



Research Article

“Perrotta Psychotherapeutic Protocol for Disorders of the Neurotic Area” (PPP-DNA): Proposal of protocol, profiles and clinical applications. Research

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Abstract

Purpose: This research addresses the topic of anxiety, phobic and obsessive disorders. In this research, the theme is addressed to the psychopathological investigation of personalities, according to the PICI-2TA model (Perrotta Integrative Clinical Interviews, version 2-TA), the PAD-Q (Perrotta Affective Dependency Questionnaire), the PSM (Perrotta Sexual Matrix), the PDM-Q (Perrotta Defence Mechanisms Questionnaire) and the PHEM model (Perrotta Human Emotions Model), in order to design a direct and functional psychotherapeutic protocol to manage the psychopathological process in the shortest time possible, according to the principles of efficiency, effectiveness and economy, trying to reduce the symptomatology until the total regression by the fifth-tenth session.

Methods: Clinical interview and administration of the PICI-2, the PAD-Q, the PSM, and the PDM-Q.

Results: In the male group, aged 18-36 years, there were 8 people, of whom 6 (75%) reacted to the total resolution of the neurotic symptomatology described between the fifth and ninth sessions, while only 2 (25%) said they felt their neurotic symptoms had subsided. In the male group, aged 37-54 years, there are 5 people, of whom 4 (80%) reacted to the total resolution of neurotic symptomatology described between the fifth and ninth sessions. In the male group, aged 55-72 years, there were 6 people, of whom 4 (66.6%) reacted to the total resolution of neurotic symptoms described between the ninth and tenth sessions. In the female group, aged 18-36 years, there were 22 people, of whom 18 (82%) reacted to the total resolution of neurotic symptoms described between the fifth and ninth sessions. In the female group, aged 37-54 years, there were 13 people, of whom 9 (69.2%) reacted to the total resolution of neurotic symptoms described between the fifth and ninth session. In the female group, aged 55-72 years, there were 11 people, of whom 8 (72.7%) reacted to the total resolution of neurotic symptoms described between the fifth and ninth sessions.

Conclusions: The research showed that the PPP-DNA protocol, for neurotic disorders, was effective in the total population sample for 74.36%, for the fractionated male population sample for 73.86% and for the fractionated female population sample for 74.86%, with resistance to change identified in adverse conditions of family, environmental, socio-cultural and temporal type (of duration of neurotic symptomatology), however able to promote an attenuation of the symptomatology suffered by at least 50%.

Contents of the manuscript

Introduction and background

Starting from the general concepts of “anxiety” [1-4], understood as a psychic state characterized by intense perceptions capable of modifying the psychophysical state, “phobias” [1], understood as distressing fears with strong

pathological connotations, and “obsessions” [5], understood as serious and persistent worries that manifest themselves with ideas words and images persistent and pervasive, the present research takes up the theoretical basis of the models PICI-2 (Perrotta Integrative Clinical Interviews) [6-10] and PHEM (Perrotta Human Emotions Model) [11], in order to demonstrate the validity of the proposed protocol for patients



suffering from anxiety, phobic and obsessive states, comorbid dysfunctional and / or pathological.

PICI-2 [6-10] is a theoretical model that is based on the assumption that psychiatric disorders are all “personality disorders,” and that individual personality traits draw the psychopathological picture in its detail, both functionally (PICI-2FT) and dysfunctionally (PICI-1C for children and PICI-2TA for adolescents and adults).

PHEM [11] is a theoretical model that is based on the assumption that “emotional states” (or emotions) are the basic modes that our mind knows (and “installed” by default) by which we are able to adapt to internal and external circumstances, while “emotional-behavioral reactions” (or feelings) are subjective emotional experiences experienced by the person due 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 feelings), 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 (anxiety and pleasure) and not in anxiety itself: in fact, working in psychotherapy on basic emotions allows to unlock the anxiety (and not vice versa) 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.

