Graduate thesis

NTNU
Norwegian University of Science and Technology
Faculty of Medicine and Health Sciences
Department of Public Health and Nursing

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General practitioners' thoughts and experiences regarding patients with Personality Disorder

Graduate thesis in Medicine
Supervisor: Aslak Steinsbekk
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Abstract

Aim

The aim was to explore what experiences, thoughts, and attitudes general practitioners (GPs) have from meetings with patients with personality disorders (PDs) in primary care or at the out-of-hours general practice.

Method

This was a qualitative study based on semi-structured interviews conducted autumn 2021. Six GPs situated in Trondheim, Norway were recruited and interviewed about their opinions and feelings towards working with PD patients in primary care and the out-of-hours GP. The data was analysed according to the technique for systematic text condensation.

Results

All the informants found patients with PDs to be challenging and time-consuming to work with. They often experienced that treatment comes to a standstill due to refusal from the special health care service (mental health care) or poor cooperation with the patient. The GPs also found it difficult to diagnose PD patients in primary care and whished for better competence. They were of the impression that many patients are undiagnosed. It was also uncovered that PDs are stigmatised and might face resistance in the health care system.

Conclusion

It is difficult to treat and follow up patients with PDs in primary care. The GPs are not confident in their knowledge about PDs. Many patients might go undiagnosed due to this. The diagnosis is stigmatised and might lead to discrimination and improper medical treatment, especially considering attitudes in the mental health system (special health care system). It is therefore likely necessary to focus more on this patient group with more guidance and support for GPs, in order to provide beneficial treatment and support of patients with a PD.

Content

1.Introduction

What personality is and why some people seem to have what seems to be more noticeable personality traits than others have been a topic for discussed ever since the term "personality psychiatry" was introduced in the 1930s (1). Throughout history multiple aims have been made to categorize personalities and understand the more extreme versions of some personality forms (2). Theories about how people behave, think, and feel in different ways and how this make up their personality have been studied and suggested by for instance Sigmund Freud and William Stern (1). Consequently, there have been done many approaches to categorize and uncover different personality traits (3), and the leading scientific theory today is called "the Big 5" which is based on the 5 major personality traits; openness, consciousness, extraversion, agreeableness and neuroticism. This is a very thorough test, but it does not cover everything that a personality concern. It is therefore not suited in a clinical practise for instance where personality pathology is suspected (2). Today Minnesota Multiphasic Personality Inventory-2 (MMPI-II) is used together with Structural Clinical Interview for DSM (SCID-5-PF) (4) when doing a personality pathology diagnosis, for instance to uncover personality disorders.

Personality disorders (PDs) have been defined in ICD-10 as "*evidence that the individual's characteristic and enduring pattern of inner experience and behaviour deviate markedly as a whole from the culturally expected and accepted range (or norm)*" (5). A person with a PD diagnosis will therefore be affected in their daily life by problems caused by their way of experiencing others, social situations (interpersonal dysfunction) and themselves. This definition is based on Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-IV) (6) catherization of 3 groups, A-C ranging from severe to mild PDs. Many of the PDs are overlapping, express different intensities and might have different causes. In ICD-11 this problem has been addressed by changing the primary focus of the diagnosis to specifically state the severity of the disorder; mild, moderate, severe, more like the DSM-5 classification. The dominating traits are then selected from a list of five (negative affectivity, detachment, disinhibition, dissociality and anankastia) (2) (7). The aim with these clinical specifications is to make it accessible to create personal specifications related to treatment and follow-up for each patient.

Over the years general medicine has struggled to be acknowledged as an own speciality (8), alongside internal medicine and the surgical practises. Today, the field of the general practitioner (GP) is the only speciality in Norway that requires a renewal of the specialist license every 5th year. GPs play a key role in treatment and follow-up of the patients in the Norwegian

health system offer medical follow up to patients with both severe and minor health issues. It is also the GP's responsibility to get an overall view of their patients struggles and health issues. Having a regular and familiar doctor to seek and rely on for medical advice has an essentially important value, especially concerning the follow-up after treatment in the specialist health service. A research from Australia shows that family carers and patients believe that GPs are an important source for support and follow up, especially facing the secondary health care system (mental health service) and general discrimination against PD in society (9).

About 10% of the general Norwegian population have at least one personality disorder (2). In addition to having a persistent behavioural and emotional pattern that gives these patients a low quality of life, they also have a higher risk for symptom disorders/comorbid disorders for instance anxiety, depression, eating disorders, and sleeping disorders (7). PD patients are therefore a regular patient in the primary health care system. A study from the UK has shown that GPs in general have a negative attitude towards patients with PDs (10). This is a result of that they find them difficult to deal with in a primary care setting. GPs in the same study were also frustrated by the lack of communication between primary and secondary care institutions and found it difficult to follow-up their patients. Many of the same challenges were presented by Wlodarckzy et al. from in-depth interviews with GPs in Australia about their experiences with patients with a borderline personality disorder diagnosis (11). In general, they found that the GPs found it challenging to treat their patients' mental health problems alongside their physical health problems. At the same time, they addressed their concerns about how vulnerable this patient group is and how dependent they are on their GPs' quality of care, which they did not always have the resources to offer. As well as this, Imbeau et al. also addressed these issues in a French research where the conclusion was that the GPs in general needed more training and knowledge about PDs to be able to communicate and collaborate with both patients and other health care services in a more effective and sufficient manner (12).

No similar studies done in Norway have been found. There has been a continuous survey among general practitioners evaluating how satisfied they are with the specialist psychiatric health care system in the districts (District psychiatric centre; DPS) (13). From the survey conducted in 2018, it found GPs to be less satisfied with the collaboration with specialist health care system than before. They expressed the aspiration for better follow up and seminars about psychiatric health care (13).

From previously mentioned articles doctors in both England and Australia find these patients tiresome and challenging to work with and there has been uncovered that they do not feel competent to handle these patients in an effective and proper manner. This is important

information that can make the health care service more effective and considerate towards these patients who easily fall out of terms with the people they meet and generally struggle with taking care of themselves.

The aim of the study was to explore what experiences, thoughts and attitudes GPs have from meetings with patients with PDs in primary care or at the out-of-hours GP.

2. Method

2.1 Study design

This was a qualitative study based on semi-structured interviews conducted autumn 2021. A qualitative study was chosen to uncover GPs opinions and feelings towards working with personality disorder (PD) patients, which there is no data on in Norway today.

