Redefining personality disorder: a Jamaican perspective

Frederick W. Hickling¹ and Vanessa Paisley¹

Objective. To characterize and assess the factor structure of phenomenological features of DSM-IV personality disorder diagnosis in Jamaican patients and determine any similarities with those of traditional criteria, associations with disorder severity, and/or significant relationships between variables to inform the current debate on the relevance of established personality disorder diagnostics.

Methods. This was a case-control study. All the patients included were seen by one private psychiatric practice from 1974 to 2007. The study sample group (n = 351) were patients diagnosed with a personality disorder (DSM-IV Axis II). The control group was composed of patients with DSM-IV Axis I clinical disorders, who had not been diagnosed with a personality disorder, and matched exactly on gender, and closely on age, as well as socioeconomic variables.

Results. Of the 351 individuals in the study sample group, 166 (47.3%) were male and 185 (53.7%) were female; 50 (14.2%) were white and 301 (85.8%) were black; 293 (83.5%) were born and raised in Jamaica; and 202 (57.6%) were from socioeconomic classes I and II. Mean age was 33.92 (standard deviation 10.236). Disaggregating the phenomenology, the conventional DSM-IV personality disorder diagnoses disappeared. Factor analysis of 38 clinical phenomena identified five components: psychosis, major depression, power management problems, psychosexual issues, and physiological dependency. Independent t-tests revealed patients without personality disorder had significantly higher mean scores for psychosis; both groups scored equally for depression; and those with personality disorder had significantly higher mean scores on the remaining factors. Analysis of variance indicated these factors differed significantly for three levels of severity (mild, moderate, and severe).

Conclusions. The phenomenology clustering into three major groups suggested an Axis I (clinical) diagnostic disorder of impulse control and authority and conflict management.

Keywords. Personality disorders; Jamaica.

ABSTRACT

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personality traits of Western cultures are not appropriate in or transferable to Eastern cultures (8), underscoring the difficulty in using “one-size-fits-all” criteria to classify personality. The recognition that personality dimensions and traits may differ from one culture to another has made the reformulation of the classification of personality disorders a priority for DSM-V (9).

The work of Walton et al. (1970) (10) challenged the conceptualization of personality disorder as being separate from mental illness by acknowledging the repeated co-occurrence and association between psychiatric illnesses and personality deviations, and the influence of personality deviations on prognosis. A pilot study using Walton’s perspective was carried out from 1974 to 1980 in Jamaicans diagnosed with DSM-III personality disorder. The phenomenological features of personality disorder diagnoses were disaggregated and then re-aggregated through statistical analysis. The results indicated three distinct clusters, forming a clinical triad of abnormal thoughts, feelings, and actions manifested as 1) power management and authority problems; 2) dependency issues (psychological and physiological); and 3) psychosexual problems (11). The current study expands on this pilot study using a larger cohort of patients seen over a period of 33 years.

The objective of the current study was to characterize and assess the factor structure of phenomenological features of the DSM-IV diagnosis of personality disorder in Jamaican patients and determine 1) any similarities with those of the personality disorder features and categories outlined in the DSM-IV; 2) associations with disorder severity, as conceptualized in Walton’s research; and/or 3) significant relationships between these variables to help inform the current debate on the relevance of established personality disorder diagnostics.

**MATERIALS AND METHODS**

This research was a case-control study. Cases were obtained from the naturalistic clinical setting of a private psychiatric practice in Kingston, Jamaica.

**Sample**

The study sample group included all patients seen by one private psychiatric practice from 1974 to 2007 and diagnosed as having an Axis II personality disorder based on 1) the criteria of the DSM-III, the revised DSM-III (DSM-III-R), and the DSM-IV classification systems; 2) subjective phenomena identified by the patient; and 3) objective phenomena observed by external correspondents and the therapist. A control group composed of patients with Axis I clinical disorders who had not been diagnosed with a personality disorder was drawn from a database from the same private psychiatric practice. The study sample and control groups were matched exactly on gender, and closely on age, as well as socioeconomic variables, based on the United Kingdom’s Registrar General’s Social Class (RGSC) five-class scheme according to occupation (12).

