"But what can a Psychiatrist do about my Bowel?!"
Borderline Personality Disorder in Primary Care:
A Qualitative Analysis of Patient Experience.

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Declaration

Other than the above mentions, I declare that I am the sole author of this thesis and that the work contained herein is my own. This thesis, or any part of it, has not been submitted for any other degree or professional qualification.

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ABSTRACT

Background: Borderline Personality disorder (BPD) is one of the most common disorders presenting to General Adult Psychiatry. Characterized by mood instability, impulsive, self-harming behaviour and significant difficulties in interpersonal relationships this disorder presents a significant challenge to those involved in their care. General Practitioners (GPs) are an important part of health care. In addition to meeting physical health needs they support the management of psychiatric illness and are the gatekeepers to other services. In recent years research into personality disorders has proliferated, mainly within specialist mental health services. Less is known about patterns of health care in primary care and what the experience of these services is like for individuals with BPD.

Aim: The aim of the study is to ask individuals with a diagnosis of BPD about their experience of going to see their GP.

Methods: Eleven individuals with a diagnosis of BPD were asked about their contact with GPs by way of a semi-structured interview. Interviews were recorded and analysis was carried out using an Interpretive Phenomenological Analysis (IPA).

Results: Five super ordinate themes were identified: *Experience of Having a BPD Diagnosis, Perceptions of GPs, Invalidating Experiences, Sense of Self* and *What Works Well.*

Conclusions: The findings demonstrate that many individuals with a diagnosis of BPD struggle in their consultations with GPs. Unsatisfactory encounters are internalised and reinforce perceived stigma thus perpetuating an already damaged sense of self. GPs need to have more awareness about such issues in order to deliver services more effectively to this population due to possible implications for mental and physical well being.

CHAPTER ONE

INTRODUCTION

1.1. Overview

Borderline Personality Disorder (BPD) is one of the most commonly presenting problems in specialist mental health services (Bender Dolan, Skodol et al., 2001). Characterised by intense interpersonal relationships with high frequency of self-harm and completed suicide, this disorder is one of the most challenging to deal with (Nehls, 1999; Paris 2005). Over the last ten years there has been a zeitgeist in the way all personality disorders are conceptualised (Sperry, 1999). For many years, individuals with this diagnosis were told they were in some way flawed and despite experiencing great distress were denied offers of help; indeed they have been one of the most stigmatised groups within society (Haigh 2006; Kane 2006; Pilgrim, 2001). Once considered untreatable, there is an emerging evidence base from pharmacological and psychotherapy suggesting that although current treatments cannot 'cure' this group of disorders these can certainly facilitate improved function and improvements in quality of life by targeting specific symptoms. This is by no means accepted, however, and individuals with personality disorder are consistently highlighted as being undeserving of treatment as a result (Mr G Report, Mental Welfare Commission for Scotland (2007)).

Whilst patterns of health care use in specialist mental health services by people with BPD is now well established, what is less clear, is the impact of BPD in primary care. General Practitioners (GPs) are an important part of health care. In addition to managing physical health they also support the management of psychiatric illness and are the gatekeepers to other services. On average, individuals in Scotland visit their GP five times each year (Scottish Executive 2005). Recent government strategies such as "Delivering for Mental Health" (Scottish Executive, 2006) acknowledged that individuals with severe and enduring mental health problems find it difficult to access health care and consult in practice much less than expected, yet the reasons why are still poorly understood.

This thesis aims to examine the experiences of people with BPD in general practice. To properly understand the factors that may influence this, it is first necessary to understand what exactly is meant by *disordered* personality. To understand this, however, one must first consider what the term personality means; and something of the difficulties inherent in defining both.

1.2. Personality

The word personality comes from the Greek word-meaning mask (Livesley, 2001). Personality is a complex concept that has been the muse of human thinking for centuries, (Ferguson & Tyrer, 2000; Livesley, 2001). Indeed Allen (2006) has suggested that attempts to reduce the concept to simple definitions may have limited our understanding. Preoccupations with the uniqueness of human behaviour can be dated to Ancient Greece (Livesley, 2001; Blackburn, 2006), most notably Hippocrates and his attempt to describe the human personality through the description of the four humours (Ferguson & Tyrer, 2000; Tyrer, Coombs, Ibrahim, Mathilakath, Bajaj, Ranger, Rao & Din, 2007). Currently there still lacks a clear working definition of personality and, indeed, changes in the use of the term both in psychiatry and psychology has further complicated communication in reaching an agreed definition (Allen, 2006; Alwin, Blackburn, Davidson, Hilton, Logan & Shine, 2006; Livesley, 2001; Sperry, 1999).