2.2 Participants

The aim was to include with general practitioners (GPs) working in Trondheim, Norway

To recruit GPs, knowing that this can be challenging, different approaches were used: Firstly. the student talked to GPs she knew from her studies and work relations and invited them to join the research. Secondly. an informative email was sent twice to medical doctors teaching at the medical faculty at the Norwegian University of Science and Technology (NTNU) from a contact list provided by the Faculty of Medicine. GPs who agreed to participate in the research were asked if they knew of other GPs that could be interested in participating.

All GPs who were interested in participating received written and oral information about the study and signed an informed consent.

2.3 Interview guide

As suggested by Malterud (14) an interview guide, where important themes and questions were listed was made to ease the flow of the interviews. This was used as a guiding tool during the semi-structured interviews. Questions were listed under each theme to help in case the conversation came to a stop or came of tracks.

The GP was first asked about herself, why she wanted to be a GP, her medical background and how long she had worked as a GP. This was done to make the subject comfortable but also to register age and work experience.

The opening question related to the aim of this study was "what do you think of having patients with diagnosed personality disorders as patients?". The rest of the guide was based on three main themes that were to be brought up if the GP did not do so herself. The three main themes with examples of questions were:

- Knowledge of personality disorders
    - What do you think of your level of knowledge when it comes to PDs?
    - How do you follow up a patient that you suspect has a PD?
- Competence and treatment: challenges concerning treatment
    - What do you think of the cooperation between the primary and secondary care when it comes to providing the best possible treatment for the patient?
    - How do you handle patients with PD when they are in a crisis?
- Experiences and attitudes: encounters with PD patients
    - How do you experience yourself in encounters with patients with PDs?
    - What do you think of this group of patients?

The interview guide was not changed between the interviews.
The complete interview guide (in Norwegian) can be found in the appendix 1.

2.4 Data collection

The interviews were individual, semi-structured and scheduled to last 20 minutes. They were recorded and transcribed consecutively. To uncover if new topics emerged, meaning that the interview guide needed to be modified, each interview was partly analysed within 2-4 days after the interview.

2.5 Data analysis

The data was analysed according to the technique for systematic text condensation (14). This approach consists of 4 steps: total impression – identifying themes and sorting out meaning units and codes – text condensation – synthesising.

The interviews were analysed in pairs. The analysis started by reading the transcripts with an open view, without focusing on the themes chosen in the interview guide. After getting a general impression of the transcript, a list of themes was identified for each pair, for instance "time consuming treatment" and "challenging patients". The student then looked for meaning units (text fragments) that illustrated the themes. The themes were revised as the meaning units got organised and formed "codes", text fragments that fitted the chosen themes. The following step was to condensate, where the meaning units were organised into subgroups before the text was written as a condensate to ensure that the voice of the GP was kept. This process was repeated multiple times, adding, and adjusting meaning units as well as themes as the coding got along, going back and forth adjusting codes and adding meaning units to make the different analysis cohere. Many of the same themes repeated themselves between the pairs and became clearer as more interviews were analysed. Finally, the condensates were rewritten to analytic text, which is presented in the result section.

An example of systematic text condensation is presented in table 2.1

Table 2.1: Example of systematic text condensation

Meaning units	**Condensate**	**Analytic text**
« The main idea is that we initiate help to those that want it and is ready to receive it and support the patients that do not manage to receive the help they are given or realise their own problems » *«You have to initiate help when the patient is ready for it and dears to talk about that their personality can lead to challenges in their lives»*	The best treatment is achieved when the patient is ready for it. Then they dear to talk about that their personality can lead to problems in their lives. These patients are aware of the challenges they meet and need that someone helps them get a grip of things. It easily snowballs for these patients because	It was generally acknowledged that it is important to try to help patients with PD, yet many GPs were critical to when the treatment should be initiated. The patient needs to be ready and able to carry her own PD to be able to work with her negative personal traits. Only then is the patient ready to acknowledge that her personality can be a

«Actually, I believe that many of them are a little aware of their own diagnosis when they come to me for help. When they first get conscious of their own diagnosis they tend to develop in a positive direction, while the ones that are still in the dark lets their personality disorder flourish »	they struggle to get a grip of themselves and turn the problem in a positive direction.	challenge in her life and lead/be connected to the other problems she faces.

2.6 Informed consent and confidentiality

The participation in this study was voluntary and a written consent was collected. The study was approved by the Norwegian Centre of Research Data (NSD) to gather personal data in form of audio recordings (see appendix 2). The recorded data was encrypted, password-protected and stored in a secure password-protected computer. The transcribes were made anonymous.

3. Result

The informants are six general practitioners (GPs) based in Trondheim, Norway. They were four men and two women, in their twenties to forties. All of them had work experience from primary care and out-of-hours GP. Three of them had experience from working in the mental health service.

3.1 Perceptions of patients with personality disorders

General practitioners said they meet patients with personality disorders both in their GP and at the out-of-hours GP. Most GPs found this a challenging group of patients and different from working with other patients. One GP called them a troubled group of patients.

3.1.1 How the general practitioners understand patients with personality disorders

"I have the impression that patients with personality disorders have a lack of understanding for their own torments, especially the psychiatric ones"

Even though patients with PDs make up a diverse group, the GPs said they found them to generally give the impression that they struggle to communicate in a constructive manner and have a diminished ability to see a situation from different angles. In addition, they tend not to follow social norms and customs. When asked about their opinion of this group of patients, many negative connotations were used, for instance “unpleasant”, “vulgar” and “ungrateful”.

Furthermore, the GPs said that patients with PDs generally appear to have a chaotic life which affect their interpersonal relations (family and friends), their work relations and economy. Because of their bad coping strategies, this frustration often resolves in parasuicidal behaviour as a matter of coping.

“I observe that they get very tired by trying to get a grip, but they fail in changing the situation. They then turn to parasuicidal behaviour or suicide attempts as a coping method.”

When a new patient’s journal states that the patient has a PD, most of the GPs expressed that they expect the patient to be tiresome to work with. They also supposed that they would end up using a lot of time trying to help them, without making the patient better.

“*I do have some experience with these patients, especially those with an emotional unstable PD. They know how to make a lot of themselves, use a lot of time and recourses”*

Not getting any better would often frustrate the patient and her poor coping mechanism would make her behave rudely towards the doctor. Some of the GPs said they found this frustrating and thought the patient to be ungrateful. This would affect the patient-doctor relationship in a negative way and result in less appropriate help for the patient. The GPs said that the key to avoid this is to have a good relation before any treatment is initiated. To aim at a continuous care was also important, where the GP’s response to the patient’s behaviour calms her and does not trigger her.

