes, consisting mainly of one or more psychotic symptoms, have a total duration of less than or equal to 1 month, even if not continuous.
Chronic episode	The psychotic episode, which consists mainly of one or more psychotic symptoms, has a total duration of more than 1 month, in continuous form.
Presence or absence of hallucinations	The patient has in his or her medical history one or more episodes, even if not continuous, of hallucinations, regardless of form and content.

Table 3: Specifiers of the “Psychotic Personality Disorder” (DPD).

4. Conclusion

This editorial completes the research work on the PPP-DNA clinical protocol of the nosographic hypothesis of "Neurotic Personality Disorder" (NPD), which is a synonym of cluster A according to the PICI model. According to what is reported in this publication, Cluster B of the same model can be named "Dramatic Personality Disorder" (DPD), while Cluster C can be named "Psychotic Personality Disorder" (PPD). Such new nosographies, with indications of the specific types and subtypes, have the task of facilitating the clinical interpretive process by encouraging a rationalization of structural and functional matrices (in dysfunctional terms) in psychodiagnostic terms. As was already the case with the research related to PPP-DNA and NPD, studies related to the diagnostic utility of these new nosographies are being carried out, using an adequate and representative population sample. Future perspectives will therefore be related to the confirmation or not of the usefulness and thus the possible reorganization of the PICI-3, as a questionnaire to investigate functional and dysfunctional personality traits, into a more evolved and rational version (PICI-4).

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