**Diagnostic methods**

The lead author conducted clinical examinations on all patients, obtaining and recording the demographic, clinical, phenomenological, and socioeconomic information, and determining the DSM diagnoses, which were supported by handwritten, verbatim case notes and based on the psychobiological model of Adolf Meyer and the Edinburgh tradition of David Henderson. Patient diagnoses were originally derived from DSM-III and DSM-III-R specifications as well as DSM-IV specifications (13) but were all converted to DSM-IV diagnostic stipulations for the purposes of this study.

Case notes included information on the referral source, history of presenting complaint, systematic inquiry, mental status examination, phenomenology (in detail), diagnosis, and treatment plan. Approximately 30 of the 351 cases were discussed with a consultant clinical psychologist, trained in the United States but practicing in Jamaica (14), who assisted in the diagnostic formulation of the cases using the criteria of the DSM-III. General diagnostic criteria were used to confirm the presence of personality disorder, and the 11 categories specified in the DSM-III were used to specify type of personality disorder.

**Statistical analysis**

Version 17.0 of the Statistical Package for the Social Sciences (SPSS) (Chicago, IL, USA) was used for all statistical analyses. Five Axis I and 10 Axis II patient diagnoses were identified for the study population. The symptoms of these disorders were disaggregated and recorded as individual phenomenological markers of dysfunction, with a total of 38 phenomenological variables recorded as present or absent.

All phenomenological variables were entered into an exploratory principal component factor analysis to extract the factor solution using a variance maximizing (varimax) rotation. Item loadings of 0.40 and higher were considered significant. Items were summed and recoded to create the respective factors, and severity was scored from 0 to 9 (with zero signifying lack of presence). Correlations were determined to assess the direction and strength of the relationship between the factors.

Chi-squared analysis was used to assess the association between phenomenological markers and the Axis I and Axis II diagnoses, and the differences between patients diagnosed with Axis I and Axis II disorders in relation to the factors identified. Multiple regression analyses were carried out to determine if the identified factors were able to predict the type of Axis II cluster based on patients’ diagnoses. Independent t-tests and one-way analysis of variance (ANOVA) were used to measure mean differences between variables.

**RESULTS**

The sample’s demographic characteristics are reported in Table 1. Of the 351 individuals in the study sample group, 166 (47.3%) were male and 185 (52.7%) were female; 50 (14.2%) were white and 301 (85.8%) were black; 293 (83.5%) were born and raised in Jamaica; and 202 (57.6%) were from socioeconomic classes I and II. Mean age was 33.92 (standard deviation 10.236). In the study sample group (“Axis II”), significantly more individuals were diagnosed with major depression (38.5%) versus other Axis I disorders (psychosis, 6%; substance-abuse disorder, 17.9%; and anxiety disorder, 19.1% \( \chi^2 = 166.212, P < 0.001 \)). In the control group (“Axis I”), just under half of those previously diagnosed with major depression also qualified for an Axis II (personality disorder) diagnosis (44.7%; \( n = 135 \chi^2 = 5.951, P < 0.001 \)). Significantly more control group (“Axis I”) patients were found to have symptoms related to Axis I (clinical disorders
The Cronbach’s alpha value was 0.71 for all phenomenological variables in the study, indicating a sample size adequate for obtaining stable and reliable results. All phenomenological variables identified from psychiatric assessment were entered into a principal component factor analysis. A total of nine factors were identified, with a clear break in the scree plot at the sixth principal component, indicating a six-factor model of disorder. The varimax-rotated factors, which cumulatively accounted for 47.2% of the variance in the 38-item set, were retained. Eigenvalues for these six factors ranged from 1.04 to 5.58, with each factor accounting for 3.4% to 18.6% of the variance. The pattern of factors in the second factor analysis (after rotation) is shown in Table 3.

The clinical interpretation of the six-factor solution was assessed by the current study’s research team and the following factor titles were assigned: psychosis (Factor I); conflict management problems (Factor II); control issues (Factor III); psychosexual problems (Factor IV); major depression (Factor V); and physiological dependency (Factor VI). The items comprised by each factor were summed to create continuous variables that were named as outlined above. Because there was some overlap in the variables comprised by Factors II and III, and all of the comprised variables were conceptualized as being representative of problems with interpersonal power management, the items on these two factors were clustered and summed to form one continuous variable (“power management problems”). The internal consistency of the variables comprised by Factors I, II, and III, as measured by Cronbach’s alpha, was good ($\alpha = 0.77$), ranging from 0.724 to 0.837 for individual items.