“I believe that many [GPs] dislike working with these patients. This creates an evil spiral; the patient disgusts the GP which results in them getting poorer help than they could have got. The patient then gets displeased which ends up strengthening the GPs disgust and the spiral continues.”

Not one of the interviewed GPs said that they talked with their patients about their potential PD. Many practitioners think it is uncomfortable because the diagnosis is thought to be stigmatized. If they brought it up they were afraid that they would offend the patient because PD is thought of as a taboo which nobody wants to hear about themselves.

"From my opinion, the word "personality disorder", that is something that nobody wants to be connected to. It is easier to hear that you have a depression or have a broken leg. Nobody talks about a personality disorder at a Christmas Party or on the bus. I feel it is very under a taboo"

In addition, some GPs pointed out that patients with PDs are known from the media as "bridge jumpers", which support the negative connotations related to this patient group.

3.1.2 How do general practitioners meet patients with personality disorders?

Even though most of the GPs find it difficult and tiresome to work with patients with PDs, several of the interviewees emphasised that they think of this group of patients as more fun and interesting to work with than other patients in primary care. The reason is that PD patients often present both challenging and diverse problems that the GPs find engaging to approach. It would be especially rewarding and motivating if they succeeded in creating a good relationship with the patient and things worked out.

"It can be more varying and more challenging, but also more fun and exciting to work with patients with PDs. Especially when you get to know them, and things work out and we get a good professional relationship. Even though it often is more stressful to work with than completely healthy people."

Other GPs found patients with PDs frustrating to work with due to never succeeding in helping them, no matter how much they tried. Many GPs described it as feeling powerless in the situation. As a result, the GPs admitted that they felt it was hard not to give up on them and keep treating them the same way they do others.

Two GPs also mentioned that it helps to look at the situation from a bird's eye view to handle a difficult and offensive patient, to try to understand why the patient behaves in this manner. This could often be difficult and require experience to manage.

"I understand that the discontent, anger and aggression that the patients present towards me is an expression off the hopelessness they experience in their situation, rather than displeasure with what I have done or who I am. It is not that I lack empathy, because I really understand that they must have it horrible since they can get so angry with me who is only trying to help."

Sometimes, the patient and GP do not match, regardless of the effort. One GP said that if this happened, he would inform the patient about this mismatch without hesitation and advice the patient to find a new GP. Hopefully this would provide her another GP who she could communicate better and consequently succeed in helping her. Other GPs did not look at this as an alternative and would rather focus on further relationship building to see if things could get better.

"In a working relation you have to deal with these people, you have to try and make the relationship work. Sometimes you succeed, sometimes you do not. For both yourself and the patient it might be just as well to agree on that the difference between us is too great and that it is best to part ways. That the patient should find a GP that understands him better and the GP another patient he might be able to help."

All the interviewed GPs said they aim at treating all patients in a professional manner, by approaching them with respect and meet them at the same starting point. Yet, when questioned about the differences between patients with PDs and other patients in general, many of the GPs pointed out that they find it especially demanding to appear professional in relation to patients with PDs. They tell this often is due to all the challenges that meet the GP in these specific patient appointments, usually concerning the patient's life in addition to somatic and psychiatric difficulties. Their immature way of communication also affects the patient-doctor relationship by demanding more patience and indulgence from the GP.

"Some of them are accustomed to lead the conversation and the problem of discussion. If you direct the topic of conversation, it often gets very difficult for them to relate to you. The dialogue gets immature with for instance arguing."

Even though none of the GPs felt personally affected by uncomfortable experiences, all of them had experienced encounters that had made an impression on them. Threats, crushing of furnishing and serious self-harm were mentioned. Verbal confrontations where dissatisfaction or aggression was towards the GP often affected them more than the physical outbursts.

"Doctors are only human, if I am talking to a person and suddenly receives trets against me, my family, children, […] well it's obvious that I get frightened and thinks it's uncomfortable"

3.2 Treatment of patients with personality disorders in general practise

Usually, the GPs emphasised what personality disorder they had in mind when expressing thoughts or experiences. In most cases it was the emotionally unstable/borderline, avoidant or the dependent PDs they were relating to.

3.2.1 Diagnosing patients with personality disorders in primary care

During the interviews, some PD types were brought up by all the GPs. These were the emotionally unstable PD, depending PD or avoidant PD. All these groups of patients are frequently met by the GPs, and they all seem to struggle with interpersonal relations and everyday challenges. In contrast, the GPs do not meet many patients with antisocial PD in primary care. The GPs expressed concern relating to that these patients might never seek medical help and therefore suffer alone without anyone noticing.

"One gets the impression that some of them [the PD patients] make a sport out of seeking medical help or call on the health service. While other [PD patients] perish without seeking help when needed."

It differed between GPs how well they thought they could discover patients with a personality disorder in their GP. Most of the GPs did not think that they had the needed skill and consequently just registered who they thought had a difficult personality and were hard to communicate with. The suspicion was usually raised over time, after multiple consultations.

Many efforts on helping them had been tried without any improvement. To get them to comply to treatment was also considered demanding.

Most of the GPs have multiple patients that do not have the PD diagnosis officially but have multiple treats that make them likely to belong to this patient group. Most likely many of these patients do not have a PD diagnosis, yet the GPs have experienced that they often benefit from being treated as if they have the diagnosis, with the means of more focus on structure and communication. The general impression of the GPs in this study was that the personality disorder diagnosis is under diagnosed in the population.

3.2.2 Is it favourable to know of a personality disorder before the appointment or not?

It was pointed out by half of the subjects that they preferred to know of a patient's PD diagnosis before their appointment. Then they could prepare the consultation and apply more time to structure and a communal agenda, which would ease the communication. It would also ease the GP's understanding of the patient's emotions and way of thinking. In this way, some GPs believed that they were prone to know the person and see solutions. One GP found it also easier to understand factors that could influence the patient's behaviour and motivation. That the patient was diagnosed therefore made the treatment better.

"It differs from person to person what is motivating and actuating factors and what makes the main reward from their behaviour. It is very useful to register/to see if there possibly can be/exist something than I can offer them that can substitute their parasuicidal or threatening behaviour that has taken its hold on the patient."

However, the other half of the GPs in this study stressed that there also were negative consequences for the patients with a PD diagnosis. They pointed out that there is stigma towards PDs and that they had experienced that this diagnosis could affect how the patient was treated in the health care system.

3.2.3 Handling of patients with personality disorders

It was generally acknowledged that it is important to show compassion and try to help patients with PD, yet many GPs were critical to when the treatment should be initiated. According to the GPs, the patient needs to be able to carry her PD diagnosis and acknowledge that her

personality is connected to the difficulties she faces. From their experience this step is most important to succeed in helping them. Those who do not have this insight will be difficult to help and the GPs therefore focus on supporting them rather than trying to fix what they struggle with.

