Prescribing in personality disorder: patients' perspectives on their encounters with GPs and psychiatrists

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ABSTRACT

Objective The purpose of this study was to explore the views of patients with personality disorder on their experiences of prescribing practices by general practitioners (GPs) and psychiatrists, and their expectations of primary and secondary mental health services.

Design This was a qualitative study involving two focus groups. Discussion in the focus groups was recorded, transcribed verbatim and then analysed by a thematic analysis process to generate the key themes.

Setting The study took place at a specialist outpatient personality disorder service in the UK.

Participants A total of seven participants took part in the study. They were purposively sampled from an NHS specialist outpatient personality disorder service. All participants had a primary diagnosis of emotionally unstable personality disorder and their age ranged from 20 to 52 years.

Results Five key themes emerged. Participants felt that medication has a powerful impact on their mind and body but expressed confusion and uncertainty on how it is affecting them. Participants had a need for a good relationship with their doctors (GPs or psychiatrists). They described a feeling of being dismissed and not believed, expressing a desire to confront the 'powerful' position of their doctors by showing anger. The nature of the doctor-patient relationship was seen to moderate positively or negatively the experience of doctors' prescribing. Finally, there were key expectations of the primary-secondary care interface, including continuity of care, diagnostic clarity and a desire for different healthcare professionals to communicate with one another.

Conclusion The doctor-patient relationship is an important medium for providing validation and seeking negotiation of therapeutic treatment strategies in patients with personality disorder. Given that personality disorder is associated with high rates of physical and mental health comorbidity, it is therefore vital for clinical guidelines and training packages to take more account of the relational aspects of prescribing in consultations for this patient group with a view to improve outcomes.

INTRODUCTION

Personality disorders are commonly diagnosed psychiatric disorders characterised by enduring maladaptive patterns of behaviour, cognition and traits exhibited across many

Key points

Question
► This study explored the views of patients with emotionally unstable personality disorder on their experiences of prescribing practices by general practitioners (GPs) and psychiatrists.

Findings
► This study highlights the complexity that patients with emotionally unstable personality disorder face when in consultations with their GP and psychiatrist.
► We found that the nature of the doctor-patient relationship was perceived as having an important role on the outcome of consultations, with prescriptions being intimately linked to feeling validated or invalidated.

Meaning
► Clinical guidelines and training packages should take more account of the relational aspects of prescribing in consultations, especially with this patient group.
► Further research should address whether the relational aspects of managing personality disorder are skills based or attitudinal in origin, to inform further interventions designed to improve clinical care and outcomes in this patient group.

contexts and deviating markedly from those generally accepted by the individual's culture.[1] The prevalence rate has been reported as 12.2% for personality disorder in Western countries, with a prevalence rate of 1.9% specifically for borderline personality disorder.[2]

Borderline or emotionally unstable personality disorder is characterised by an enduring pattern of unstable self-image and mood, together with volatile interpersonal relationships, self-damaging impulsivity, recurrent suicidal threats or gestures and/or self-mutilating behaviour.[1] The condition is associated with a high risk of self-harm and suicide and thus this group of patients are often frequent users of mental health resources in both primary and secondary

care settings.[3] It has been noted that personality disorder is associated with a sevenfold increase in suicide risk compared with the general population without mental illness.[4] In the UK, total service costs were estimated to be £704 million for people with personality disorder in contact with primary care, rising to £1.1 billion by 2026.[5]

The UK National Institute for Health and Care Excellence recommends that for borderline and antisocial personality disorder, psychiatric medication should only be prescribed for comorbidities but not for the individual symptoms or behaviours associated with the disorder itself.[6 7] However, in reality approximately 80% of patients with personality disorder are prescribed psychotropic medication for reasons such as managing crisis and dealing with high emotional distress.[8–10]

While personality permeates all doctor-patient interactions, some clinicians feel that the management of personality disorder is an area best left to specialists. Such attitudes are thought to contribute to fragmentation and inconsistency of treatment, which adds to the challenge of managing this patient group.[11]

Previous studies have researched prescribing practices for this patient group,[12 13] and explored psychiatrists' perspectives when prescribing for people with personality disorder,[14] but research into patients' own experiences remains sparse. There would be value in further understanding patients' experiences of prescribing practices as such understanding would be expected to have implications for adherence to prescriptions, care plans, therapeutic alliances with healthcare professionals and general well-being.