A moderate relationship was found between power management problems and psychosexual problems ($r = 0.460$, $P < 0.001$), and a weak relationship was found between power management problems and physiological dependency ($r = 0.202$, $P < 0.001$), as well as psychosexual problems and physiological dependency ($r = 0.204$, $P < 0.001$).

**Associations between factors and personality disorder**

Significant relationships were identified between a personality disorder diagnosis and power management problems ($\chi^2 = 172.847$, $P < 0.001$); physiological dependency ($\chi^2 = 82.347$, $P < 0.001$); and psychosis ($\chi^2 = 22.225$, $P < 0.001$). Among those diagnosed with an Axis II personality disorder, 79.7% reported power management problems, 88.0% had physiological dependency, and 88% had some feature of psychosis (versus 30.2%, 57.5%, and 97.2% respectively for those diagnosed with an Axis I clinical disorder). The factors of major depression and psychosexual problems were not significant. The proportion of patients with symptoms within the major depression factor was about equal for persons diagnosed with an Axis II personality disorder versus those diagnosed with an Axis I clinical disorder (82.9% and 83.5% respectively).

**Predictive ability of factors for DSM-IV-TR cluster diagnosis**

A step-wise multiple regression equation was constructed to assess the predictive factors associated with the three types of DSM-IV-TR Axis II clusters. The analysis revealed a statistically significant regression model for type-of-cluster diagnosis ($F(6, 329) = 15.656$, $P < 0.001$). Power management problems, psychosexual problems, psychosis, and major depression together explained only 19% of the variance in type-of-cluster diagnosis. Analysis of the $\beta$ coefficients of the significant regression functions showed...
psychosis was the best predictor of type of cluster ($\beta = -0.295$, $t(1331) = -5.385$, $P < 0.001$), followed by power management problems ($\beta = -0.294$, $t(1331) = -5.732$, $P < 0.001$); psychosexual problems ($\beta = 0.234$, $t(1331) = 4.600$, $P < 0.001$); and major depression ($\beta = 0.135$, $t(1331) = 2.359$, $P < 0.001$). Due to the distribution of features of psychosexual problems and major depression within the sample, these factors are likely to be positively related to cluster diagnosis. The results indicate a weak correlation between the factors formed from the phenomenological features of personality disorder and the DSM-IV-TR Axis II clusters.

Comparison of factor scores by diagnosis

The control group had a higher mean score for the psychosis measure ($M = 2.8$, standard deviation [SD] = 1.93) than patients who were originally diagnosed with a personality disorder ($M = 2.0$, SD = 1.30, $t(700) = 6.72$, $P < 0.001$). On the other hand, patients in the study sample had significantly higher mean scores for four of the other measures: conflict management problems ($M = 2.2$, SD = 1.74, $t(698) = 16.69$, $P < 0.001$); control issues ($M = 1.7$, SD = 1.59, $t(699) = -17.77$, $P < 0.001$); psychosexual problems ($M = 3.9$, SD = 0.94, $t(699) = -24.18$, $P < 0.001$); and physiological dependency ($M = 0.9$, SD = 0.33, $t(700) = -9.65$, $P < 0.001$). Patients in the study sample also had higher mean scores for the combined “power management problems” measure ($M = 2.9$, $SD = 2.35$, $t(698) = -17.26$, $P < 0.001$). There were no significant differences between the two groups for the major depression factor.

Severity of disorder

One-way ANOVA was used to assess differences in power management problems, psychosexual problems, and physiological dependency for the three levels of disorder severity (mild, moderate, and severe). Because the assumption of homogeneity of variance was violated, the Brown-Forsythe $F$-ratio is also reported. Results indicated the three severity groups differed significantly for power management problems ($F(3, 314.92) = 92.514$, $P < 0.001$); psychosexual problems ($F(3, 398.06) = 198.044$, $P < 0.001$); and physiological dependency ($F(3, 464.08) = 53.193$, $P < 0.001$). Post hoc Tukey tests indicated the severe group ($n = 56$; mean = 3.82, SD = 1.99) had a significantly higher mean score for power management problems versus both the moderate group ($n = 184$; mean = 3.09, SD = 2.50, $P = 0.030$) and the mild group ($n = 109$; mean = 2.00, SD = 1.96, $P = 0.000$). For physiological dependency, both the severe group ($n = 57$; mean = 0.96, SD = 0.19) and the moderate group ($n = 185$; mean = 0.91, SD = 0.28) had a significantly higher mean score than the mild group ($n = 109$; mean = 0.78, SD = 0.42, $P = 0.034$, and $P = 0.040$ respectively). There were no significant differences between the moderate and severe groups on this measure. For psychosexual problems, there were no significant mean differences between the three severity groups (see Table 4).