Further, it was vital that the patient was involved in deciding what the primary focus of the appointment should be. In this way the patient would feel in charge of their own situation and not overshadowed by the auspices of the GP.

"In consultations with PD patients I juggle with sorting out what is important, work on structure and make a common agenda where the patient get to tell me what she thinks is most important to get a grasp on now. With this patient group it will not work to say they have to take medication for their high blood pressure for instance, if they are not genuinely interested and motivated for the plan."

Many GPs have noticed that the patients that often are most motivated and interested in getting help are the ones that have lived long with their PD or have multiple diagnoses, for instance eating disorders or somatic illnesses.

"Often, when a person only has a PD diagnosis and no other medical problem, they struggle to realize that their personality disorder is a problem, at least in the beginning. Usually, it is related to maturity and immaturity as with all other diagnoses. Some patients are ready to get help, they realize their problems and challenges."

Continuity and consistency in treatment and response to this behaviour were elements that GPs focused on as especially important in primary care. They expressed how inconsistency in feedback to the patient's behaviour could result in unfavourable outcomes where the patient got harmed or ended up killing herself. This would happen due to an escalation of her parasuicidal behaviour. For instance, if the GP has been inconsistent and indulgent concerning medication, the patient believes that she will get what she wants if she hurts herself even more than last time. As a result, she can end up killing herself without meaning to. Still, the GPs explained that this often was hard to consider if they met the patient at the out-of-hours GP where they usually would not know the patient.

"Unfortunately, it can happen. The patients do have a chronically increased risk of suicide. And they can and will, maybe not on purpose, take their own life"

Several GPs mentioned a typical difficult situation where the patient does not agree with what has been decided as the best medical approach to their problems. Often this happen if the patient demands medication or hospital admission which the GP does not think is medical responsible. The patient can then appear disrespectful and rude. To stay professional in these situations was something the GPs found demanding, yet they expressed the importance of not to turn a blind eye to the bad behaviour of the patient and bend in. To set boundaries and know when the line is crossed makes it easier for the GPs to stay professional. In addition, it makes them better equipped to make professional decisions they can rely on. This is especially important when patients present a black or white way of thinking and are not susceptible for solutions that do not match their expectations.

"You examine the patient, take a good history and thereby have a solid professional basis for the decisions you make. If you then have made up your mind based on the physical findings, I think it is wise to stand by them and not change your decision based on other grounds."

Like other patients, patients with PDs also can get depressed or have "real" plans for attempting suicide. It is therefore up to the GP do decide if the threats are due to their PD and linked to their normal behaviour or if it is something that recently has presented itself. This can be quite demanding and stressful for the GP to uncover. In special cases, the GPs also can risk ending up being the one that provoke the patient's crisis. It was generally stressed that the GPs actively work for this not to happen, but that it sometimes is impossible to prevent or foresee.

Another challenge is the patients' high expectations to what can be done in an appointment of twenty minutes. This leads to much frustration among the GP.

"When it comes to patients with PD it is kind of harder, you meet the same patients time after time, year in, year out. [...] It is something that we as general practitioners often experience in our practises. I believe we are quite unison in what we feel, because we meet them again and again. It is not like they disappear after 20 minutes when they walk out the door, they will come back again next week and next month."

The GPs' degree of journaling is often different in patients with PDs compared with others. The GPs emphasised that journaling always is important, but that it often needs to be more detailed regarding this patient group. The reason for this is that it more frequently can be aftermath with these patients than with others. A worst-case scenario is that the patient's parasuicidal thoughts and statements are thought to be part of her chronic suicidal behaviour, but then she ends up taking her life. If this happens it is of vital importance that the GP has documented what has been said and done in the consultation, so that the account of affairs is as correct as possible.

"I am even more thorough with these patients than others, at least when it comes to journaling. The reason why is that I know that it sometimes can be an aftermath. That the patient can do parasuicidal actions and sometimes it goes wrong. Or they make a formal complaint about me or attack me. Therefore, it is wise to document everything that is said and done in the consultation. It is more important with these patients than with others, even though journaling always should be done"

3.4 Treatment of patients with personality disorders outside general practise

When the GPs have encounters at the out-of-hours GP, they either meet patients they have never seen before or patients they have tried to help multiple times before. As in primary care, patients with emotional unstable PD are the dominating patient group in the out-of-hours GP.

3.4.1 Meetings with patients at the out-patient-GP

According to one GP, there is about 10 patients they regularly meet if they frequently work at the out-of-hours GP. These meetings often bear traces of patients in crisis, presenting injuries from parasuicidal threats (jumping of bridges, self-harm). If they have tried to help the patient before, the GPs question if there is a waste of resources to initiate initiatives because "everything" has been tried out before. However, the GPs are aware of this tendency of thinking, and they wish things were different. One GP explained that they get marked by the hopelessness of things in these meetings. To repeatedly see the same patient contact the out-of-hours GP with the same problem again and again is demotivating and discouraging.

"If I have seen the same case 700 times in one year and I am part of the emergency medicine chain, it makes me feel "orhg!", it is an expression of deep concern, but I do not manage to

see the human in the same way as before because I feel it is a waste of recourses to try and help them once again because it did not work the first 699 times, right?"

Patients with PDs are regularly seen in the health care system and usually have been upon other health care services and DPS before. From the GPs experiences they often demand more time than other patients, not only considering treatment but also because the GP needs to get to know them to be able to help them. In addition, the patients tend to have unworkable expectations that cannot be meet or fixed in a short time. The GPs therefore easily feel pressed for time. One of the GPs tried to suffice by setting up these patients at the end of the workday so that they could talk without a time limit. Unfortunately, there are not many GPs that have capacity for this individual adaptation.

"It is important to make the patient understand that we have limited time and options for fixing things here and now. There needs to be a good understanding between patient and GP. There is no magic wand that can solve everything in 20 minutes."

3.2.6 Cooperation with the secondary health care service

Among some of the GPs there were much frustration towards the special health care service. Most of them had experienced that patients they had referred to the special health service because they had assessed the patient to be in need of professional psychiatric help were rejected. According to the GPs, the rejection was reasoned for based on the patients PD diagnosis or that she had been treated at the clinic before. Many GPs have the impression that the PD diagnosis marks the patients and overshadows the other psychiatric problems they have. The special health service therefore gives the impression of not prioritising them because of this.