This study aimed to explore the views of patients with emotionally unstable personality disorder on their experiences of prescribing practices of GPs and psychiatrists, and their expectations in regard to primary-secondary care interface, with a view to inform awareness of the relational aspects of prescribing among healthcare professionals.

MATERIALS AND METHODS

This was a qualitative research study, designed to explore opinions and experiences of patients with personality disorder, on their treatment within healthcare settings.

Purposive sampling was used to ensure that the sample obtained was sufficiently heterogenous based on demographics. Participants were recruited from an NHS specialist outpatient personality disorder service. The service is a tier 3 group-based therapy service for people who fulfil criteria for a diagnosis of personality disorder.

Prescribing is undertaken outside of the service. Some patients are held in secondary care and are reviewed by psychiatrists while others are only held in primary care (with the GP having access to secondary care for medication advice if needed). Patients admitted to the service have a structured assessment of their personality difficulties (informed by a structured clinician administered questionnaire, Personality Diagnostic Questionnaire-4 (PDQ-4)).[15]

Individuals eligible for inclusion in the study were those actively participating in group therapy in the service and those who had received a primary diagnosis of emotionally unstable personality disorder, among other secondary diagnoses. Participants were required to give informed written consent prior to participating.

Potential participants who met inclusion criteria were first approached about the study by their care team in the personality disorder therapy service. Further information regarding the study, including information leaflets, were then given to potential participants who expressed an initial interest in taking part.

Consented participants were invited to attend focus groups which took place in a group therapy room at the end of a therapy day. Out of 16 patients who were approached regarding the study, 4 participants gave informed written consent and attended the first focus group, and a further 3 participants gave informed written consent to participate in the second focus group. The focus groups were facilitated by two members of the research team. The researchers were independent to the participants with no professional relationship to them.

Focus group methodology was chosen as opposed to individual interviews, to allow participants the opportunity to raise points and counterpoints in what is a highly polarised subject.[16]

The focus groups lasted for 60 min and followed a semi-structured interview format. The semi-structured focus group questions were generated by the research team and were based on relational themes with prescribers which had emerged from previous literature, including the role of the prescriber within the wider context of healthcare provided to this patient group. Examples of focus group questions asked were as follows:

1. How do you experience prescribing by your doctor?
2. We sometimes have expectations going into encounters with other people—do you have any expectations when going into an encounter with healthcare professionals?

Data were analysed via a thematic analysis process[17] by three researchers. Audio recordings of the focus groups were made on encrypted recording devices which were transcribed verbatim. Transcripts were independently read and re-read several times by the researchers to become familiar with the data. The entire scripts were initially independently coded manually by the three researchers by highlighting specific excerpts of text and assigning relevant codes. The researchers then convened together and collated common codes. The codes were then collaboratively reviewed, refined and sorted by the researchers to form the main themes discussed in results.

With regard to data saturation, despite a limited participant sample, the researchers did not pursue further interviews after two focus groups were run. It was perceived that there were rich enough themes, good understanding of patients' experiences were developed and the data collected largely represented the construct (patients' experiences) under investigation.[18]

A feedback session of the themes generated was arranged for the participants. They were satisfied with the feedback and did not provide further comments or corrections.

RESULTS

A total of seven participants took part in the study. Four were female and three were male, the age range was 20–52 years. Participants all had a primary diagnosis of emotionally unstable personality disorder. Three participants had secondary diagnoses of depressive disorder.

Five key themes emerged. Participants felt that medication had a powerful impact on their mind and body, but expressed confusion and uncertainty on how it is affecting them. Participants had a need for a good relationship with their doctors (GPs or psychiatrists). They described a feeling of being dismissed and not believed, expressing a desire to confront the 'powerful' position of their doctors by showing anger. The nature of the doctor-patient relationship was seen to moderate positively or negatively the experience of doctors' prescribing. Finally, there were key expectations of primary-secondary care interface, including continuity of care, diagnostic clarity and a desire for different healthcare professionals to communicate with one another. These are explored in more detail as below.

Medication powerfully impacting on body and mind

Patients felt that medication had a powerful impact on how their mind and body works but expressed confusion and uncertainty on 'how' it is affecting them. There was a positive subtheme about the helpful effects of medications.