**DISCUSSION**

The proposed re-conceptualization of personality disorder in the upcoming DSM-V has faced major scrutiny due to its confusing, inconsistent, and incoherent criteria (5). The purpose of the current case-control study of a Jamaican sample was to determine whether the individual phenomenological features of personality disorder would cluster into patterns similar to those for traditional personality disorder features and categories.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Axis I control group ($n = 351$)</th>
<th>Axis II study sample ($n = 351$)</th>
<th>$P^*$</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Abnormal appetite</td>
<td>117</td>
<td>53.7</td>
<td>101</td>
</tr>
<tr>
<td>Abnormal behavior</td>
<td>108</td>
<td>65.5</td>
<td>57</td>
</tr>
<tr>
<td>Aggression</td>
<td>59</td>
<td>28.6</td>
<td>147</td>
</tr>
<tr>
<td>Anxiety</td>
<td>192</td>
<td>42.4</td>
<td>261</td>
</tr>
<tr>
<td>Competitive</td>
<td>1</td>
<td>0.6</td>
<td>159</td>
</tr>
<tr>
<td>Compulsive</td>
<td>14</td>
<td>24.6</td>
<td>43</td>
</tr>
<tr>
<td>Conflict/power struggles</td>
<td>50</td>
<td>12.7</td>
<td>344</td>
</tr>
<tr>
<td>Delusions</td>
<td>92</td>
<td>80.0</td>
<td>15</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>80</td>
<td>66.7</td>
<td>40</td>
</tr>
<tr>
<td>Depression/sadness</td>
<td>224</td>
<td>48.1</td>
<td>242</td>
</tr>
<tr>
<td>Drug use</td>
<td>202</td>
<td>39.5</td>
<td>309</td>
</tr>
<tr>
<td>Playboy/attention-seeking</td>
<td>8</td>
<td>7.3</td>
<td>101</td>
</tr>
<tr>
<td>Guilt</td>
<td>39</td>
<td>25.5</td>
<td>114</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>97</td>
<td>83.6</td>
<td>19</td>
</tr>
<tr>
<td>Immature</td>
<td>13</td>
<td>18.6</td>
<td>57</td>
</tr>
<tr>
<td>Impotence</td>
<td>15</td>
<td>13.4</td>
<td>97</td>
</tr>
<tr>
<td>Inadequacy</td>
<td>109</td>
<td>30.3</td>
<td>251</td>
</tr>
<tr>
<td>Insomnia</td>
<td>222</td>
<td>53.2</td>
<td>195</td>
</tr>
<tr>
<td>Irritability</td>
<td>82</td>
<td>42.1</td>
<td>13</td>
</tr>
<tr>
<td>Jealousy</td>
<td>31</td>
<td>23.8</td>
<td>99</td>
</tr>
<tr>
<td>Manipulative</td>
<td>11</td>
<td>5.7</td>
<td>187</td>
</tr>
<tr>
<td>Negativistic</td>
<td>45</td>
<td>72.6</td>
<td>17</td>
</tr>
<tr>
<td>Pain</td>
<td>89</td>
<td>47.1</td>
<td>100</td>
</tr>
<tr>
<td>Paranoia</td>
<td>119</td>
<td>58.9</td>
<td>83</td>
</tr>
<tr>
<td>Passivity</td>
<td>19</td>
<td>21.6</td>
<td>69</td>
</tr>
<tr>
<td>Poor concentration</td>
<td>79</td>
<td>50.0</td>
<td>79</td>
</tr>
<tr>
<td>Psychological dependence</td>
<td>81</td>
<td>20.8</td>
<td>308</td>
</tr>
<tr>
<td>Rage</td>
<td>54</td>
<td>23.3</td>
<td>178</td>
</tr>
<tr>
<td>Rape</td>
<td>10</td>
<td>3.3</td>
<td>20</td>
</tr>
<tr>
<td>Seductive</td>
<td>3</td>
<td>3.4</td>
<td>86</td>
</tr>
<tr>
<td>Sexual experience</td>
<td>Poor</td>
<td>156</td>
<td>32.6</td>
</tr>
<tr>
<td>Good</td>
<td>187</td>
<td>89.6</td>
<td>21</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Heterosexual</td>
<td>344</td>
<td>52.7</td>
</tr>
<tr>
<td>Homosexual</td>
<td>7</td>
<td>18.4</td>
<td>31</td>
</tr>
<tr>
<td>Shame</td>
<td>24</td>
<td>30.0</td>
<td>56</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>75</td>
<td>49.7</td>
<td>76</td>
</tr>
<tr>
<td>Suicidal attempts</td>
<td>19</td>
<td>41.3</td>
<td>27</td>
</tr>
<tr>
<td>Talking foolishness</td>
<td>84</td>
<td>90.5</td>
<td>9</td>
</tr>
<tr>
<td>Withdrawn behavior</td>
<td>49</td>
<td>79.0</td>
<td>13</td>
</tr>
</tbody>
</table>