In this sense:

- a) “Anxiety” becomes from “a psychic state characterized by intense perceptions capable of modifying the psychophysical state” to the activator par excellence, net of pathological descriptions. Generally, we discuss the role of dysfunctional anxiety in different psychopathological conditions and how it feeds them. Rarely, in the clinical setting, is the role of functional anxiety exalted, namely that mechanism of psychophysical activation that allows us to interact with the external and internal space through cognitive and adaptive activation: in fact, anxiety allows us to activate different cognitive processes, such as attention and perception; it allows us to react to external events according to adaptive mechanisms of attack-escape and emergence (in the presence of a threat or danger); it allows us to put in place emotional-behavioral reactions necessary for adaptation with the external environment; it allows us to trigger adaptive cardiovascular and neurovegetative body mechanisms. It becomes dysfunctional only when the Self (first ego function) is unable to manage primary emotions and these dysfunctionally hyperactivate the defense mechanisms managed by the Superego (second ego

function), favoring exaggerated reactions up to real chronic psychopathologies such as anxiety disorder and panic attacks. Therefore, in the proposed model, anxiety is not considered an emotion but returns to be that functional and adaptive mechanism, in itself neutral, consistent with neurobiological dictates, which allows adaptation to the environment, in essence, the power of the whole circuit that becomes a potentiator of dysfunctionality and maladjustment only if it is so the management of the specific basic emotion.

- b) the “*phobia*” becomes from “an anguished fear with a strong pathological connotation” to the basic assumption of “phobic personality disorder”, where fear (which is not an emotion but a feeling) is hyperintensified becoming in fact a real personification.
- c) the “*obsession*” becomes from “serious and persistent concerns that are manifested with persistent and pervasive ideas, words and images” to the basic assumption of “obsessive personality disorder”, where the obsessive manifestation is the body’s reaction to manage the excessive burden of anxiety, amplified by the dysfunctional management of the basic emotion (which in this case is anxiety).

In fact, the “*Pathological scheme of the neurotic area*” is reconstructed as follows:

- 1) **Emotional phase:** Dysfunctional management of the basic emotion (distress or pleasure, according to the PHEM model), managed by the Self (first function of the Ego, according to the PICI-2 model), condition the level of anxiety.
- 2) **Reactive phase:** Anxiety, as an activator of the functional processes of the Ego (through the Self and the Superego, according to the PICI-2 and PHEM models), actually prevents the proper functioning of the Superego (second function of the Ego, according to the PICI-2 model), precisely because the energy level is dysfunctional and not adaptive to the internal and/or external needs. Whether it may be lower or higher, this level is inadequate and causes the Super-Ego to hyporeact or hypereact, which is responsible for the activation of defense mechanisms [12].
- 3) **Defensive phase:** The dysfunctional activation of defense mechanisms thus conditions the entire perceptual and reworking process, giving rise to a series of emotional-behavioral reactions that are inadequate with respect to the need for external stimuli. Certain defense mechanisms will intervene, according to the PDM-Q model, in a dysfunctional way, thus causing reactions that the internal and external environment could live as maladaptive and disturbing for the balance of the general system.
- 4) **Balancing phase:** The Ego, again through its “Super-Ego” function, will try to secondarily balance the responses received from the first dysfunctional process



(“Emotional dysfunction - Anxiety - Self - Super-Ego”), relatively to the defense mechanisms) using some compensatory mechanisms to lower the levels of anxiety too high. These secondary, automatic, unconscious compensatory mechanisms, which are used by the Ego (via the Superego) to temporarily bring the emotional system back to an acceptable level, are:

- a) **Avoidance:** Using the phobic mental projections, the ego intensifies the emotion of anxiety, the system collapses and triggers avoidance as a compensatory mechanism capable of lowering the level of anxiety to an acceptable and tolerable threshold.
- b) **Compulsion:** Using the obsessive mental projections, the ego intensifies the emotion of anxiety, the system collapses and triggers the compulsion as a compensatory mechanism able to lower the level of anxiety to an acceptable and tolerable threshold.
- c) **Agitation:** Using the manic mental projections, the ego intensifies the emotion of anxiety, the system collapses and triggers the frenetic agitation or agitation as a compensatory mechanism able to lower the level of anxiety to an acceptable and tolerable threshold.
- d) **Hysterical attack:** Using the mental projections from panic, the ego intensifies the emotion of anxiety, the system collapses and triggers the hysterical attack as a compensatory mechanism able to lower the level of anxiety to an acceptable and tolerable threshold.
- e) **Fixation:** Using the somatizing mental projections, the ego intensifies the emotion of anxiety, the system collapses and triggers the fixation as a compensatory mechanism able to lower the level of anxiety to an acceptable and tolerable threshold.

