Shakatani: The Phenomenology of Personality Disorder in Jamaican Patients

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ABSTRACT

Objective: *To examine the distribution and clinically significant patterns of the phenomenology of a cohort of Jamaican patients with a Diagnostic and Statistical Manual of Mental Disorders (DSM) Axis II diagnosis of personality disorder and to clarify the conventional diagnostic deficiencies of DSM-based personality disorder categories.*

Methods: *In a case-control study from the naturalistic clinical setting of a private psychiatric practice in Kingston, Jamaica, between 1974 and 2007, the phenomenology of a cohort of 351 patients with an Axis II DSM diagnosis of personality disorder is qualitatively described and quantitatively compared with that of a control group of patients with an Axis I DSM clinical diagnosis, matched for age, gender and socio-economic class.*

Results: *There were 166 males (47.3%); 238 (67.8%) of the patients were between age 18 and 39 years. Ethnically, 325 (92.6%) were Black, 10 (2.8%) White and 16 (4.6%) Other. The majority of patients (20.7%) had a DSM-IV diagnosis of dependent personality disorder. Patients with an Axis II diagnosis were significantly more likely to display symptoms of a 'clinical triad' of power management, dependency and psychosexual issues. Qualitative analysis of the phenomenological symptoms of personality disorder diagnosed patients suggests aetiological interconnections based on early childhood experiences as explained by object relations and attachment theories.*

Conclusions: *The phenomenological approach to personality disorder may be a viable replacement for the four-cluster classification of DSM-IV in a Jamaican population with the clinical triad called Shakatani, derived from the Swahili words* shaka *(problem) and* tani *(power). This phenomenological approach may provide more clinical utility to practitioners.*

Keywords: DSM-IV Axis I and II personality disorder, Jamaican patients, Shakatani, phenomenology

Shakatani: La Fenomenología del Trastorno de Personalidad en Pacientes Jamaicanos

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RESUMEN

Objetivo: *Examinar la distribución y los patrones clínicamente significativos de la fenomenología de una cohorte de pacientes jamaicanos con diagnóstico de trastornos de personalidad de eje II según el Manual Estadístico Diagnóstico (DSM), y aclarar las deficiencias diagnósticas convencionales de categorías de trastorno de la personalidad basadas en DSM.*

Métodos: *Se describe cualitativamente la fenomenología de una cohorte de 351 pacientes con diagnóstico de trastorno de la personalidad de eje II DSM, en un estudio de caso control a partir de un contexto clínico naturalista en una práctica psiquiátrica privada de Kingston, Jamaica, entre 1974 y 2007. Dicha fenomenología fue comparada cuantitativamente con la de un grupo control de pacientes con un diagnóstico clínico de eje I DSM, pareados por edad, género y clase socio-económica.*

Resultados: *Hubo 166 varones (47.3%); 238 (67.8%) de los pacientes tenían entre edades entre 18 y 39 años. Étnicamente, 325 (92.6%) eran negros, 10 (2.8%) blancos, y 16 (4.6%) étnicamente diversos.*

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La mayoría de los pacientes (20,7%) tenía un diagnóstico DSM-IV de trastorno de personalidad dependiente. Los pacientes con un diagnóstico de eje II tuvieron significativamente más probabilidades de mostrar síntomas de una 'tríada clínica' de manejo del poder, dependencia y problemas psicosexuales. El análisis cualitativo de los síntomas fenomenológicos de los pacientes diagnosticados con trastorno de personalidad, sugiere interconexiones etiológicas basadas en experiencias de la niñez temprana, tal cual lo explican la teoría de la relación de objetos y la teoría del apego.

Conclusiones: *El enfoque fenomenológico de los trastornos de personalidad puede ser un substituto viable para la clasificación de cuatro clústeres de DSM-IV en una población jamaicana con la tríada clínica denominada* Shakatani, *término derivado de las palabras Swahili* shaka *(problema) y* tani *("poder"). Este enfoque fenomenológico puede ofrecer mayor utilidad clínica a los profesionales.*

Palabras claves: Trastornos de personalidad del eje I y II del DSM-IV, pacientes Jamaicanos, fenomenología