Uncertainty about how medication affects body and mind

C: "I get confused that I should be feeling something now but I am not […] but I don't know whether that's a reflection of medication or whether that's just me generally struggling and shutting down, I am not sure".

D: "I've been on meds for so long, now I don't know if it's the medication or if it's just the fact that I'm empty and there's nothing there".

Medication helps you engage with life and with therapy

F: "When you take the medications that are prescribed to you, it gives you energy, it clears your mind, it allows you to tolerate difficult feelings, distressing feelings, and it allows you to engage in some of the work that you do here, well, by being on medication".

F: "Medication…gets you to a point where you can be reached by other people".

Needing a relationship with doctors (GPs and psychiatrists)
Needing the prescriber to be available, take time out to listen, negotiate and persevere

G: "I think you should be able to book an appointment with your doctor [GP] that lasts 15–20 min if need be, even if it's in the evening or anything like that just for people that do have questions and stuff, that do need medication reviews".

A: "Having someone not rush in and tell me how to do it […] to actually just acknowledge it, yeah, it's a powerful thing and I don't think doctors are told that's even an option".

B: "We both agreed a trial period [of medication] although I didn't get what I wanted, I felt that we had a proper discussion about it and a relatively positive outcome".

Needing to see the doctor's human side

Both examples below are of GPs who have known the patient for a long time. Doctors expressing their human side is seen as positively contributing to how the patient perceives them.

E: "Maybe it's her laughing that makes me see her as less of a doctor and more of a human maybe".

E: "They get really happy and smiley and they say 'oh well done, I'm proud of you' for doing that and stuff".

Feeling there is loss of continuity and that doctors are rushed, scripted and uncaring

B: "I had to ask the doctor to stop looking at her screen and actually turn and face me […] that's terrible […] it's like people are scared of their patients to some extent".

G: "Doctors don't explain what the medication is, what it's for […] they just put you on it and you don't have a clue what it is, you only get five minin the doctors and then that's it you get kicked out after that".

G: "Back in the day, that sounds really silly, but you used to have one GP and you'd go and see that GP. Now you have like six, seven, eight, doctors in a GP surgery and you just see anyone that can fit you in".

F: "I feel like they are stressed because it's busy and they have to quickly get me in and get me out".

Confronting the 'powerful' position of the doctor

Patients were acutely aware of the 'powerful position' of the doctor and perceived themselves as powerless, often feeling dismissed and having to take some power back by expressing anger. They also felt compelled to bring a relative in order to be believed.

Anger in response to perceived dismissal

G: "I was going to take an overdose and I tried to go to my doctors […] they said 'can't get you in, sorry you're gonna have to ring back in the morning', so I thought […] Ok then, I'm gonna go home and take my overdose and I did".

G: "I went in and asked to talk to my psychiatrist that was supposed to be there and they were like 'He's not here today' […] basically you are telling us that we are supposed to pick and choose when we are gonna have a really bad day or really bad thoughts".

A: "The reason why I struggled as much as I did was that my GP never did want to put me on anything and I had many years of trying to persuade him to do so and the only good thing he ever did was to refer me to somebody else, somebody who wanted to help me".

Having to bring a family member to be believed

D: "I've actually had to take my wife with me to actually tell GPs how bad it is at home before they've actually prescribed me diazepam".

E: "I'd go to the doctors with my hood up and I wouldn't look at people in the face or let them look at me, so it helped me (bringing my sister) because otherwise I'd just be sat there starring at the floor".

G: "Most of the time a family member has to come with me cos I'm sure they think I am telling porkies (lies) or something".

Doctor-patient relationship as a moderator to the prescribing experience

In this theme, there is a strong connection between the experience of the relationship with the doctor and the prescribing outcome.

Validating experience

B: "He prescribed me something that I didn't feel was working for me, I went back to him, we talked about it, we talked about medication that I had been on that worked for me, but he wasn't happy about me going back on it, so we agreed that we would try me going back on a medication that I'd taken before and we would see how that would go [...] although I didn't get what I wanted I felt that we had a proper discussion about it and a relatively positive outcome came from it".

A: "There was this young doctor there and he was extremely compassionate, open to listening to me for as long as I needed to talk and would try and work with me with medication and that was much, much better".

Invalidating experience

A: "I feel medications have not been prescribed to me out of a place of calming me down [...] it's been more of a sort of, so that you can go away and just not bother me anymore attitude".