5) **Restorative phase:** The Ego Through these “emotional aggravating factors” (phobias, obsessions, manias, panic and somatization), the Ego manages to collapse the system to such an extent as to bring it back to the conditions of balance (avoidance, compulsion, frenzied action or agitation, hysterical attack and fixation), albeit temporarily, as these remedies bring only for a short period of time serenity and peace, with the function of “valve” of release; However, if the emotional dysfunctionality with respect to the basic emotions continues, the pathological process will be repeated over time and reinforced through external events (for example, the belief that the attempted solution found solves the problem immediately), which will generate over time the personality disorders of the neurotic area.

Phobias, obsessions, mania, panic and somatization 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. Also according to the PICI-2 model, the depressive and bipolar disorder are considered disorders of cluster B (Borderline) and not cluster A (neurotic)

and therefore to be addressed require a different protocol than the present one, because their mechanism is partially different, as well as for psychotic disorders of cluster C.

Research objectives, methods, limits and conflicts of interest

This research addresses the topic of anxiety, phobic and obsessive disorders [13–20], for the 6 personality disorders of the neurotic area (anxiety, somatic, phobic, obsessive, avoidant and manic), according to the PICI-2 and PHEM models, in order to design a direct and functional psychotherapeutic protocol to manage the psychopathological process in the shortest possible time, according to the principles of efficiency (organized clinical intervention), effectiveness (clinical intervention aimed at improving the symptoms, until the complete resolution) and cost-effectiveness (positive and effective results in the shortest possible time), trying to reduce the symptoms until the total regression within the fifth–tenth clinical session.

The phases of the research were divided as follows:

- 1) Selection of the population sample, in relation to the request for collaboration in the research, 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 borderline or psychotic area?”
- 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, that 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) Final research phase: Results and conclusions.

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

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 [6-10,21-23].

Setting and participants

The requirements decided for the selection of the sample population are:

- 1) Age between 18 years and 72 years.
- 2) Residence or domicile on Italian territory for at least 5 year, regardless of nationality and/or citizenship.
- 3) Well-defined male or female gender, regardless of sexual orientation.
- 4) 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 [1,5,24].

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 September 2019 to July 2021 (23 months).

In particular:

- 1) In the first phase of the research, the sample of the population that requested in total to participate (September 2019 - December 2019) was 834 individuals, 170 male and 664 female, in relation to the request for collaboration in the research and who could answer the following clinical question: "Do you believe that you suffer from a neurotic disorder, markedly anxious, in the absence of psychopathological diagnosis of borderline or psychotic area?".
- 2) In the second phase of the research (January 2020 - December 2020), individual clinical interviews, 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 individuals with at least 4 dysfunctional traits of the exclusionary disorders (clusters B and C of the PICI-2TA) [25-51].
- 3) Post-administration data processing related to data obtained from clinical interviews and administration of all instruments used (January 2021).
- 4) Selection of the population sample meeting the research inclusion criteria (January 2021). The population sample finally selected is as follows: Out of 834 people initially convened, only 65 people were found to be eligible for

the research, of which 19 were male (8 aged 18-36 years, 5 aged 37-54 years and 6 aged 55-72 years) and 46 were female (22 aged 18-36 years, 13 aged 37-54 years and 11 aged 55-72 years). [Table 1].

5) First clinical session (February 2021).

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

7) Final Research Phase: Results and Conclusions (July 2021).

PPP-DNA: the protocol

The "Perrotta Psychotherapeutic Protocol for Disorders of the Neurotic Area" (PPP-DNA) is a protocol that insinuates itself into the seventh and eighth processes (deconstruction and reconstruction of functioning) of the "Deca Model" [52], according to an optimal constructivist and strategic [53,54].

This protocol acts as a power "injector", able to orient the patient, according to a strategic language, towards the deconstruction of his own 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 the maximum number of sessions of 10. Beginning the process with the first maneuver, the subsequent ones will be ordered in a progressive manner and if performed correctly, the patient will always proceed to the next maneuvers. Otherwise, the therapist will have to go back to the previous maneuver to rework in a more complete way what is required by the specific task. Let's see them individually:

1) "First maneuver": Identification of the problem you wish to solve. In the clinical session, in the previous steps of the "Deca Model", the patient has already narrated the problem that he cannot solve. With this first maneuver, the patient is asked to focus on the problem in detail and to make three corrections, based on the neuroprogrammable school [55,56].

a) *Personification*: The patient is asked to identify the problem by giving it a physical and bodily connotation,

Table 1: General population sample.