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INTRODUCTION

Newspaper reports of heinous crimes of murder, rape, domestic and sexual abuse in Jamaica in recent years have led to the conclusion that these crimes are linked to severe personality disorders, and triggered escalating social demands that "this madness has to stop" (1). The current classification systems of mental disorders – the International Classification of Diseases, [ICD] (2) and the Diagnostic and Statistical Manual of Mental Disorders [DSM] (3) – have for many decades been the leading guides for the description and diagnosis of mental illness. However, several problems with the definition and diagnostic classifications of personality disorder have been consistently identified (4–7). A clinically relevant concern is that the current international versions of the classification systems are unable to provide practitioners with clear directions for treatment (6) and the proposed revisions to these classifications are not likely to provide much more clarity (7). Concerns about applying Eurocentric and North American methods of defining and diagnosing personality disorder in culturally diverse populations have also been documented (8). For practitioners from developing countries, the diagnostic and therapy-deficient challenges surrounding personality disorders are especially problematic as these imported approaches have delivered unsatisfactory outcomes (9, 10).

Few Jamaican or Caribbean studies have focussed on the pattern or prevalence of personality disorder in this region. The Jamaican challenge to this clinical and classificatory conundrum began in 1974, with a pilot study of 34 patients diagnosed with DSM axis II personality disorder seen at a Jamaican private psychiatric practice (11), by Jamaican-trained psychiatrists who were schooled in the Adolf Meyer method of phenomenological clinical investigation (12). Using the Meyerian method of phenomenological investigation, the 34 patients in the pilot study were subjected to a rigorus psychiatric analysis. The phenomenological features of the patients in this cohort were collated and aggregated and fell into three distinct clusters which were labelled 'power management issues', 'dependency issues' and 'psychosexual issues'. The pilot study definied these three distinct clusters as a 'clinical triad' of abnormal thoughts, feelings, and actions (11). The pilot study was extended into a follow-up study conducted over 30 years in the same Jamaican private psychiatric practice, in which a cohort of 351 patients diagnosed with DSM Axis II personality disorder were matched with a cohort of patients from the same private practice who were diagnosed with Axis I disorders (13). In this case controlled study, factor analysis of the 38 clinical phenomena identified replicated the 'clinical triad' of power management problems, psychosexual issues and physiological dependency identified in the initial pilot study. It was concluded that in this Jamaican clinical population, this clinical triad may be the phenomenological representation of patients with DSM personality disorder. The authors of that study suggested the term *Shakatani* as a possible name for this Axis II condition, derived from the Swahili words *shaka* (problem) and *tani* (power). The objective of this current study is to examine the distribution and clinically significant patterns of symptoms and signs of the '*Shakatani* clinical triad' elaborated in the initial Jamaican study. Qualitative representations of the phenomenological symptoms and signs from the study cohort are described and a simple diagnostic model that can be utilized in replicable psychotherapeutic formulations in the Jamaican clinical context is presented.

SUBJECTS AND METHODS

This was a case-control study with the sample obtained from the naturalistic clinical setting of a private psychiatric practice in Kingston, Jamaica. All patients (n = 351) seen in a single psychiatric practice in Jamaica during the years 1974 to 2007 who had received an Axis II diagnosis of personality disorder based on: 1) the DSM-III, III-R, and IV classification systems, 2) the subjective phenomena identified by the patient and 3) objective phenomena observed by external correspondents and the therapist. A matched convenience sample of patients diagnosed with DSM Axis I disorders and

who did not have a diagnosis of personality disorder were drawn from the same private psychiatric practice database and constituted a control group for comparison with the DSM personality disordered cohort.

Diagnostic methods

The lead author conducted clinical examinations on all patients, recording the demographic, clinical and social class information, detailed notation of phenomenology and made the DSM diagnoses. Over the 30 years of clinical assessments, the patient diagnoses were converted to current DSM-IV specifications (3). Approximately 30 of the 351 cases were discussed with a senior consultant clinical psychologist, trained in the United States of America (USA) but practising in Jamaica (14), who assisted in the diagnostic formulation of the cases using the DSM-III diagnostic criteria.

Statistical analysis

The Statistical Package for the Social Sciences (SPSS), version 17.0 was used for all statistical analyses. Chi-squared analysis was used to assess the association between phenomenological markers and the Axis I and Axis II diagnoses.