A: "The reason why I struggled as much as I did was that my GP never did want to put me on anything and I had many years sort of, of trying to persuade him to do so [...] his rejection of me led to me struggling with a mental health problem before I got any help".

B: "It was not that he said I don't think I am going to prescribe you anything, it was lack of acknowledgement that there was a problem there to begin with".

Expectations when different healthcare professionals are involved

The theme relates to the experience of the patient within a multiagency system.

Patients expect continuity of care, they expect professionals to communicate with one another and they expect specialist treatment, a unified approach and diagnostic clarity of their difficulties.

Patients' expectations of their psychiatrists

E: "I think psychiatrists and doctors are there to refer you onto a place like FDL (specialist psychological services) or to give you medication, like prescribe medication".

Patients' expectations of their GPs

A: "GPs should not be dabbling in the realm of psychiatrists [...] surgeries should have in-house psychiatrists".

A: "GPs [...] they are trained with drugs but they are not trained with the mind [...] not to the extent psychiatrists are".

Patients' expectations of therapists

B: "Medication is not an ideal situation to leave someone in, but waiting 18 months to two years to get into talking therapy, I would think some kind of antidepressant or antipsychotic is the only option that you have really".

E: "Therapists are there to give you therapy like talking treatment or psychotherapy".

Patients' expectations from the system

D: "I don't think that my GP, my psychiatrist, my counsellor, the hospital, I don't think any of them actually communicate at all [...] I see a psychiatrist and I see a counsellor and one of them is at my actual GP surgery and they don't even talk to my doctors, because my doctor, well doctors, didn't even know that I'd been referred to here (specialist psychological services) even though my psychiatrist did and it was in the same building".

C: "I think in the Therapeutic Community they have reviews and they invite professionals like your GP or someone to come with you here. But I've heard that they haven't got many of them actually to come in and I think that should be made more important that they do come in".

DISCUSSION

This is the first UK-based study to our knowledge that explores relational aspects of medical consultations in primary and secondary care settings, in patients with a diagnosis of personality disorder.

This study highlights the complexity that patients with personality disorder face when in consultations with their GP and psychiatrist. Given that prescriptions are discussed and offered within the context of the doctor-patient relationship, and personality disorder is itself a relational disorder and a disorder of attachment,[19] it is not surprising that this study found various complex interpersonal dynamics which come in to the consultation room.

We found that patients can become angry and engage in self-destructive behaviours as a reaction to perceived neglect by their doctor. Patients perceived doctors handing over decision making to them as a dismissive act, yet they perceived doctors who quickly turned to medications, as controlling and uncaring. Ultimately, they valued the doctors who showed that they cared by listening, being 'human' and who were prepared to enter into a balanced professional 'relationship' with them, in keeping with findings in many other patient groups such as medically unexplained symptoms,[20] and bipolar affective disorder.[21]

We found that patients with personality disorder often experienced aspects of the healthcare system as uncaring and invalidating. How the doctor relates and validates their

suffering was found to have a vast impact on the way patients subsequently managed and contained their emotions, extending even to moderate the effects of prescribing.

The study found that the nature of the doctor-patient relationship was perceived as having an important role on the outcome, with prescriptions being intimately linked to feeling validated or invalidated. It would therefore be important to acknowledge and improve awareness of emotions that arise in consultation rooms from the clinician and patient perspective. Enhanced awareness of these emotions are likely to impact on various outcomes and satisfaction for both clinicians and their patients. There is evidence that patient-centred communication impacts positively on patient outcomes such as recovery and emotional health.[22]

The final theme which emerged was perceptions and expectations regarding the healthcare system when different professionals were involved. Participants valued continuity of care and specialist input but felt that professionals did not communicate well with each other leading to fragmented experiences. People with personality disorder often require multiagency input because of their multiple needs and attachment styles.[17 19]

Despite development of healthcare structures such as the stepped-care model and shared-care agreement to promote continuity, patients might continue to be passed from one clinician to another with nobody taking responsibility for the patient as a whole. Balint captured the inevitable loss of patient trust best by the phrase 'the collusion of anonymity' to describe the confusion a patient and their family feel when 'vital decisions are made without anyone feeling fully responsible for them', reflecting clinicians' reluctance to hold responsibility for complex and high-risk patients.[23] Thus, a lack of communication between professionals, splits in treatment approaches and differences in levels of training can serve to further alienate the patient from professionals, especially prescribers, who might resort to prescribing as a quick solution to unmanageable distress in times of crisis.