Gender of the sample population	Bands of age	Quantity per selected population sample
Male	18-36	8
Male	37-54	5
Male	55-72	6
Female	18-36	22
Female	37-54	13
Female	55-72	11

according to imagination. Basically, he is asked to “see the problem” and describe it according to a color and a smell and then to describe it according to where he sees/feels it on his body (kinaesthetic level); then, describe where he physically sees it, how far away from it it is, how big it is and how heavy it is (physical level). At this level of mental abstraction there will be an increase in distressing emotion and therefore the therapist must reassure the patient that the object is not real and that he can manipulate it as he is told.

- b) **Packaging:** The patient is asked to place between himself and the personified object a wall or something that in his opinion can get in the way, in order to temporarily remove its presence. The patient knows that it exists and it is there but it is not a current and imminent danger for him.
- c) **Detachment:** The patient is asked to modify the characteristics of the object in order to be able to physically move it from inside himself to outside or on a different dimensional plane, so that it is no longer possible to perceive its negative characteristics, although it continues to exist.

2) **“Second maneuver”:** *relaxation* [57-59]: The patient has, in the clinical session, identified the problem to be addressed and has found with the therapist the line to follow; however, his interpretation of reality [60] prevents change because it continuously generates interpretative errors, self-deception, vicious circles and attempted dysfunctional and redundant solutions. In the first maneuver, the patient performed an embodiment, a packaging and a disconnection of the problem that is now more manageable but still exists. The patient, in this second maneuver, must then enter a state of relaxation, so that they can relax from the mental effort performed in the first maneuver. In this phase, then, the patient must proceed with the implementation of relaxation techniques for 10 minutes, aimed at muscular and mental relaxation. Relaxation is a state of calm and tranquility on a physical and mental level. However, it is a state of alertness and not of numbness, typical of when we are getting sleepy on the couch or on the train. Neither should it be confused with rest or sleep that bring with them altered states of consciousness. The human body has two systems that regulate the activation of the entire organism. The orthosympathetic system and the parasympathetic system. The orthosympathetic system is the accelerator. It was used to make us able to fight or run away from predators. It is able to energize with a complex chain reaction that releases neurotransmitters and hormones that prepare the body for action. Releases adrenaline and increases heart rate. It moves blood from the digestive system to the muscles because in threatening situations it is more important that the muscles are functioning than the stomach and intestines. There are many other changes that the body goes through and they are all aimed at preparing to escape or fight. In fact, this is also referred to as the “attack/escape reaction”. The parasympathetic system, on the other hand, is the brake. It decreases heart rate, promotes digestive processes at the expense of muscle reactivity, reduces respiratory rate, and other psychophysical implications. These

modifications serve to conserve and recover energy in the absence of threats. Relaxing effectively involves knowing how to apply specific methods, such as:

- a) **Progressive muscle relaxation** (Jacobson): This technique involves training to perceive tension and subsequent muscle relaxation with specific exercises. The exercises involve isolating the muscles of the body and training them one by one in succession. People always keep their muscles tense (as an unconscious reaction) without realizing it. This training teaches you to become aware of it and learn to relax your muscles completely.
- b) **Autogenic training** (Schultz): This is a technique that is based on imagination. Historically it was born as a form of self-hypnosis; the author in fact claimed that people were able to induce states of calm and relaxation in themselves. In the initial phase of the training prevails a suggestion caused by the psychologist who leads it. Then, little by little, autosuggestion is introduced. Instructions are given to perceive heaviness in different parts of the body and to imagine being calm.
- c) **Ericksonian hypnosis:** This is a very directive technique that usually requires a person to hypnotize, although it is possible to self-hypnotize. Hypnosis uses suggestion techniques that involve the judicious use of words, tone of voice, and sometimes even leading one to fixate on a point or vividly imagine certain scenes. Through these means a sleep-like state can be induced, where consciousness is altered and can work on both the body and the mind itself.
- d) **Meditation:** It has been studied and used in psychology since the 1970s even though it has very ancient origins from the Far East. An evolved form of meditation integrated with the knowledge of cognitive psychology and neuroscience is called “mindfulness”. Mindfulness, however, is not a simple relaxation technique but a more complex technique with greater benefits. Benson taught the relaxation response to his clients, a technique derived from meditations using mantra repetition. This very simple technique involves the following steps: sit comfortably; close your eyes; relax the muscles of the body starting from the feet and moving up to the face; breathe through the nose using diaphragmatic breathing; each time you exhale (let the air out) you must say (or think) “OM” (letting the M continue for 3-5 seconds) and repeat it for 10 minutes.