Whilst a definitive definition has yet to be achieved it is generally accepted that the study of personality concerns the uniqueness of individual behaviour (Alwin, Blackburn, Davidson et al., 2006). More specifically personality theorists are interested in those *stable* and *consistent* behaviours that an individual enacts across a variety of situations. Personality therefore refers to the organisation and structures that underpin the motivation for, and initiation of, behaviour (Alwin et al., 2006; Livesley, 2001). The study of personality is inferred through observable behaviour often within an interpersonal context. Thus when personality is considered disordered it often implies serious consequences for the individual in terms of

interpersonal functioning and supports. It is likely that these difficulties will extend to relationships in help seeking also.

1.2.1. Traits

Traits may be thought of as the vocabulary of personality (Blackburn, 2006). They are the descriptive words used to describe individuals, for example, argumentative, caring or helpful. The main feature of traits, which make them distinguishable from transient mood states, is that they are considered to be stable over time (Matthews & Deary, 1998). This proposition fuelled a significant debate within the personality field, the main critic being Mischel (1968) who did not subscribe to the view that traits could account for all the variance of human behaviour across situations. The scope of this current study does not permit a full review of this debate but it is now accepted that traits describe likelihood or propensity for an individual to behaviour in a certain way across a variety of situations and in that sense represent the average behaviour of individuals (Alwin et al., 2006; Blackburn, 2006; Matthews & Deary, 1998).

1.2.2. Temperament

The distinction between temperament and personality is often unclear as the terms are frequently used interchangeably (Livesley, 2001; Sperry, 1999). Whilst there have been many definitions of temperament one way in which it has been conceptualised is to regard temperament as the biological expression of personality traits (Livesley, 2001; Sperry, 1999). Rutter (1987) used the term personality to describe innate primitive personality traits commonly expressed in early infancy.   In this sense temperament may be seen as genetic underpinnings of personality, considered to be almost predetermined explaining its pervasive and enduring nature (Ferguson & Tyrer 2000). A less determinist view would suggest that temperament is the extent to which various developmental pathways are reinforced and indeed will be influenced by external factors, (Millon, Meagher & Grossman, 2001).

1.2.3. Character

Character is synonymous with personality and has been and continues to be used in a number of different ways (Livesley, 2001). The term dominated early psychological descriptions of personality, namely psychodynamic theorists who used the term character as the equivalent to personality; an example being Freud and his descriptions of the oral, anal and phallic characters (Allen, 2006; Sperry, 1999). A more contemporary view uses the term character to reflect the psychosocial influences on personality (Livesley, 2001; Sperry, 1999). Personality therefore is not simply the constellation of various traits that an individual possesses to a greater or lesser degree but instead is the confluence of character and temperament (Cloniger, Svrakic & Przybeck, 1993).

1.2.4. Nomothetic and Idiographic Approaches to Personality

Two main approaches have been adopted in the study of personality. The nomothetic approach proposes that personality reflects a basic set of principles and general laws that are applicable to all. Each individual's personality is therefore an expression of a finite number of traits that each person possesses to a greater or lesser degree (Allen, 2006; Tyrer & Ferguson, 2000). One of the most notable nomothetic theorists was H.J. Eynsenck whose three-factor model dominated early personality research (Allen, 2006; Gletiman et al., 1999). A major strength of the nomothetic approach is the ease at which theories can be generalised and systematically reviewed through statistical methods such as factor analysis (Allen, 2006; Millon, Meagher & Grossman, 2001).

In contrast the idiographic approach is concerned with the uniqueness of human behaviour. Gordon Allport (1937) was highly influential in the development of the idiographic approach and was concerned that the dominance of nomothetic theory had neglected the individual in society (Allen, 2006). Whilst Allport (1966) also spoke of personality traits he disagreed that an individual's behaviour could be explained by generalised laws. So whilst individuals may be said to possess the same trait, the expression of such a trait will be unique to the individual, dependent on past experience and context (Allport, 1966).

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1.3. Personality Disorders

The term personality disorder (PD) is used to described patterns of maladaptive thinking and behaviour that are stable over time and resistant to change (Livesley, 2001; Ward, 2004). Defined by the American Psychiatric Association (APA) in the Diagnostic and Statistical Manual 4th Edition – Text Revised (DSM IV -TR) as;

"An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture…is inflexible and pervasive…leads to clinically significant distress or impairment … is stable and of long duration"

p287 APA (2000)

Such working definitions of personality disorder appear to pay little attention to the on-going controversy in trying to define and explain personality.