Encounters in the consultation room are known to activate powerful emotions for doctors. A qualitative study of psychiatrists' perspectives when prescribing for personality disorder, exposed a number of themes such as 'difficulty in collaborating in emotionally charged consultations', 'feeling helpless when unable to relieve suffering' and 'the drug as facilitator in the doctor-patient relationship' among others.[14] The authors concluded that 'prescribing decisions may be powerfully influenced by emotional factors' in the doctor-patient relationship and emphasise the need for psychiatry to regain the psychotherapeutic perspective that can sometimes be lost in biological determinism and diagnostic pursuits.

Research shows that personality disorders continue to be stigmatised by clinicians themselves. A recent study found that psychiatry trainees in the UK hold more negative attitudes towards patients with personality disorder compared with depression, and hold significantly less sense of purpose when working with personality disorder.[24]

Clinicians clearly face numerous challenges when in consultations with this patient group. Given the difficulties that they face not least at an emotional level, it would be imperative to improve clinicians' attitudes towards personality disorder for the benefit of both clinicians and patients. Personality disorders are associated with numerous adverse long-term outcomes including physical health comorbidity[3] and prolonged contact with mental health services in both inpatient and outpatient settings.[25]

Although 'psychotherapeutic medicine' is a concept that has been embedded in the practice of medicine for many years,[26] it would be important not to lose the human skill of being a doctor in what can be a busy and rushed working environment. The Royal College of Psychiatrists has re-emphasised the importance of 'psychotherapeutic psychiatry', 'from cradle to the grave', as seen in strategic developments aiming to reinforce psychotherapy skills throughout training and practice.[27]

Strengths and limitations

The focus group methodology in this study allowed for a meaningful interaction and we believe an in-depth exploration of the subject compared with conducting individual interviews. The sample size of seven service users (three and four in each of the two focus groups) was small. Despite initial stated enthusiasm for participation, fewer individuals than expected participated in the group. It was unclear why this occurred but could be attributed to lack of reward for participants or fatigue at the end of a therapy day. Despite this, we believe the groups still allowed for a rich and meaningful exploration of the subject matter as evidenced by the emerging themes.

Participants in this study were all recruited from a single centre, which would limit the extent to which broader conclusions can be made as their experiences are not generalisable. It is possible that different data might be generated if participants were recruited from a GP or community mental health team setting. However, this study serves as a useful basis for preliminary research in a field which has not been explored in depth previously.

There will be relational aspects between primary care and secondary care, in terms of views of who should prescribe medication, which may form part of primary-secondary care dynamics. These dynamics might interfere with the study design, however they might also reflect patient complexity as already mentioned in the 'Discussion' section.

As with any qualitative study, it is important to acknowledge reflexivity.[28] This study was designed from a medical psychotherapy perspective and therefore data were approached from a relational perspective, that is, that relational themes are played out in consultations and that prescribing is influenced by the doctor-patient relationship.

Participants were already engaging in group psychotherapy therefore it is possible that there were established dynamics between them, which may have affected responses to discussion and group interactions. We have no reason to believe that this adversely affected their ability to participate fully, as they were all vocal in their opinions. In addition, feedback was later received from staff that this study promoted further medication discussions in their group therapy programme.

CONCLUSION

This paper contributes to the qualitative research literature on the management of people with personality disorder. It exposes the importance of the doctor-patient relationship as the medium to providing validation and seeking negotiation of therapeutic treatment strategies. It is impelling therefore for clinical guidelines to take into account the relational aspects of prescribing in consultations, especially with this patient group.

Training packages, as well as regular supervision, have been identified as interventions to reduce prejudices and help improve the management of this patient group, outside of specialist personality disorder services.[29] In addition, Balint groups have been identified as being beneficial and essential to the working life of GPs and psychiatrists who have participated in them. In one study, GPs reported Balint groups as increasing their perceived competence in patient encounters, enabling them to endure in their job and find joy and challenge in their relationships with patients.[30]

In terms of further avenues for research, it would be important to understand whether the relational aspects of management of personality disorder are skills based or attitudinal in origin, and how attitudes might affect the acquisition of skills and vice versa as this would inform interventions designed to improve clinical care of this patient group.

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