"Sometimes I have used a lot of time talking with the patients and decided to refer them to the special health service, but they get rejected and do not get an appointment at the DPS. In a way the patients have got their personality disorder diagnosis which labels them as hopeless cases where everything has been tried without success."

These kinds of declinations make the GPs question their own judgement and feel insufficient concerning treatment of this patient group. The result is that the GPs do not know what to do,

they have tried to help them and has reached a standstill in treatment. Yet, they feel solely responsible for the patient.

"Sometimes the DPS refuse to follow up the patient as they should. My theory is that this is based on the fact that the patient is manipulative, dramatizing and a little difficult to relate to. Yet, the patient obviously has a good effect upon treatment for the other afflictions that lies on top of the PD and that she is entitled to. It is a very sad thing to observe."

The disagreement between the primary and secondary health services makes the relationship stiff and difficult to work through. But as pointed out by one GP, the health care service is not perfect and not adapted to meet this patient group. They should have an alternative treatment option, for instance a polyclinic.

Yet, some of the GPs are of another opinion. They say that the collaboration between themselves and the special health service works quite well and that they usually agree if the patient is refused hospital admission when they reflect upon it.

4. Discussion of method

This section follows the structure of "Methods" to ensure that the consequences of what was done is discussed in relation to their possible impact on the finding and generalisability. First, some notes on the researcher's reflexivity are given.

4.1 Reflexivity

Personality disorders are frequently mentioned during the medical study. Often, I would sit back with the feeling that they represented some of the more difficult patients we will meet as future medical doctors. They require close follow-up and often present with many different symptom disorders that need treatment alongside their psychological problems. This interested me and I started to read about PDs in general and suggested treatments, for instance STEPPS (15) which is a behavioural course designed for patients with borderline personality disorder. After being a visiting student at the psychiatry department I wanted to learn more about how PD patients are experienced in primary care, as GPs seemed to play an important part in follow-up and support for these patients. In addition, I was aware of the exertion primary care and GPs are under these days and I wondered how this affected work with PD patients (who are believed

to a challenging group of patients). By doing this I hoped to uncover positive and negative elements that could possibly improve the care of these patients and ease GPs everyday work life in future.

This being my motive for studying how GPs experience patients with PDs made me aware of my potential bias from the start. I therefore focused on making the interview guide as neutral as possible and dwell on GPs handlings and meetings with this patient group. During the interviews I also aimed to appear as neutral as possible and let the GPs express any emotions or opinions. Yet, what I chose to focus on and ask follow up questions about were of course coloured by my perspective. My point of view will also affect the choice of themes and thereby the outcome of this study.

4.2 Participants

It turned out to be difficult to requite GPs to this study. Despite the many different approaches used to reach and engage as many as possible, only six GPs were requited during two months. Due to the deadline, there was no time to engage more participants. This resulted in all GPs that agreed to participate was included in this study. Furthermore, all the GPs were situated in Trondheim/Norway. However, there were rather good variation in age, gender and years worked as a GP among the informants, which improves the generalisability. Still, the representativeness of the sample is likely to be limited.

At the moment there is a general recruitment crisis in Norwegian GP, due to a relatively new health reform, an increased workload is put on the GPs as tasks are shifted over from secondary to primary health care (16). The involvement in making this known have especially been hight among GPs from Trondheim. It is therefore possible that GPs in Trondheim feel this more strongly than other GPs in Norway. If this is the case, their overfatigue might affect how they experience to work with demanding patients as PD patients are known to be.

4.3 Data collection

During the interviews the researcher tried to appear neutral and create a relaxed and safe atmosphere. The subject is known to be regarded as heavy and negatively charged based on literature and previous research (10, 11, 17, 18). Even though the interviews went well, the following analysis showed that the interviewer could have elaborated more on some themes,

for instance why some GPs found these patients motivating to work with, dig deeper into why GPs found it difficult to diagnose PD patients and what their actual knowledge about PDs were. This was likely due to an inexperienced interviewer.

Two out of six interviews were held digitally. In both, the camera of the interviewer did not work, and the GPs could therefore not see the interviewer. This might have affected what the persons experienced as comfortable to talk about. A consequence is that less sensitive information has been shared. The digital format also led to some misunderstandings of questions which was not misunderstood by any other subjects. This was unfortunate as the interviews were promised to only last for 20minutes.

The length of the interviews of 20 minutes was estimated to be enough time to talk about the research question. The reason why is that the research question was quite specific, and the interviewer could therefore quite easily delve deeply into the subject in this limited amount of time. Many of the GPs also found this relieving as they did not have too much time on their hands.

4.4 Data analysis

The process of analysing bear traces of the researcher being inexperienced. The interviews were analysed in pairs, and the identified themes were compared and matched continuously. The analysis was also discussed with the supervisor who is experienced in doing qualitative studies. Thus, analysis was done as systematically and scrupulously as the researcher's ability allowed for. Still, it might be that the whole potential of the data material might not have been retrieved.

Personality disorders are a heterogenous group and includes many subtypes of PDs. When the GPs talk about PD patients in general it was not always clear if they had one specific patient or PD type in mind. Yet, most of the GPs highlighted that they tried to talk about PD patients as a common group and pointed out if there was a special PD type they had in mind as they shared their experiences. It is worth noticing that the PD patients that the GPs believe to meet the most are the emotionally unstable PD, avoidant PD and depending PD, which match the PD types frequently seen in primary care in the UK (19). Therefore, the GPs most likely share experience from working with the same PD types, even though this cannot be clarified as the subtype was not mentioned in all situations. Nevertheless, it is therefore likely to believe that their reflections

are representative, especially since they stressed what type of PD they had in mind when they came with thoughts of specific situations or challenges. Yet, this means that the result/analysis must be understood as a presentation of GPs general views of PD patients in primary care. It also illustrates that it is easy to think of them as a unified group, even though they do not necessarily share the same challenges and appearance in contact with the health care system.

5. Discussion of result

5.1 Summary of findings

All the general practitioners interviewed for this study had a wide variety of experiences from working with patients with PDs and patients with apparent personality pathology. The general impression was that PDs are underdiagnosed in the population and in addition most of the GPs did not feel competent to diagnose PDs. Consequently, none of the GPs discussed a potential PD diagnosis directly with their patients, even though they suspected them to have an undiagnosed PD. The study showed that there were different interpretations regarding the consequences of knowing if a patient had a PD diagnosis. Some GPs said that it made it easier for themselves to approach the patient and plan the consultation, while others had the impression that a PD diagnosis made life more difficult for the patient. Most of the GPs considered this group of patients as being tiresome and challenging to deal with in their clinical practise, but some also underlined that they found them interesting and motivating to work with. Even though all the GPs had experienced dramatic situations or received threats from patients with a PD, no one said that this bothered them after the situation had been resolved. Most of the GPs showed understanding for the patients' outbursts and challenging behaviour.