RESULTS

Demographics

There were 166 males (47.3%) and 185 (53.7%) females. All patients were between the ages 18 and 69 years, with 238 (67.8%) between ages 18 and 39 years. Of the cohort, 325 (92.6) were Black, 10 (2.8%) White and 16 (4.6) Other. Jamaica was the country of origin of 329 (93.7%). Of the cohort, 300 (85.4%) belonged to socio-economic classes (15) I, II and III.

DSM personality disorder diagnosis

Patients in the study group were diagnosed with nine of the 10 conventional DSM Axis II personality disorder diagnoses, the majority of patients (20.7%) with dependent personality disorder (Table 1).

The phenomenological symptoms and signs

When the phenomenological symptoms and signs of the 'clinical triad' were compared between patients diagnosed with Axis I *versus* Axis II disorders, patients with an Axis II diagnosis were significantly more likely to display symptoms of the 'clinical triad'. In contrast, patients diagnosed with an Axis I disorder were significantly more likely to be clinically observed as having/reporting positive sexual experiences, significantly less homosexual activity and less substance use ($p = 0.000$) [Table 2].

An examination of co-morbidity revealed that patients diagnosed with personality disorder were also diagnosed with major depression (38.5%), substance abuse disorder (17.9%), an anxiety state (19.1%) and psychosis (6.0%). In comparison to patients diagnosed with Axis I disorders, patients with an Axis II diagnosis were significantly more likely to also have a substance abuse disorder or an anxiety state diagnosis (Table 3).

Table 1: Frequency of DSM-IV Axis II cluster diagnoses

DSM Axis II Cluster	Diagnosis	n (%)
Cluster A		
	Paranoid	19 (2.7)
	Schizoid	10 (1.4)
	Schizotypal	0 (0.0)
Cluster B		
	Antisocial	27 (3.8)
	Borderline	2 (0.3)
	Histrionic	80 (11.4)
	Narcissistic	21 (3.0)
Cluster C		
	Avoidant	10 (1.4)
	Dependent	145 (20.7)
	Obsessive-Compulsive	24 (3.4)
PD-NOS		13 (1.9)

DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, 4th edition; PD-NOS = personality disorder not otherwise specified

Qualitative phenomenological elaboration of the 'clinical triad'

Using the qualitative results of this study of 351 patients with personality disorder in Jamaica, brief definitions of the phenomenological symptoms and signs of the 'clinical triad' illucidated are presented in Table 4.

Jaspers in 1923/1963 defined phenomenology as ''*…the subjective and objective experiences of human psychic life…*' He suggested that *"Phenomenology is … purely an empirical method of enquiry maintained solely by the fact of the patient's communications…"* (16). Mullen (17) suggests that the final employment of the phenomenological descriptions is to inform and direct subsequent examinations and to lay the basis for subsequent classification, which then seeks its reflection in the science of systematic enquiry.

The qualitative findings of this study presents a theoretical delineation of the multidimensional construct of a 'clinical triad' of personality disorder in Jamaican patients.

Abnormal power management relations

Abnormality in power management relations refers to an individual's difficulty in controlling drives that underlie their ability to manage intrapersonal and interpersonal power relationships. This abnormality is constructed of a constellation of emotions and behaviours such as aggression, rage, manipulativeness and competitiveness, which may be expressed individually or coalesced, and are repeatedly exhibited at pathological levels, frequently resulting in interpersonal difficulties across social domains. This latter qualifier is critical in understanding the distinction from normal expression of these emotions and behaviours. For instance, although anger

Table 2: Distribution of phenomenological variables for DSM-IV Axis II personality disorder (study sample) and Axis I clinical disorder (control group)