* Based on the chi-square ($\chi^2$) test.
When the phenomenological features of personality disorder are disaggregated and analyzed, the resulting clusters do not resemble the conventional categories of personality disorder as specified by the DSM-IV-TR. Instead, they cluster into three distinct categories of factors that seem to represent problems of psychoemotional nature, indicating a singular, completely separate concept, stemming from problems with impulse control and authority and conflict management, to replace the current iteration of personality disorder classification.

The components of the factors representing power management problems, psychosexual problems, and physiological dependency are features of dysfunction that are variable and not representative of personality traits typically assessed by other [traditional] measures of personality disorder. The authors of the current study theorize that the underpinning dysfunctions manifest in different ways: the neurobiological dysfunction, the presentation of which is colored by the personality traits that an individual possesses. In this way the dysfunction may be similar to an Axis I disorder. It has been previously suggested that features of personality disorder are no different from the symptomatology of mental disorders as both are “caused by biological and psychosocial factors and, like those of other disorders, they wax and wane over time” (3). Schneider’s (1923) (15) distinction between abnormal personality (as an extreme of normalcy) and personality disorder (that causes harm/suffering to self and society) predates and supports this perspective.

The authors of the current study suggest a conceptual shift be made, reconfiguring the classification systems by remerging “personality disorder” with Axis I disorders as suggested by Livesley et al. (3). Axis II would serve as the location for listing important personality indicators that could help clinicians understand how the dysfunction is manifested and how various personality traits may at work in ways both beneficial and harmful for an individual’s functioning and treatment outcome. Axis II classification of the personality traits of patients (with or without a personality disorder diagnosis) would help clinicians select the most appropriate intervention for each case (9).

The fact that power management problems, psychosexual problems, psychosis, and major depression together explained only 19% of the variance in type-of-cluster diagnosis indicated a weak correlation between the factor structure formed from the phenomenological features of personality disorder and traditional (DSM-IV-TR) cluster diagnoses in this cohort of patients in Jamaica. Together this suggests that the disaggregated phenomenology of patients with personality disorder do not match the conventional DSM diagnostic categories.

**TABLE 3. Pattern of factors\(^a\) for phenomenological variables in one private-practice caseload for DSM-IV\(^b\) Axis II personality disorder, Kingston, Jamaica, 1974–2007**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Factor I</th>
<th>Factor II</th>
<th>Factor III</th>
<th>Factor IV</th>
<th>Factor V</th>
<th>Factor VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking foolishness</td>
<td>0.801</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal behavior</td>
<td>0.796</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delusions</td>
<td>0.779</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoia</td>
<td>0.764</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinations</td>
<td>0.736</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negativism</td>
<td>0.673</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawn behavior</td>
<td>0.655</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>–0.401</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td>–0.453</td>
<td>0.548</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Based on varimax rotation. Factor titles were as follows: psychosis (I); conflict management problems (II); control issues (III); psychosexual problems (IV); major depression (V); and physiological dependency (VI).

\(^b\) DSM-IV: American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 4th edition.