5.2 Diagnosing personality disorders in primary care

The GPs in this study reported that they had met quite a few patients who they experienced to have difficulties with interpersonal relationships, themselves, and everyday living, yet most of these patients did not have a PD diagnosis. Thus, they believed many patients with PD were undiagnosed. Karterud et.al suggests that the population prevalence in Norway is 10% (2). The prevalence for PDs in the general population in UK is 4% (10), but the prevalence is estimated to be higher, about 24%, among patients in primary care in the UK (19). It is therefore likely that there is a higher prevalence in the Norwegian primary care than in the population.

Aragonèsa et.al (20) conducted a study in Spain where the number of diagnosed patients with Borderline Personality Disorder (BPD) was much lower than the suggested population prevalence, both in Spain and abroad. They concluded that the most reasonable explanation was that many patients were undiagnosed because of not being recognized in primary care by their GP. This adds up to the fact that the GPs in this study and others (10) (11) have stressed that they lack knowledge of PDs and find it difficult to diagnose them.

Most of the GPs in this study expressed that they wished to learn more and improve their knowledge about PDs which would be helpful when trying to aid and guide them. Similar findings were done by French et.al (10) where GPs expressed challenges connected to having little knowledge of PDs. GPs interviewed by Wlodarczyk et.al (11) communicated the same want for improved competence regarding PD patients. This suggests that PDs in general needs more attention in primary care then there is today. No studies investigating GPs knowledge on PDs have been found, and such a study is thus warranted.

5.3 Stigma

As previous studies have shown (10, 17) also GPs in this study expressed negative feelings towards patients with PDs in primary care. Most of the GPs think of this group as tiresome and challenging to deal with. Nevertheless, some GPs emphasised that they found them interesting and motivating to work with. These GPs also admitted to feel frustrated and powerless after difficult consultations with this patient group, but they expressed that they understood the patients's struggles and accepted that their behaviour had little to do with them as their GP in terms of bad treatment or unprofessionalism. Reavley et al. (18) did a study on attitudes towards patients with mental health issues (not only PDs) among health professionals and the general public. They discovered that health professionals had fewer negative views on this patient group than the general public. However, they uncovered that mental health professionals were much more understanding and considerate towards patients with PDs than GPs, who in general were found to have stigmatising attitudes towards these patients. (18). Yet, in this study the GPs were of the belief that they were more understanding and professional than their fellow co-workers in the mental health care service.

Many GPs in this study had the impression that having a PD diagnosis only made things more difficult for the patient, both regarding the mental health care system and the society in general.

Interestingly, a group of researchers from England (17) have looked at this aspect and discovered that mental health professionals associated a PD diagnosis with patients that are harder to treat and manage. Possible confounders were analysed and dismissed as obvious biases. Accordingly, they asked if this attitude could be explained as stigma towards PD and that the patients were automatically labelled as difficult to manage in comparison to other patients who, despite a lack of a PD diagnosis also had pathological personality traits. Many of the GPs in this study said that they had experienced those patients not getting appropriate help from the secondary health care service based on their PD diagnosis.

5.4 Having consultations with personality disorder patients

Wlodarczyk et. al. (11) found that GPs often prefer that a PD (or Borderline PD) is recognised and diagnosed before they meet the patient the first time. Moreover, they found that this makes the GP better prepared to act appropriately and handle any possible challenging situations. Some of the GPs interviewed in this study expressed the same thoughts, feeling that it was an advantage that as many (as possible of) the PD patients were diagnosed before they were followed up by their GP. In this way they would get to the core of the problem more effortlessly and efficiently. Resultantly, they believed this to be important,

A reoccurring aspect in the studies on this topic shows that PD patients are known to demand much of their GP. Wlodarczyk et.al (11) found that GPs often felt overwhelmed by the needs these patients presented to them. French et al. (10) also reported that GPs in Britain experienced it to be difficult to handle their PD patients' expectations and needs in one appointment in comparison to their other patients. Concurringly, the GPs in this study also had viewpoints on this. Their PD patient’s expectations were often difficult to meet in one appointment and could result in uncomfortable situations. What often made this easier for the doctor was to know the patient so that they understood what the patient needed, and sign pose where the treatment was headed. Setting boundaries for themselves and for the patient was also thought important. In similarity, statements relating to the same situations were also reported by French et. Al (2).

6. Conclusion

This paper has shown that it is challenging to be the GP of a patient with a PD. Resultantly, the doctor struggle to meet the patients' expectations and communicate with them. Hence, knowing that a patient has a PD before the appointment might help the GP in helping the patient. Yet, the diagnosis is stigmatised and might lead to discrimination and improper medical treatment, especially considering attitudes in the mental health system (special health care system). The GPs in this study said that they found it challenging to diagnose these patients, but still believed that PDs are underdiagnosed.

They also found it difficult to discuss this possible diagnosis with the patient. One possible reason is that the GPs feel they have insufficient knowledge and experience with diagnosing this group of patients. The challenges connected to cooperate with the secondary health service (mental health service) can also be a possible explanation.

Personality disorder patients make up a sizable proportion of the GPs patient group. It is therefore important that GPs have the needed knowledge to understand and communicate with them. The GPs tend to follow the PD patients over a long period of time, and they wish to help as best they can. Yet, there are many factors that make them feel alone in the situation which leads to a standstill in treatment. It is therefore likely necessary to focus more on this patient group with more guidance and support for GPs, in order to provide beneficial treatment and support of patients with a PD.

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Appendix 1: Interview guide in Norwegian

Intervjuguide til semistrukturerte og fokusgruppe intervjuer

Problemstilling

Oppfølging og behandling av pasienter med personlighetsforstyrrelse i allmennpraksis/i møte med primærhelsetjenesten.

Mål med intervjuene

Formålet med intervjuene er å kartlegge hvilke erfaringer, tanker og holdninger fastleger har fra møte med pasienter med personlighetsforstyrrelse i allmennpraksis/primærhelsetjenesten.

Jeg ønsker å avdekke hvilke utfordringer fastlegene står ovenfor, hvilke erfaringer de har gjort seg i møte med denne pasientgruppen, hvilken kunnskap de har rundt PF, tanker om hvordan samhandling mellom institusjoner fungerer og hvordan de forholder seg til disse pasientene.