Triad component	Phenomenological symptom/sign	Axis I (n = 351) n (%)	Axis II (n = 351) n (%)	*p*
Power management	Aggression	59 (28.6)	147 (71.4)	0.000
	Rage	54 (23.3)	178 (76.7)	0.000
	Jealousy	31 (23.8)	99 (76.2)	0.000
	Competitive	1 (0.6)	159 (99.4)	0.000
	Manipulative	11 (5.7)	187 (94.3)	0.000
	Flamboyant/attention-seeking	8 (7.3)	101 (92.7)	0.000
	Seductive	3 (3.4)	86 (96.6)	0.000
	Immature	13 (18.6)	57 (81.4)	0.000
Psychosexual issues	Inadequacy	109 (30.3)	251 (69.7)	0.000
	Emotional [psychological] dependence	81 (20.8)	308 (79.2)	0.000
	Impotence	15 (13.4)	97 (86.6)	0.000
	Sexual experience			
	Poor	156 (32.6)	322 (67.4)	0.000
	Good	187 (89.6)	21 (10.4)	
	Conflict/power struggles	50 (12.7)	344 (87.3)	0.000
Physiological dependency	Drug use	202 (39.5)	309 (60.5)	0.000
Other variables of interest	Anxiety	192 (42.4)	261 (57.6)	0.000
	Compulsive	14 (24.6)	43 (75.4)	0.000
	Guilt	39 (25.5)	114 (74.5)	0.000
	Irritability	82 (42.1)	139 (57.9)	0.005
	Negativistic	45 (72.6)	17 (27.4)	0.000
	Passivity	19 (21.6)	69 (78.4)	0.000
	Rape	10 (33.3)	20 (66.7)	0.046
	Sexual orientation			
	Heterosexual	344 (52.7)	309 (47.3)	0.000
	Homosexual	7 (18.4)	31 (81.6)	
	Shame	24 (30.0)	56 (70.0)	0.000

Table 3: Comparison of the study (Axis II) and control group (Axis I) by Axis I diagnoses

Personality disorder diagnosis	Axis I Diagnosis None	Psychosis	Depression	Substance abuse disorder	Organic brain syndrome	Anxiety state		
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	χ^2	*p*
Control	11 (14.5)	119 (85.0)	167 (55.3)	6 (8.7)	4 (100.0)	4 (39.6)	166.212	0.000
Study	65 (85.5)	21 (15.0)	135 (44.7)	63 (91.3)	0 (0.0)	67 (60.4)		

is a normal human emotion, the frequency and intensity of the recurrent rage displayed by persons experiencing this abnormality is beyond the regular expression of anger. It is instead a pathological emotional state that is often a precursor to abnormal psychological behaviour, expressed as verbal or physical conflict, domestic fighting and violence; behaviours indicative of an inability to appropriately manage intrapersonal and interpersonal power and/or authority challenges. In this context, such power management problems may also stimulate transgressive behaviour displayed as authority and regulatory challenges, organizational suspension and/or expulsion, theft, police arrest, or prison sentences.

Psychological and physiological dependency

Dependency is a structured composite pattern of damaged psychological abnormalities with dysfunctional consequences, and is an emotional or physical need that individuals cannot provide for themselves and which is deemed necessary for that individual's survival. The crucial feature of dependence is a negative effect experienced in the absence of a drug, object or activity (18). This need can span the

Table 4: Brief definitions of phenomenological signs and symptoms identified in the Jamaican study sample

Feelings/Thoughts (described by patients in this study)	Definition	Actions (observed by clinician)	Definition (literature reference)
Competitive narcissism	Grandiosity, entitlement, and lack of empathy. Narcissism describes a problem in a person's relationships with self and others; unhealthy self-absorption due to a disturbance in the sense of self (38).	Strange, bizarre behaviour	Unusual actions without rational basis (39).
Compulsive	Overwhelming, impulsive thoughts and actions. A dominating or persisting thought or action without cause that cannot be controlled (39).	Rape (distortion)	The experience of proven and unproven rape (26).
Flamboyant/attention-seeking	A form of narcissism; bragging, boasting, exhibitionism, histrionic, shocking, exaggeration (40).	Sexual experience (poor)	Experience of sexual dysfunction generally associated with poor quality of life (47).
Immature	Lacking complete growth, differentiation, or development (41).	Anxiety	Free floating and unattached (42); morbid anxiety (39).
Jealousy	Negative thoughts and feelings of insecurity, fear, and anxiety over an anticipated loss of something that the person values, particularly in reference to a human connection. It often consists of a combination of emotions: anger, sadness, resentment and disgust (9, 39, 42).	Shame	A violation of cultural and social values (48); the dividing line between shame, guilt and embarrassment is not fully standardized (40).
Irritability	Abnormal or excessive excitability, with easily triggered anger, annoyance or impatience (43).	Guilt	Emotional state associated with self-reproach and the need for punishment (43); guilt arises from violations of one's internal values (50).
Manipulative	Cognitive manoeuvring by patients to get their own way (44).	Impotence	Sexual dysfunction characterized by the inability to develop or maintain an erection of the penis during sexual performance (43).
Negativistic	Verbal or non-verbal opposition or resistance to outside suggestion or advice (45).	Inadequacy	Feelings of low self-worth, incompetence, powerlessness, and even shame that interfere with one's ability to maintain relationships, and succeed at work or in school (51).
Passivity	Awareness of lack of will (16)	Drug abuse	Impaired control over drug use, continued use despite harm, and/or craving (52).
Seductive	Inappropriate sexually provocative behaviour involving temptation and enticement (44).	Ego-dystonic sexual orientation	Disorder of sexual development and orientation; gender identity is clear, but persistent and marked distress about one's sexual orientation (2).
Rage	Not merely anger, but a phenomenological symptom of intense fury that often triggers abnormal characteristics of conflict/violence (45).	Conflict/power struggles	Clash/disagreement, often violent between two opposing individuals/groups; escalating fights over power (39).
Emotional dependence (described/observed)	The emotional needs of the individual for love; attention, support and nurture by another closely related person (46).	Aggression (described and observed)	Forceful goal-directed action that can be verbal or physical – the motor component of rage (45).