These techniques can also be recombined with each other, as long as the ultimate goal is to promote the total relaxation of the person, to prepare him for the following maneuvers.

3) **“Third maneuver”:** *Analysis of one’s own emotional state, in relation to the problem.* The patient, having returned from the state of relaxation, begins to rework his emotional content on the basis of the PHEM model, addressing his experience in a binary and emotional key: anxiety/pleasure. The patient, with the help of the therapist, must reread the problem in an emotional key, eliminating any influence or belief on his



own state of psychic health or on his own level of anxiety: what matters, in this phase, is that the patient reasons in an emotional key in order to reconstruct exactly the emotional path he takes to get to the activation of defense mechanisms, starting therefore from the two basic emotions: anxiety and pleasure. Once the emotional pathway has been identified, and therefore the emotional states and reactions (emotions and feelings), the patient must unravel his self-deceptions, fully understanding his attempted solutions and where the mechanism has jammed. If the mechanism of recognition, deconstruction and reconstruction is difficult or resistant, due to the patient's lack of awareness or strong internal resistance, the therapist may use the "Technique of emotional state management" [61], of the NLP school (remodeled by the writer), which consists of the following procedure:

- a) deep breathing, comfortable position of the patient and closed eyes;
- b) recognition by the patient of the problem to be solved;
- c) identification of the keyword that identifies the problem for the patient;
- d) ask the patient to choose the right shoulder or the left shoulder, in order to position the hand (of the same side, e.g., the right hand on the right shoulder) where it will "rest" on the identified problem (negative anchoring phase);
- e) ask the patient to lower his hand and answer the question "how do you feel?", in an emotional key, also giving a value from 0 to 10;
- f) ask the patient to imagine themselves without the problem and describe their emotional state in its absence;
- g) ask the patient for a particularly good moment in her life when she felt as she did in point f). Find the most appropriate, positive, functional moment that has a higher value than the one stated in point e) and ask the patient to rest the opposite hand used in point d) (e.g., that is, the left hand in the left shoulder) while thinking about that positive moment. At this moment, the left shoulder has become the support of the positive emotion (positive anchoring phase). Ask him/her for the value from 0 to 10 of the positive moment;
- h) ask the patient to take 5 deep breaths, always keeping the eyes closed;
- i) distract the patient, always with eyes closed, with a question completely external to the process (e.g., "What are you going to have for lunch?");
- j) ask the patient to open their eyes and take 5 deep breaths;
- l) with eyes open, invite the patient to put the right hand (the positive one) on the left shoulder (the negative one), asking to imagine that all the negative is absorbed and disintegrated, with the simple touch of the hand (integrative phase)

m) always with eyes open, ask the patient to describe his emotional state in this moment, giving a positive value from 0 to 10. If it should be low (equal to or less than 7) or negative, the process is repeated from point g), until the positive result.

4) **"Fourth Maneuver"**: *Focusing on possible solutions*. The patient, functionally anchored in his emotional alphabet, as deconstructed and reconstructed, now reworks the problem in a strategic key, identifying at least 3 solutions that are real, concretely, effectively and do not clash with his resistance to change. The solutions identified can be applied by the patient, from time to time, in the form of functional and adaptive strategies, to solve the problem when it reoccurs. The longer the problem has been present, the more difficult it will be for the patient to eradicate it completely; therefore, only the constant application of the new emotional alphabet, rationalization as a mental procedure, and positive reinforcements (or corrective emotional experiences) will be able to produce resistant and consistent results over time.

5) **"Fifth Maneuver"**: *Cognitive-Behavioral Readjustment*. The patient is invited to describe his problem emotionally and according to the solutions found. He is invited to rationalize the mental processes and disengage from his previous dysfunctional beliefs or ideas, in order to favor the permanence of the new graft. Several techniques can be suggested for accomplishing this maneuver, such as journaling and constant mental repetition. Follow-up meetings are suggested biweekly for the first month and then monthly for the first semester, unless otherwise indicated to be evaluated on a case by case basis and different needs of the patient.