Start

Introdusere meg selv

Be legen(e) om å introdusere seg selv

- Spesialisering (hvorfor allmennlege?)
- Hvor lenge vært allmennlege
- Alder

Introduksjonsspørsmål

Kan du si hva du mener om å ha pasienter med kjent personlighetsforstyrrelse som pasienter?

Følgende skal dekkes i intervjuet, tas aktivt opp hvis ikke intervjuobjektet tar det opp selv

- Kjennskap til PF
- Kompetanse og tilbud: utfordringer knyttet til behandling
- Erfaringer og holdninger: møte med pasienten og erfaringer

Utfyllende spørsmål som kan brukes hvis samtalen må stimuleres, eller for å stille utfyllende spørsmål om tema som intervjuobjektet selv tar opp

Kjennskap til PF

- Hva tenker du om ditt eget kunnskapsnivå knyttet til P?
    - Hva vet du om PF?
    - Diagnosekriterier osv
- Hva skiller denne pasientgruppen fra andre pasienter på listen din?
    - Spesielle problemer, utfordringer
- Hvordan følger du opp en pasient som du mistenker kan ha en PF?
    - Hvordan selektere hvem som kan ha nytte av henvisning til DPS/STEPPS?
- Hvor mange pasienter på din liste vil du anslå har en PF?
- I hvor stor grad mener du at PF oppsøker hjelp hos fastlege/legevakt?

Kompetanse og tilbud: utfordringer knyttet til behandling

- Hvordan synes du samarbeidet er mellom primær og sekundær helsetjenesten for å tilby pasienten best mulig behandling
    - Når du søker råd hos for eksempel DPS/psykiatrien, hvordan føler du deg møtt?
- Kjenner du deg kompetent til å tilby adekvat behandling og oppfølging? Evt henvising
- Hvordan håndterer du pasienter med PF i en krisesituasjon?
- Hvordan foregår behandling av andre plager/sykdom som pasienten presenterer til deg som sin fastlege?
- Hva kunne gjort behandling og oppfølging av disse pasientene bedre?
- Hvilke tanker har du gjort deg om hvordan behandling og oppfølging burde vært bedre for denne pasientgruppen?
    - Hva burde være med i en effektiv behandling av dem med PF?

Erfaringer og holdninger: møte med pasienten

- Hvordan opplever du denne pasientgruppen?
- Hvordan håndterer du denne pasientgruppen?
- Hvordan opplever du deg selv i møte med pasienter med personlighetsforstyrrelse?
- Tror du at dine holdninger er representative for dine kollegaer i helsevesenet?

Avslutning

Har du noe du ønsker å dele eller fortelle om som vi ikke allerede har snakket om?

Appendix 2: Written consent in Norwegian

Vil du delta i forskningsprosjektet

Allmennpraktikeres oppfølging og behandling av pasienter med personlighetsforstyrrelser i primærhelsetjenesten?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å undersøke fastlegers holdninger, tanker og erfaringer i behandling av pasienter med personlighetsforstyrrelser i allmennpraksis/primærhelsetjenesten. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål

Formålet med intervjuene er å kartlegge hvilke erfaringer, tanker og holdninger fastleger har fra møte med pasienter med personlighetsforstyrrelser (PF) i allmennpraksis/primærhelsetjenesten.

Det finnes 6 hovedgrupper av PF, hvor noen ses svært ofte i helsevesenet (borderline/emosjonelt ustabil), mens andre svært sjeldent oppsøker helsevesenet med sine problemer (antisosial). På befolkningsbasis er det estimert at 10% av befolkningen har en personlighetsforstyrrelse. Estimatet er mulig noe lavt ettersom det trolig er mange som er udiagnostisert eller ikke oppsøker helsevesenet med sine problemer og utfordringer.

PF er dermed noe en ser ofte i allmennpraksis og for eksempel på legevakt. Felles er at de generelt sliter med interpersonelle relasjoner, impulskontroll og funksjonssvikt sosialt. Dette tar de selvfølgelig med seg i møte med primærhelsetjenesten og det kan dermed være utfordrende å møte disse pasientene der de er og utøve tilstrekkelig helsehjelp både psykisk og somatisk.

Ved å intervjue leger som møter denne komplekse pasientgruppen og evt følger dem opp over tid, søker jeg å avdekke hvilke utfordringer fastlegene står ovenfor (både på legevakt og i allmennpraksis), hvilke erfaringer de har gjort seg i møte med denne pasientgruppen, hvilken kunnskap de har rundt PF, tanker om hvordan samhandling mellom institusjoner fungerer og hvordan de forholder seg til disse pasientene.

Det har blitt utført lignende studier i Australia, England og Frankrike, men ingen i Norge. Ved å kartlegge hvordan leger opplever denne pasientgruppen og hvilke utfordringer de står ovenfor i behandling vil behovet for mer kunnskap/tverrfaglig samarbeid/institusjoner kunne bli avdekket.

Disse intervjuene vil danne grunnlaget for hovedoppgaven min på medisinstudiet ved NTNU.

Hvis det blir avdekket en interessant trend eller forståelse fra analyse av disse intervjuene vil hovedoppgaven mulig kunne omformes til en artikkel.

Hvem er ansvarlig for forskningsprosjektet?
Medisinsk fakultet og Institutt for samfunnsmedisin og sykepleie.
Veileder: Aslak Steinsbekk
Biveileder: Sara Germans Selvik

Hvorfor får du spørsmål om å delta?
Utvalget av leger som blir spurt om å delta er bekjente og kollegaer av Celine Gradek. I tillegg kommer «Snow-ball» metoden til å bli benyttet, hvor dem som intervjues foreslår aktuelle kandidater de selv kjenner. Til prosjektet trengs det 5-10 allmennleger i Trondheimsområdet. Hver enkelt blir kontaktet direkte av ansvarlige student.

Hva innebærer det for deg å delta?
Hvis du sier ja til å delta i prosjektet innebærer det at du vil bli intervjuet i ca.30 min om dine erfaringer knyttet til å møte og behandle pasienter med en personlighetsforstyrrelsesdiagnose i allmennpraksis. Intervjuet kan skje fysisk på ditt legekontor, digital plattform eller på telefon, alt ettersom hva som passer deg best.

Intervjuet kommer til å bli tatt opp på en godkjent båndopptaker og slettes når oppgaven er godkjent. Intervjuet bli transkribert elektronisk fortløpende etter hvert intervju.

All informasjon blir anonymisert underveis og ingen personopplysninger blir med i hovedoppgaven.