spectrum psychologically from individual personal needs to the unequal economic relationships of organizations and countries sociologically. The qualitative data of this study reveal two broad swathes of dependency: psychological dependency and physiological dependency.

Psychological dependency: Psychological dependency was conceptualized as the phenomenon of emotional reliance, termed 'lean pon' (lean upon) in the Jamaican parlance (11). It is classified as the excessive emotional needs of an individual for love, attention, support and nurture by another closely related person such as a parent, a family member, a

spouse or an intimate associate. In this formulation, psychological dependency is likely to present as co-dependence – a relational pattern in which a person attempts to derive a sense of purpose through relationships with others, which can occur in any type of relationship, including family, work, friendship, and also romantic, peer or community relationships (19).

Physiological dependency: Physiological dependency is a behavioural addiction to a physical substance or activity for the pleasurable rewards received, until the said substance or activity causes serious negative consequences to the person's physical, mental, social, and/or financial well-being (20, 21). One sign that a behaviour has become addictive is if it persists despite these consequences. Such addictions are not limited to illicit substances but can also include gambling, food, sex, pornography, use of computers/internet, playing video games, work, exercise, spiritual obsession (as opposed to religious devotion) and pain (22). It is suggested that addictive disorders should be included as non-substance-related disorders with licit and illicit substance use and abuse (23), subsumed under the main classification of physiological dependence. This includes the use of legally prescribed psychoactive medication such as the benzodiazepines and legally available substances such as alcohol. Westermeyer (24) suggests that psychoactive substances serve several human functions that can enhance both individual and social existence, including relief from adverse mental and emotional states, anticipatory anxiety and relief of physical symptoms, and stimulation to function in fatigue and other stressful situations, but can also torment and de-civilize us.

Psychosexual dysfunction

The third triad category was classified as psychosexual disorders, defined as disturbances in sexual function secondary to emotional and/or mental causes. All of these disturbances in sexual function are considered to be ego-dystonic (ego alien) and result in dysfunctional behaviour with a partner or with the social/cultural environment. Sadock and Sadock (25) define ego-dystonic/alien as '…aspects of a person's personality that are viewed as repugnant, unacceptable or inconsistent with the rest of the personality….' In this conceptualization, psychosexual dysfunction includes sexual dysfunctions, sexual perversions (paraphilias), and gender identity disorders that, despite their existence, are not acceptable to the individual thus causing emotional anxiety. Added to these features are disturbances of sexual desire, arousal, or orgasm; sexual pain; or difficulties with sexual performance causing significant anxiety, guilt and shame, none of which is due to a medical condition, medication, or substance abuse. All of these characteristics of the sexual experience are classified as poor or good when expressing problems phenomenologically.

Most causes of disturbed sexual desire and performance in patients have been of mental origin and resulted in the individual's inability to fully enjoy sexual intercourse. In men, sexual dysfunctions may manifest as reduced sexual desire, premature or delayed ejaculation, impotence, or painful intercourse. The equivalent sexual dysfunctions were also identified in women. The experience of rape was also included as an adjunct to this description of psychosexual dysfunction, since it was so often described in the clinical interview by members of the Jamaican cohort diagnosed with personality disorders. These experiences were, however, not classified as rape in the conventional sense, but instead as what have been termed 'rape distortion' (26). These patients reported various instances of rape, in some cases by a known perpetrator, others unknown, and undoubtedly in some cases the rape reported was in fact sexual coercion through emotional pressure. These past experiences continued to have a psychological impact on the patients several years later and were associated with strong feelings of guilt and insecurity.