**TABLE 4. Power management problems, psychosexual problems, and physiological dependency for three levels of severity of DSM-IV\(^b\) Axis II personality disorder in one private-practice caseload (n = 351), Kingston, Jamaica, 1974–2007**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mild Mean SD</th>
<th>Moderate Mean SD</th>
<th>Severe Mean SD</th>
<th>(P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power management problems</td>
<td>2.00 1.96</td>
<td>3.09 2.90</td>
<td>3.82 1.99</td>
<td>0.000</td>
</tr>
<tr>
<td>Psychosexual problems</td>
<td>4.01 0.86</td>
<td>3.90 1.02</td>
<td>4.04 0.82</td>
<td>0.000</td>
</tr>
<tr>
<td>Physiological dependency</td>
<td>0.78 0.42</td>
<td>0.91 0.28</td>
<td>0.96 0.19</td>
<td>0.000</td>
</tr>
</tbody>
</table>

\(^a\) DSM-IV: American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 4th edition.

\(^b\) SD: standard deviation.

\(^c\) Based on one-way analysis of variance (ANOVA).

**Depression and personality disorder**

The association between depression and personality disorder has long been established: a lengthy history of depression can predispose individuals to the condition, and stressful life events (common among those with personality disorders) can lead to depressive episodes (16). Several patients in the study sample had either undergone treatment for depression (38.5%) in which features of personality disorder were revealed, or reported symptoms of depression (30.4%) over the course of their treatment for personality disorder. Furthermore, of all the co-morbid Axis I diagnoses, persons diagnosed with personality disorder were significantly more likely to also have a di-
agnosis of major depression than any of
the other Axis I disorders that were diag-
nosed. Although individuals with fea-
tures of personality disorder were not
significantly more likely than those with-
out these features to be depressed, the
high rate of depression (82.9%) found in
this population suggests that major de-
pression, regardless of the chronology of
diagnosis, is likely to be associated with
having problems with impulse control
and authority and conflict management.
If this is the case, treatment of this under-
lying pathology will resolve the symp-
toms of the depression. Further research
is required to explore the possible rela-
tionship between these two conditions.

Measuring severity

There are several challenges inherent in
measuring personality disorder severity
based on current diagnostic guidelines.
Both the DSM and ICD systems rate per-
sonality disorder severity based on the
patient’s description of his/her condition.
The use of nonstandard nomenclature in
the diagnostic process has significantly
impaired psychiatrists’ ability to ade-
quately ascribe severity, and has been crit-
icized for limitations in its logical basis
and clinical application (10). Like Walton
et al. (10), the authors of the current study
suggest that “social disruption” and “so-
cial insight” (as self-reported by patients)
be used as indicators of severity, and a
graded rating of “mild,” “moderate,” or
“severe” be based on the level of dysfunc-
tion. Concurrence of the current findings
with Walton et al.’s premise supports this
proposition.

In a recent article in New York Times
Magazine, author Ethan Watters (17)
states that the United States has “for
many years been busily engaged in a
grand project of Americanizing the
world’s understanding of mental health
and illness,” and bemoans the world’s
steady adoption of European and Ameri-
can values of mental illness. Elsewhere,
the editor of the British Journal of Psychia-
try acknowledged that his journal was
“bound to see the panorama of psychiatry
through British spectacles” (18). The pre-
sent study attempts to address this prob-
lem by investigating personality disorder
in another culture, using the case-control
method. In their research, the authors
grapple with the difficulty of applying
European and American concepts to clas-
ify personality disorder in a Jamaican
sample. Based on their results, the au-
thors propose a complete reframing of
personality disorder conceptualization.

While many of the phenomenological
features of personality disorder identi-
fied in the Jamaican study sample are
similar to the dimensions postulated by
Widiger et al. (19), the clustering pattern
is entirely different, forming a unique,
singular construct. The authors propose
this new phenomenon, which appears to
be associated with problems with im-
pulse control and authority and conflict
management, as a replacement for tradi-
tional DSM criteria in the reclassification
of personality dysfunction, and suggest
the term Shakatani as a possible name for
the condition. The concept of Shakatani—
derived from the Swahili words shaka
(“problem”) and tani (“power”)—stems
from an early Jamaican anthropological
study by Kerr (20) and sociological work
by Stone (21, 22) that chronicle the ten-
sions caused by economic oppression,
racism, biased methods of education,
and the economic and psychological in-
security caused by centuries of colonial
domination by the British.