1.3.1. Classification

The diagnostic classification system for both the International Classification of Disease tenth edition (ICD-10) (WHO, 1992) and the DSM IV – TR (APA, 2000) is categorical and in this sense represents a dichotomy; either the individual has a personality disorder or does not. The DSM IV –TR operates a multi axial system that separates transient state disorders that may occur through out the life cycle (Axis I) from disorders that have an early onset and pervasive course (Axis II). BPD was introduced into DSM third edition (DSM III) in 1980 and placed on Axis II alongside mental retardation (APA 1980). The DSM-IV identifies ten categories of Personality Disorder illustrated in table 1 below:

Table 1: DSM-IV –TR, Diagnostic Categories of Personality Disorder:

Category	Cluster
Schizotypal	
Paranoid	A
Schizoid	
Antisocial	
Borderline	
Histrionic	B
Narcissistic	
Avoidant	
Dependent	C
Obsessive-Compulsive	

As can be seen, these ten categories are grouped under three higher-order categories referred to in the DSM-IV as 'Clusters'. Disorders falling within Cluster A are defined as 'odd/eccentric' referring to traits including those of distrust, social detachment, suspiciousness and cognitive distortions. Disorders falling within Cluster B are the impulsive, excessive emotionality type, defined as the Dramatic/Emotional group. Cluster C represents Anxious/Fearful disorders, characterised by anxiousness, perfectionism and fear of negative evaluation. BPD is classed under Cluster B. The DSM IV - TR (2000) describes BPD as *"pervasive patterns of unstable emotional states, self-image, marked impulsivity and difficulties in establishing and maintaining relationships,"* (DSM IV-TR 2000). The World Health Organisation's (1992) International Classification of Diseases – 10th Edition, (ICD−10) uses the term "Emotionally Unstable Personality Disorder (EMPD) – of Borderline type" is used to refer to the same cluster of symptoms. The term BPD will however be used throughout the remainder of the report as this term is most used in the literature.

Whilst there is diagnostic overlap for each of the PDs, one of the most common is BPD. It is best described as a chronic disorder characterised by emotional instability, marked impulsivity that includes self-injurious behaviour and difficulty in establishing and maintaining relationships. As a consequence of these core difficulties BPD is now recognised as being one of the most challenging of personality disorders to manage, not only within mental health services but primary, social care and the voluntary sector (Gunderson & Hoffman, 2005; Paris, 2005).

1.3.2. Prevalence

The prevalence of individuals meeting diagnostic criteria for any of the personality disorders has been estimated to be 10 per cent in a community sample (Alwin et al. 2006). In a recent UK study however the estimate was more conservative, only 5.2 per cent of males and 3.6 per cent of females fulfilled PD diagnostic criteria (Coid, Yand, Tyrer et. al., 2006). The prevalence rates consistently increase in both psychiatric and forensic populations. Almost half of all psychiatric inpatients and between 30 to 40 per cent of outpatients meet criteria for a personality disorder (Alwin et al., 2006). Prevalence rates of BPD are again variable. It has been suggested that the prevalence of BPD in the general population is between 1 and 2 per cent (Torgersen, Kringlen & Cramer, 2001). Again higher prevalence rates are evident in psychiatric populations, 10 per cent of outpatients and between 15-20 per cent of inpatients are thought to meet diagnostic criteria for BPD (Widiger & Frances, 1989).

It is reported that 75 per cent of patients who are given a BPD diagnosis are female (APA, 2000) yet there is considerable debate as to whether this reflects a true sex bias or instead is an artefact of sampling bias as women are more likely to be seekers of treatment and therefore have more chance of being over represented in clinical samples (Skodol, 2005). Society has well defined sex roles associated with gender defined behaviours and it has been suggested that women are more likely to be given a BPD diagnosis if behaviour represents the women acting out of their socially constructed role (Becker, 1997; Simmons, 1992). The association of BPD and

childhood sexual abuse may also explain the over representation of women within this diagnostic category as girls are more likely to be the victims of this form of abuse (Jarrett, 2006; Herman, Perry & van der Kolk, 1989).

1.3.3. Theories of Personality Disorder

Due to the complexity of personality and personality pathology a coherent theoretical underpinning remains elusive (Millon, Meagher & Grossman, 2001). In early studies of personality psychological theories proliferated the literature and the development of trait /type theory dominated (Allen, 2006; Millon, Meagher & Grossman, 2001). The main advantage of this 'pigeon hole' approach where every individual could be assigned a type was also its major flaw. The resulting infinite number of traits /types proved to be an unwieldy and unpractical theory (Millon, Meagher & Grossman, 2001).

Later theories have focused on either the temperament or character components of personality. Findings that most traits are heritable (Livesley, Jang & Vernon, 1998; Jang & Vernon 2001; Plomin, De Fries, McClearn & Rutter, 1997) and that neurotransmitters are implicated in the expression of personality traits had supported the biological view. Psychological factors associated with personality disorders and in particular a history of sexual abuse and neglect amongst those with a diagnosis of BPD (Herman et al., 1989; Links, Steiner, Offord & Eppell, 1988; Zanarini, Gunderson, Marino et al., 1989) has demonstrated the influence of psychological factors. As a result, the emerging research suggests that the aetiology of PD is extremely complex; the culmination of a unique interplay between, biological, psychological and social factors (Jarrett, 2006; Lieb, Zanarini, Schmahl et al., 2004; Cooke & Hart, 2004).

One of the main limitations with theories of personality disorders is that they are difficult to falsify scientifically as a consequence of their reliance on retrospective reports that are recognised as being problematic in terms of reliability. If indeed these theories are useful then treatments would be more successful than they manifestly are.