Hvis du deltar som del av en kollegagruppe som diskuterer tema vil samtalen også tas opp på båndopptaker, transkribert og gjøres anonymt og slettes når oppgaven er godkjent.

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Alle dine personopplysninger vil da bli slettet. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Hvis du ønsker å trekke deg fra prosjektet, send en mail til celinegradek@gmail.com

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

- De som har tilgang til data innhentet fra disse intervjuene er ansvarlig student Celine Gradek, veileder Aslak Steinsbekk og biveileder Sara G. Selvik.
    - Medisinske fakultet og Institutt for allmennmedisin og sykepleie.
- Personopplysninger som navn og kontaktinformasjon vil bli oppbevart i en fysisk bok i studentens bolig, på et rom som kan låses. Navn og kontaktopplysningene dine vil omgjøres til kode og holdes avskilt fra øvrige data. Intervjuene vil lagres på minnepenn som er passordbeskyttet.
- Ingen deltagere vil kunne bli gjenkjent i hovedoppgaven eller i en eventuell publikasjon.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?

Opplysningene anonymiseres når prosjektet avsluttes/oppgaven er godkjent, noe som etter planen er 15.januar.2022. Etter godkjennelse av oppgaven (i løpet av vårsemesteret 2022) vil alle data (kontaktopplysninger, lydopptak og lignende) slettes.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg, og å få utlevert en kopi av opplysningene,
- å få rettet personopplysninger om deg,

- å få slettet personopplysninger om deg, og
- å sende klage til Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra Fakultet for medisin og helse NTNU og Institutt for allmennmedisin og sykepleie har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?
Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

- Institutt for allmennmedisin ved NTNU, Professor Aslak Steinsbekk
    - Epost: aslak.steinsbekk@ntnu.no
    - Telefon: 73597574
- Fakultet for medisin og helse: student Celine Gradek
    - Epost: celinegradek@gmail.com
    - Telefon: 92686033

Personvernombud ved NTNU: Thomas Helgesen
Epost: thomas.helgesen@ntnu.no
Telefon: 93079038

Hvis du har spørsmål knyttet til NSD sin vurdering av prosjektet, kan du ta kontakt med:

- NSD – Norsk senter for forskningsdata AS på epost (personverntjenester@nsd.no) eller på telefon: 55 58 21 17.

Med vennlig hilsen

Celine Gradek, Student Aslak Steinsbekk, Professor og veileder

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet «Fastlegers oppfølging og behandling av pasienter med personlighetsforstyrrelser i allmennpraksis» og har fått anledning til å stille spørsmål.

Jeg samtykker til:

- ☐ Å delta i studien og la meg intervjue, både personintervju og evt gruppeintervju
- ☐ Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet

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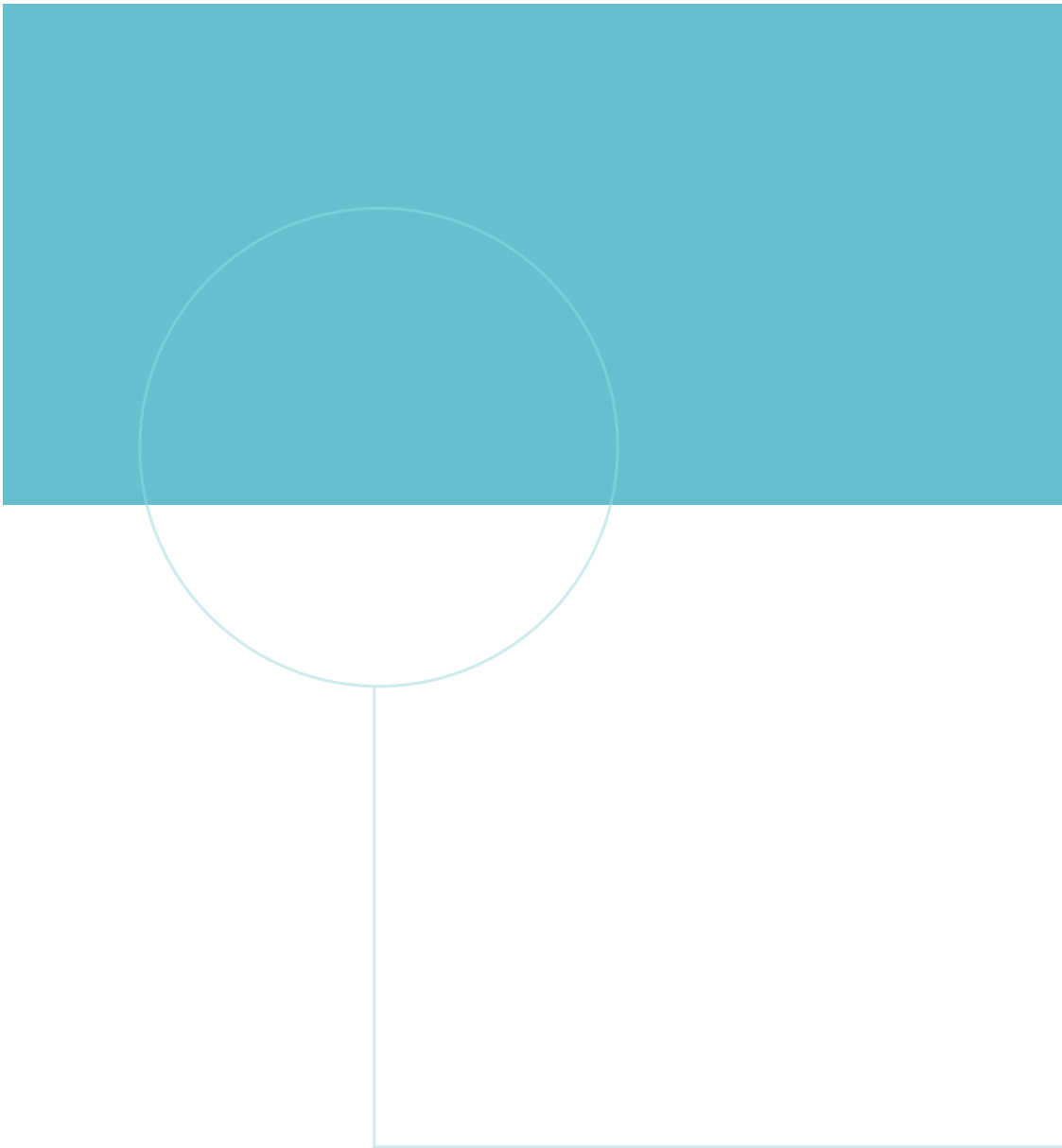
(Signert av prosjektdeltaker, dato



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Science and Technology