Results

On the basis of the interviews carried out, of 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 65 patients divided into 6 sub-samples, has shown the following (Table 2):

1) in the male group, aged 18-36 years, there are 8 people, of whom 6 (75%) reacted to the complete resolution of the neurotic symptomatology described between the fifth and the ninth session, while only 2 (25%) 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: the 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 5 people, of whom 4 (80%) have reacted to the complete resolution of neurotic symptoms described between the fifth and ninth session, while only 1 (20%) said they felt attenuated neurotic



Table 2: PICI-2 Population sample.

Gender of the Sample Population	Bunds of age	Quantity for 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	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	2 (25%)	0 (0%)	0 (0%)
			8	1 (12.5%)	0 (0%)	0 (0%)
			9	1 (12.5%)	0 (0%)	0 (0%)
Male	37-54	5	No. Sessions	No. / % Resolution	No. / % Alleviation	No. / % Failures
			5	1 (20%)	0 (0%)	0 (0%)
			6	1 (20%)	0 (0%)	0 (0%)
			7	1 (20%)	0 (0%)	0 (0%)
			8	1 (20%)	0 (0%)	0 (0%)
			9	0 (0%)	0 (0%)	0 (0%)
Male	55-72	6	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	2 (33.3%)	0 (0%)	0 (0%)
Female	18-36	22	No. Sessions	No. / % Resolution	No. / % Alleviation	No. / % Failures
			5	1 (4.5%)	0 (0%)	0 (0%)
			6	2 (9%)	0 (0%)	0 (0%)
			7	2 (9%)	0 (0%)	0 (0%)
			8	3 (13.5%)	0 (0%)	0 (0%)
			9	4 (18%)	0 (0%)	0 (0%)
Female	37-54	13	No. Sessions	No. / % Resolution	No. / % Alleviation	No. / % Failures
			5	0 (0%)	0 (0%)	0 (0%)
			6	1 (7.7%)	0 (0%)	0 (0%)
			7	1 (7.7%)	0 (0%)	0 (0%)
			8	2 (15.4%)	0 (0%)	0 (0%)
			9	2 (15.4%)	0 (0%)	0 (0%)
Female	55-72	11	No. Sessions	No. / % Resolution	No. / % Alleviation	No. / % Failures
			5	0 (0%)	0 (0%)	0 (0%)
			6	1 (9.1%)	0 (0%)	0 (0%)
			7	1 (9.1%)	0 (0%)	0 (0%)
			8	1 (9.1%)	0 (0%)	0 (0%)
			9	2 (18.2%)	0 (0%)	0 (0%)
			10	3 (27.3%)	3 (27.3%)	0 (0%)

symptoms of at least 5 points out of 10 (> 50%). These resistances to the complete resolution of symptoms are attributable to two main factors: the 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 6 people, of whom 4 (66.6%) have reacted to the complete resolution of neurotic symptoms described between the ninth and tenth session, while only 2 (33.3%) said they felt their neurotic symptoms alleviated 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 22 people, of whom 18 (82%) have reacted to the complete resolution of neurotic symptoms described between the fifth and ninth session, while only 4 (18%) said they felt attenuated neurotic symptoms of at least 5 points out of 10 (> 50%). These resistances to the complete resolution of symptoms are attributable to two main factors: the 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 13 people, of whom 9 (69.2%) have reacted to the complete resolution of neurotic symptoms described between the fifth and ninth session, while only 4 (30.8%) said they felt attenuated neurotic symptoms of at least 5 points out of 10 (> 50%).



These resistances to the complete resolution of symptoms are attributable to two main factors: the 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 11 people, of whom 8 (72.7%) have reacted to the complete resolution of neurotic symptoms described between the fifth and ninth session, while only 3 (27.3%) said they felt attenuated neurotic symptoms of at least 5 points out of 10 (> 50%). These resistances to complete resolution of symptoms are attributable to two main factors: unfavorable personal and family circumstances and the duration of neurotic symptoms for more than 2 years.

Conclusions

This research has shown that the proposed protocol (PPP-DNA), for neurotic disorders, was effective in the total population sample for 74.36%, for the fractionated male population sample for 73.86% and for the fractionated female population sample for 74.86%, with a resistance to change identified in adverse conditions of family, environmental, socio-cultural and temporal type (duration of neurotic symptoms), however, able to promote an attenuation of symptoms suffered by at least 50%. Although the sample is not representative, the results obtained are extremely positive and give hope for an application on a sample much more appropriate and representative.

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