1.4. A Controversial Diagnosis

There are a number of controversies surrounding the classification of PDs and the debate as to how these can be reconciled is gaining immediacy with the introduction of the fifth edition of the DSM in 2012 (Bernstein, Iscan & Maser, 2007). The scope of the current research does not permit a full discussion of the issues however the following section outlines some of the main debates that are currently taking place within the PD field.

1.4.1 Placement on Axis II

The decision to assign Personality Disorders to Axis II within the DSM-IV was not based on scientific empirical evidence but instead was decided upon through clinical judgement and beliefs about aetiology, course and outcome (Blackburn, 2006; DSM IV, 2000). One of the main advantages of a multi axial system is that personality disorders are considered in the presence of Axis I disorders avoiding PD's being subsumed by these transient state diagnoses (Tyrer et al, 2007). It has also meant that PDs have received specific research attention, which has served to increase our understanding of these disorders. Considering co-occurrence is necessary as Widiger (2000) argues that everyone has a personality and there is mounting empirical evidence that has demonstrated the impact of the presence of personality disorders on the outcome of other co morbid mental health problems (Reich & Vasile, 1993; Tyrer et al., 2007). As a consequence of this research there is a significant argument that suggests the split between Axis I and II is artificial and that other ways to conceptualised PDs should be considered (Oldham & Skodol, 2000).

1.4.2 Heterogeneity

The polythetic categories of the DSM IV means that any five of the nine criteria is suffice to be given a diagnosis of BPD (Livesley 2001). There are therefore 151 different ways in which any individual can meet diagnostic criteria, creating a significant amount of heterogeneity in this population (Skodol, Gunderson, Pfohl et al., 2002). As a consequence the clinical presentation is often different for each individual resulting in an ill defined category that makes the study of the course and treatment of this disorder more challenging (Paris, 2007). Asnaani and colleagues

(2007) examined the number of DSM IV criteria met by 237 outpatients with a diagnosis of BPD. Patients who met seven or more of the DSM IV criteria had higher rates of substance misuse and greater AXIS II co morbidity. They also had histories of more suicidal gestures. There was, however, no significant differences on measures of co morbid Axis I disorders or psychosocial functioning. These results would suggest that severity of the disorder cannot be based on the number of criteria met.

1.4.3. Construct Validity

Further difficulties with the categorical classification concern the validity and reliability of each personality disorder and there is a considerable co-morbidity in BPD that impacts on the outcome of other physical and mental health problems (Hayward & Moran, 2008; Tyrer, 2000). Zanarini and colleagues (1998; 2004) examined co-morbidity of Axis I disorders across all the personality disorders that included a follow up six years later. Both Avoidant and Borderline Personality Disorders had the highest rates of Axis I co morbidity. BPD was associated with higher rates of mood disorders, self-harm and substance misuse. Whilst PTSD was identified amongst a number of BPD patients the fact that not all described a traumatic background refutes some claims that BPD is a chronic form of Post Traumatic Stress Disorder (PTSD). At six year follow up there was an association between the remission of BPD symptoms and co-morbid Axis I disorders although levels particularly for affective disorders remained high (Zanarini, Frankenburg, Hennen & Riech, 2004). The authors proposed that the complex co-morbidity of Axis I disorders could be a reliable marker for BPD. Substance abuse was found to be associated with a poorer chance of remission of BPD symptoms. The remission of symptoms also questioned the assumption that personality disorders are persistent life long conditions as the diagnosis suggests.

In a further paper, structured clinical interviews were used to assess the co occurrence of Axis I & II disorders (Oldham, Skodol, Kellman et al., 1995). BPD was associated with all Axis I disorders, excluding mood disorders although there were raised levels of borderline traits in those patient assessed as having mood

disorders. An advantage of the study was its focus on separate Axis I disorders allowing for a more in-depth understanding of co morbidity and different subtypes of Axis I disorders were found to be associated with specific PDs. For example, BPD was associated with Axis I bulimia and panic disorders. Axis I disorders were had been thought to correspond and be predictive of particular clusters of PDs however the results of this study did not provide supportive evidence of this.

Further to the issues of co occurring Axis I disorders, Tyrer (1996) highlights the issue of consanguinity where an individual meets diagnostic criteria for multiple PDs. This may not be surprising if we consider the current system of classification. For example, each of the three diagnostic clusters, disorders share similar personality traits, there is therefore an increased likelihood of co-morbidity amongst disorders occurring within the same cluster, for example an individual may meet criteria for both Borderline and Histrionic Personality Disorder, both identified under Cluster B.

1.4.4 Dimensional Classification System

The traditional view that PDs are clinically distinct disorders has been questioned by growing evidence that personality disorders are not qualitatively distinct from normal personality as suggested by current classification systems but can be best understood as representing extremes of 'normal' behaviour (Kendell, 2002; Livesley, 2001; Millon, Meagher & Grossman, 2001). Given problems with the adequacy categorical system it has been suggested that a dimensional classification system may be desirable.