Seductive, flamboyant and narcissistic behaviour are phenomenological characteristics that are often elicited in the clinical interview, and are often characterized by a pattern of excessive emotionality and attention-seeking behaviour in patients who are histrionic, flirtatious and self-serving. These patients may be inappropriately sexually provocative, express strong emotions with an impressionistic style, and may be easily influenced by others. Associated features may include egocentrism, self-indulgence, continuous longing for appreciation, and persistent manipulative behaviour to achieve their own needs.

A significant behavioural abnormality observed within this triad component is ego-dystonic heterosexual activity that ranges from a prolonged absence of sexual/emotional intimacy to emotionally disturbing multiple sexual partnerships often leading to severe and bizarre emotional and physical conflict and violence. In this sample, the Jamaican cohort displayed significant features of ego-dystonic homosexual behaviour that often led to complex patterns of emotional dishonesty and aggression. A greater frequency of ego-dystonic homosexuality was identified within the personality disordered patients in comparison to patients diagnosed with Axis I disorders.

Multiple congruent partners, associated with transgressive infidelity were observed to be a common phenomenon, often associated with deliberate and calculated acts of interpersonal conflict, aggression and cruelty, significant interpersonal duplicity and distrust that are likely to be the precursor of significant interpersonal and family dysfunction. Planned promiscuity often associated with a range of transgressive behaviour is also considered a feature of this dysfunctionality.

DISCUSSION

The last decades of the twentieth century saw psychiatry facing a monumental struggle over the classification of diagnosis by phenomenological psychopathology. The World Health Organization (WHO) International Pilot Study of

Schizophrenia thrust the diagnostic struggle squarely into the arena of phenomenology (27, 28). This was paralleled by the pioneering work of Astrachan *et al* (29) and Pope and Lipinski (30) in the creation of a phenomenological checklist for schizophrenia. By the turn of the millennium the phenomenological 'die was cast' with the work of Andreasen (31), Lenzenweger and Dworkin (32) and Tsuang *et al* (33) in the establishment of a psychopathological model that was becoming acceptable internationally and led to establishment of clinical diagnostic models. These models shaped the research in schizophrenia across the world. It is in this context that the exigencies for the redefinition of the diagnosis of personality disorder was emerging (34), demanding a reliable, valid and distinct diagnostic mantra with unique and theoretically meaningful correlates, antecedents and sequelae, with which clinicians internationally should be able to have independent agreement (35). This current study suggests that, like its utility in understanding schizophrenia, the phenomenological approach to understanding personality disorder should be the conceptualization of the disorder's phenomena in as close to the actual experience as possible (36). By delineating a phenomenological approach to understanding personality disorder, this paper also suggests the reshaping of the original notions of personality disorder.

CONCLUSIONS

Recent newspaper reports have identified personality disorders as a likely cause of the extremely high prevalence of homicide, rape, domestic and child abuse and other acts of criminal violence that has been exposed in Jamaica and other Caribbean territories. The clinical characteristics of personality disorder have been poorly described in studies of psychopathology of Caribbean patients. This present study suggests that the phenomenological approach to personality disorder may be a viable replacement for the 11-group personality disorder diagnosis of DSM III and the four-cluster classification of DSM-IV in a Jamaican population. The term *Shakatani* has been identified (13) as a possible name for this Axis II condition, derived from the Swahili words *shaka* (problem) and *tani* (power). It is suggested that these phenomenological signs and symptoms can provide clinical utility to practitioners in identifying the disorder and linking it to underlying problems that can be traced to early childhood development. Consequences of disrupted or dysfunctional patterns of relating between parents and children from as early as infancy can lead to a continuum of dysfunctional patterns of thinking about and relating to the external world (37). It is further suggested that unmasking these pathways to dysfunctional development, identifying the behavioural and emotional phenomena and the consequences of these phenomena would provide greater insight for treatment formulation and implementation than the current DSM and ICD conceptualizations of personality disorder.

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