Limitations

This study had several limitations.
First, because this was a naturalistic
study carried out by a single psychiatrist
over a period spanning nearly four
decades, it is impossible to verify miss-
ing or ambiguous data, or the accuracy
of diagnoses. Second, the reliance on one
main assessor (who made approximately
96% of the patient diagnoses and assess-
ments of phenomenological features)
may have resulted in biased data record-
ing, which would have affected the way
in which the data clustered in the factor
analysis. The use of a second rater or a
standardized rating scale for compara-
tive assessment of the main inter-
viewer’s assessments would have in-
creased the diagnostic accuracy and
robustness of statistical findings. Third,
the use of a combination of phenomeno-
logical variables and DSM-IV personal-
ity disorder variables may have con-
tributed to the characteristic differences
of the personality disorder factors identi-
fied by the study (versus those for tradi-
tional diagnostics) and reduced their
comparability versus standard DSM-IV
clusters and types, thereby weaken-
ing the strength of the conclusions about
their relationship. Finally, the fact that
the patients were culled from a private
psychiatric practice skews the sample in
the direction of patients who could af-
ford assessment and treatment.

Conclusion

The findings of this study challenge
the validity of the nosological entity of
Axis II personality disorder. The authors
propose a novel Axis I unitary concept of
problems with impulse control and au-
thority and conflict management as its
replacement, and suggest the term
Shakatani as a possible name for the
condition. The authors of the current study
suggest that 1) individual and cultural
differences in the manifestation of per-
sonality disorder may be attributed to
cultural differences in how various per-
sonality traits are perceived, and 2) their
new conceptualization of this dysfunc-
tion as a completely different, singular
phenomenon may help address current
challenges in re-defining personality di-
agnostic disorder diagnosis, applying
the diagnosis cross-culturally, and mea-
suring disorder severity using tradi-
tional criteria.

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**RESUMEN**

Redefinición del trastorno de la personalidad desde una perspectiva de Jamaica

**Objetivo.** Caracterizar y evaluar la estructura factorial de las características fenomenológicas del diagnóstico de trastorno de la personalidad según el DSM-IV en pacientes jamaiquinos, y determinar sus semejanzas con las de los criterios tradicionales, la asociación con la gravedad del trastorno o las relaciones significativas entre las variables con objeto de aportar información al debate actual sobre la relevancia de los diagnósticos establecidos de trastorno de la personalidad.

**Métodos.** Estudio de casos y controles, donde todos los sujetos fueron atendidos en una práctica psiquiátrica privada de 1974 a 2007. Los casos (n = 351) correspondieron a pacientes diagnosticados con un trastorno de la personalidad, (Eje II del Manual Diagnóstico y Estadístico de los Trastornos Mentales [DSM-IV, por su sigla en inglés]). El grupo de control estuvo integrado por pacientes con trastornos clínicos del Eje I del DSM-IV, sin diagnóstico de un trastorno de la personalidad, emparejados exactamente en cuanto al sexo y estrechamente en cuanto a la edad y a variables socioeconómicas (n = 351).

**Resultados.** De los 351 individuos del grupo de la muestra del estudio, 166 (47,3%) eran varones y 185 (53,7%) mujeres; 50 (14,2%) eran de raza blanca y 301 (85,8%) de raza negra; 293 (83,5%) habían nacido y crecido en Jamaica; y 202 (57,6%) pertenecían a las clases socioeconómicas I y II. La media de la edad era de 33,92 (desviación estándar 10,236). Cuando se desagregaron las características fenomenológicas, no concordaban con los diagnósticos convencionales de trastorno de la personalidad según el DSM-IV. El análisis factorial de 38 fenómenos clínicos permitió determinar cinco componentes: psicosis, depresión mayor, problemas de manejo del poder, trastornos psicosexuales y dependencia fisiológica. Las pruebas de la t independientes revelaron que los pacientes con un trastorno de la personalidad obtuvieron puntuaciones medias significativamente mayores para la psicosis; ambos grupos obtuvieron las mismas puntuaciones para la depresión; y los que padecían un trastorno de la personalidad obtuvieron puntuaciones medias significativamente mayores para los factores restantes. El análisis de la varianza indicó que estos factores diferían significativamente según el nivel de gravedad (levé, moderado o grave).

**Conclusiones.** El agrupamiento de las características fenomenológicas en tres grupos principales sugirió un diagnóstico (clínico), correspondiente al Eje I, de trastorno del control de los impulsos y del manejo de la autoridad y los conflictos.

**Palabras clave**

Trastornos de la personalidad; Jamaica.