In support of this are empirical findings that suggested models of normal personality function may be used to understand personality disorders. One of the most robust and frequently cited models of personality is the Five Factor Model (FFM) of personality functioning (Costa & McCrae, 1992). The FFM asserts that individual variance of personality can be explained by five factors; Neuroticism, Extraversion, Agreeableness, Open to Experience and Conscientiousness. Within each factor are six associated traits along which it is proposed everyone can be placed on a continuum. The FFM is not aligned to any particular theory, instead is a lexical

model founded in the language used by society to describe human behaviour (Widiger, 2000).

The FFM model has been studied extensively and has been shown to map on to the trait structure of the DSM IV PDs (Ryder, Costa & Bagby, 2007; Widiger, 2005). Furthermore, the FFM has been shown to have clinical utility in being comparable to not only the clinical presentation but unlike the DSM IV considers the common co-morbidity found within these disorders (Lynam & Widiger, 2001). In an interesting study, Miller, Pilkonis & Mulvey (2006) used measures of Axis I and II psychopathology and scores of the FFM to look at treatment utilisation and satisfaction with care. Their findings demonstrated that in addition to describing personality disordered traits FFM scores were also related to treatment utilisation and ratings of satisfaction. The FFM has however received criticism in its attempt to explain some of the more extreme and maladaptive forms of behaviour exhibited in personality disorders (Widiger, 2000).

The decision to move towards a dimensional system however has not yet been made. Perhaps due to the multiple dimensional models that exists with varying degrees of empirical support (Livesley, 2001). Moving to dimensional classification would also be a significant disembarkment from the traditional classification used for other psychiatric diagnosis (Livesley, 2001; Oldham & Skodol, 2000). Given the heterogeneity of the DSM IV categories particularly within the BPD some have suggested that replacing the current categorical classification system with a complex dimensional system may be equally as confusing (Paris, 2007). One solution to this problems may be to introduce a system incorporating both categorical and dimensional aspects of personality functioning. Such a plan has been outlined by Livesley (2007), in which he advocates a two level classification system.

1.4.5. Borderline Term

Historically the term borderline reflected the view that this group of patients were on the border of neurosis and psychosis (Stern, 1938). Service users and professionals find it an unsatisfactory term as it does not explain the symptoms accurately. It is, however, a term that carries a considerable degree of clinical utility (Fonagy, Gergely, Jurist & Target, 2004) . One of the main reasons that service users in particular are dissatisfied with the term is due to the significant stigma that is attached to this diagnosis. It has been acknowledged however that a change in name would not alter this but instead lead to another term being given the same notoriety (Haigh, 2006).

1.5. Treatments for BPD

Many people with personality disorders find themselves struggling to access appropriate services (National Institute of Mental Health England, 2003a). People with a diagnosis of BPD are arguably one of the most excluded groups of psychiatric patients (Haigh, 2006) to the extent that BPD has been referred to as the "waste bin diagnosis" portraying a sense of hopelessness and rejection, (Nehls, 1999). Recent revisions to the Mental Health Act (2003) have challenged the traditional view that the stability of personality patterns has meant that these disorders are not amenable to pharmacological or psychological treatments. The placement of Personality Disorders on Axis II in the DSM multi axial system of diagnostic classification (APA, 2000) has however prompted more research into this area (Casey & Tyrer, 1990) and there is an increasing amount of empirical evidence that has shown the efficacy of pharmacotherapy and psychological treatments.

1.5.1 Pharmacotherapy

Whilst the use of psychotropic medication does not claim to alter the intrinsic personality of the individual and therefore not the disorder per se, this mode of treatment is instead symptom specific and has been shown to have beneficial effects on mental state presentations as well as subtle effects on more stable trait vulnerabilities (APA, 2001; Markowitz, 2001; Newton-Howes, 2006; Bateman & Tyrer, 2004). Most efficacy studies of pharmacological treatments for personality

disorder have focused on BPD, this making sense as they are the group most likely to seek treatment (Newton-Howes, 2006; Tyrer, Mitchard, Methuen, & Ranger, 2003).

Three main areas characteristic of the associated difficulties of BPD are identified that benefit from pharmacological intervention; affective dysregulation, impulsive behavioural dyscontrol and cognitive perceptual difficulties (APA, 2001; Tyrer & Bateman, 2004). Selective Serotonin Reuptake Inhibitors (SSRIs) are recommended as first line treatments for both affective dysregulation and impulsive behavioural dysregulation (APA, 2001). Where affective dysregulation is manifested as anxiety it may be more appropriate to prescribe benzodiazepines although this is not ideal given the implications of tolerance and addiction in long-term use (APA, 2001). The impulsive behaviour dysregulation is of particular concern as it will influence suicide attempts and serious risk taking behaviour. Once again SSRIs are recommended as a first line of treatment augmented with neuroleptics if self-harm is of significance (APA, 2001).

1.5.2 Psychotherapeutic Approaches

The practice guidelines for BPD (APA, 2001) states that the first line of treatment should be psychotherapeutic treatments, in particular Psychodynamic and Dialectical Behaviour Therapy (DBT) augmented with pharmacotherapy where appropriate (American Psychological Association, 2001). Similarly, the British Psychological Society advocates psychological therapy in the first instance due to the limited evidence base for pharmacological based treatments that have used small sample sizes, (Alwin et al., 2006).

Whilst a comprehensive description of the main psychological approaches used in the treatment of BPD is not central to this thesis, it is worth considering some of the key outcome data, which again provide challenge to the justification of title of "waste bin" diagnosis.

1.5.3. Dialectical Behaviour Therapy (DBT)

DBT is an approach that draws on the principles of both cognitive and behaviour therapy (Robins, Ivanoff & Linehan, 2001). In addition to these guiding principles and unique to DBT is its focus on dialectics and Zen principles (Linehan, 1993). A DBT theoretical framework asserts that the symptoms of BPD reflect difficulties in two main areas of emotional regulation; modulation of emotion and emotional vulnerability and that it is this emotional dysregulation that drives the other associated clinical features (Linehan, 1993; Robins, Ivanoff & Linehan, 2001). Emotional vulnerability is linked to an individual's biology and thus reflected in the individual's temperament. Typically those with BPD are biologically predisposed to experience heightened emotional arousal that has a slower return to baseline (Putnam & Silk, 2005). This results in increased sensitivity to further emotional experiences. In addition individuals with BPD are cognitively compromised through the effects of this elevated arousal affecting their ability to problem solve often resulting in impulsive and self destructive behaviours characteristic of a PD presentation (Feigenbaum, 2008; Linehan, Heard & Armstrong, 1993; Robins, Ivanoff & Linehan, 2001).

Dialectics in a DBT paradigm propose that the therapist accepts the individual for who they are yet strives to facilitate change in the individual. This change occurs in a holistic sense so that changes made in one area are generalised to the whole system within which the individual operates; a process referred to as 'interconnectedness' (Feigenbaum, 2008; Linehan, 1993). In therapy, DBT creates a validating environment within which the individual learn self-acceptance and the acquisition of adaptive behaviours through a process of constant change (Linehan, 1993). Therapy consists of individual one to one therapy; skills based groups and telephone consultations with therapists out-with sessions. There are also optional supportive groups to maintain success following the termination of active therapy (Linehan, 1993).

There have been a number of studies examining the effectiveness of DBT in the treatment of BPD; the most robust findings having been reported within three Randomised Control Trials (RCTs). In a seminal RCT, 44 women with a diagnosis of BPD with para suicidal and actual suicidal behaviour were assigned to either a 1-year DBT programme or treatment as usual (TAU) (Linehan, Armstrong, Suarez et al., 1991). At 12 months those in the DBT group engaged in less parasuicidal behaviour and actual suicide attempts. At six months follow up there was no significant between group differences in number of hospital admissions or parasuicidal behaviour but those in the DBT group reported fewer suicide attempts. At 12 months follow up the only significant difference was fewer days spent in hospital for those in the DBT group.

In 2003, Verheul, Van den Bosch, Koeter et al. carried out a similar RCT with 58 women. At twelve months those receiving DBT reported fewer self-mutilating and damaging impulsive acts compared to TAU but no differences in frequency of suicide attempts. In this study, baseline measures of suicidal behaviour were associated with improvement over the twelve months, those reporting higher baseline frequencies achieving most benefit from the DBT although no differences were found for those on the lower baseline severity group (Verheul et al., 2003). Those in the DBT group were also more likely to stay in the study compared to those receiving TAU.

Linehan, Comtois, Murray, et al., (2006) conducted a further RCT to address criticisms of earlier RCTs regarding small sample sizes and lack of long term follow up (Binks, Fenton, McCarthy et al., 2006; Scheel, 2000; Tyrer, 2002). This was a two year study comparing 12 months of DBT and TAU delivered in the community that included one year follow up in outpatient and community settings. 101 women with a diagnosis of BPD engaging in significant self-harm and parasuicidal behaviour were recruited and placed into either the DBT group or non behavioural psychotherapy carried out by therapists matched to DBT therapists in terms of competency, experience, availability and gender (Linehan et al., 2006). Over the duration of the study those in the DBT group engaged in fewer suicide attempts

compared to the control group treatments and utilised fewer crisis supports including hospital admissions (Linehan et al., 2006). There were however no differences between the two groups in non-suicidal self-harming behaviour. As in previous studies there were fewer attrition rates in the DBT group compared to the control group (Linehan et al., 2006).

The majority of studies, however, have focused on early stages of treatment for the reduction of self harm (Blennerhassett & O'Rallhallaigh, 2005), in particular, the reduction of parasuicidal behaviour in women diagnosed with BPD (Scheel, 2000). Although described as a manualised based treatment the majority of studies have been carried out by experts in this theoretical approach and it is not clear whether other health care professionals in community outpatient settings could achieve similar efficacy (Sheel, 2000; Tyrer, 2002).

1.5.4. Cognitive Behaviour Therapy (CBT)

Central to the cognitive theory are schemata (Clark, Beck, & Alford, 1999); the mental framework within which individuals make sense and attach meaning to both the self and the external world (Cottraux & Blackburn, 2001; Davidson, 2008). Schemata underlying personality disorders are qualitatively different from those in transient Axis I disorders on the multi axial system of diagnostic classification (APA 2000; Beck, Freeman, Davis & Associates, 2004). In personality disorder schemata are more rigid, stable and therefore more resistant to change and generalised to situations that are rarely connected to the early dysfunctional situations that led to their development (Cottraux & Blackburn, 2001).

Cognitive therapy asserts that each personality disorder is associated with a particular sub group of maladaptive schemata and their associated core beliefs and conditional assumptions (Moorey, Davidson, Evans & Feignenbaum, 2006). In BPD the core beliefs relate to feelings of worthlessness and of being inherently bad or flawed reinforcing maladaptive behavioural strategies and underdevelopment of more desired behaviour patterns (Davidson, 2008). The behavioural consequences of these beliefs are self-punishment and degradation (Davidson, 2000).

CBT is designed as a brief intervention that offers a shorter alternative to DBT or Psychodynamic approaches. Therapy aims to help the individual identify underlying schemas and beliefs that are having an impact on daily functioning, focused on here and now problems working within a collaborative therapeutic framework (Alwin et al., 2006). There have been relatively few well-designed studies looking at the efficacy of CBT in the treatment of personality disorders but early results were promising (Davidson & Tyrer, 1996; Tyrer, Thomson, Schmidt et al., 2003).

The first RCT looking specifically at CBT for BPD was conducted by Davidson, Norrie, Tyrer et al., (2006) and compared TAU with TAU augmented with CBT. The study involved one year of treatment followed by 12-month follow up. Those in the CBT augmented group were offered 30 sessions over a 12-month period. TAU involved contact with CMHTs that included psychological and psychotherapy as would have been offered had the trial not been taking place (Davidson et al., 2006). Primary outcome measures were suicidal acts, inpatient admission and Accident and Emergency (A&E) visits. A range of secondary measures included the Beck Depression Inventory II (BDI – II), State-Trait Anxiety Inventory (STAI), Brief Symptom Inventory (BSI), Young Schema Questionnaire, EURO – Quality of Life Scale (EURO-QOL), Inventory of Interpersonal Problems and Social Functioning Questionnaire.

At two years follow up data was available for 102 of the participants with both groups improving marginally across primary and secondary measures (Davidson et al., 2006). At the end of treatment and follow up there were no significant differences between the two groups for frequency of inpatient admissions and A&E visits. Whilst there was some evidence of an advantage of TAU augmented with CBT for frequency of suicidal acts at two years follow up this was not statistically significant. There was some evidence that CBT incurred less costs than TAU alone however this again did not reach statistical significance and the higher costs in TAU group may be attributable to more days spent as a psychiatric inpatient (Palmer, Davidson, Tyrer et al., 2006).

On secondary measures both groups showed some improvement. At termination of treatment however the CBT group showed greater improvement on measures on the BSI positive symptoms and at two year follow up the CBT group had improved on both the schema questionnaire and State Anxiety measures. The authors urge caution in using this as evidence of CBT effectiveness however as both groups continued to score highly on the measures at two year follow up (Davidson et al., 2006).

1.5.5. Psychodynamic Psychotherapy

A further psychological approach in the understanding and treatment of personality disorders has been informed by psychodynamics. This suggests that the problems associated with personality disorders reflect a disruption of the 'self', distinct from Axis I disorders reflecting problems within the self (Blackburn 2006). A sense of self is not innate but instead developed within an interpersonal context through the interactions with others, most importantly primary caregivers, (Stern, 2002). Each individual must learn about their own self-states and that of others through a series of developmental processes, facilitated by those in their immediate environment. Failure to achieve this fundamental psychological task leads to disruption to the core sense of self that in turn leads to significant emotional impairment, evident in most, if not all, of the personality disorders.

A related psychodynamic model is that of mentalization, the ability to understand one's own and others mental processes and emotions (Fonagy & Bateman, 2008). Based within the context of attachment theory, the mentalization model asserts that the ability to understand another's perspective occurs within the early attachment relationship, (Fonagy & Bateman, 2008) and is central to the development of the self (Blackburn, 2006). This depends however on the availability of an attachment figure who is responsive to the infant and who consistently and accurately reflects the child's emotions modelling how to regulate these effectively. Through this subtle process the infant builds up an internal system of the representation of emotional states that they use as a template for future emotional states and to interpret the mental states of others (Fonagy & Bateman, 2008). Central to BPD is the dysregulation of emotions and Fonagy & Bateman (2008) have suggested that such

individuals struggle to mentalise particularly when highly aroused and may indeed misinterpret mental states.

In a series of papers Bateman & Fonagy (1999; 2001; 2003) reported findings of an RCT that looked at the effects of partial hospitalisation compared to TAU. Thirty-eight participants meeting DSM III – R criteria for BPD were randomly assigned to one of the two conditions. Those in the partial hospitalisation programme received interventions based on a psychoanalytical model of BPD that emphasised the role of attachment, mentalization and separation tolerance (Bateman & Fonagy, 1999). This included group sessions in addition to individual psychoanalytic psychotherapy, community meetings and expressive therapy, (Bateman & Fonagy, 1999). Those assigned to TAU received psychiatric review, inpatient admission if necessary and outpatient follow-up was augmented with twice-weekly visits from a Community Psychiatric Nurse (CPN).

At six months those in the hospital group engaged in fewer suicidal acts and self harm, still evident at 18 months. Significant improvements were noted on measures of social and interpersonal functioning and days spent in hospital, compared to no improvement in the TAU group (Bateman & Fonagy, 1999; 2001). There were no significant differences in cost effectiveness as assessed by case note review and information from service providers taken at three different time points (6 months prior to entry to the trial, 18 months into treatment and at 18 months follow up). But off set, longer term cost benefits were inferred for the partial hospitalisation group as judged by fewer A&E visits and inpatient admissions, (Bateman & Fonagy, 2003).

Clarkin, Levy, Lezenweger & Kernberg (2007) compared Transference Focused Psychotherapy (TFP), an established psychodynamic therapy, with DBT and dynamic supportive therapy. Ninety participants with BPD were randomly assigned to one of the three, year long treatments. Blind measures of suicidal behaviour; impulsivity, aggression, depression, anxiety and social adjustment were taken prior to the study and at regular time points throughout the year.

At 12 months, there were significant improvements in global functioning, anxiety, depression and social adjustment across all three treatment groups (Clarkin, et al., 2007). The number of suicide events was reduced significantly in the TFP and DBT groups and both TFP and supportive therapy effected positive changes on measures of impulsivity and anger. TFP was the only group, which was predictive of change in irritability, verbal and direct assault (Clarkin et al., 2007). As the authors suggest, the findings provide limited evidence that structured therapeutic approaches can facilitate positive change in some BPD symptomatology.

Interpretation of the current available evidence is somewhat problematic given the significant amount of co morbidity and co sanguity in this patient population (Tyrer & Duggan, 2008). The lack of a comprehensive theory has meant that treatments are therapy led versus the traditional approach of being theory led (Millon, Meagher & Grossman, 2001). Whilst there is growing evidence psychological approaches may be modestly effective in the treatment of BPD, more large scale, well designed studies are needed on order to make confident claims about the efficacy of each approach (Binks, Fenton, McCarthy et al., 2006).

The current state of available treatments is of relevance to the current study as at best all approaches report only modest outcomes therefore individuals with BPD will continue to present at their GP who may indeed be involved in the management of pharmacotherapy. Moreover, individuals will only access treatments via referrals from GPs in their role as gatekeepers so increased awareness is of vital importance.

1.6. BPD in Primary Care

It is recognised within the literature that individuals with BPD are attracted to medical settings (Alwin et al., 2006) and are higher users of specialist mental health services who actively seek treatment (Bender et al., 2001; Nowlis, 1990; Tyrer, Mitchard, Methuen & Ranger, 2003). Less is known about patterns of health care utilisation in primary care (Gross, et al., 2002; Sansone, Wiederman, Sansone, 1998), yet there is an assumption that individuals with BPD are frequent attendees, place greater demands of services and are less satisfied with their care (Hueston, Mainous & Schilling, 1996; Sansone & Sansone, 1996).

There are higher rates of co-morbid health problems in this population (McGlashan et al., 2000; Zanarini et al., 1998; Moran et al., 2001) and having a diagnosis of personality disorder is associated with poorer treatment outcome as a consequence of poorer compliance particularly in the management of chronic health problems (Nowlis, 1990; Searight, 1992). Personality Disorders can have a significant impact on the presentation of coexisting medical problems and can make it difficult for the GP to have a clear understanding of the clinical presentation (Devens, 2007; Nowlis, 1990; Gross et al., 2002; Searight, 1992).

Although many people with BPD will receive treatment within specialist mental health services, General Practitioners (GPs) remain responsible for physical health care and contribute greatly to the treatment of mild to moderate Axis I disorders such as depression and anxiety (Burns, 2006). GPs will frequently encounter individuals with BPD in their everyday practice although it is unlikely that the patient presents with PD as the conspicuous problem (Devens, 2007; Searight, 1992). PDs are often under diagnosed in primary care and many patients are equally as keen to describe their difficulties in terms of physical problems (Nowlis, 1990).

One of the difficulties in the management and treatment of patients with a diagnosis of BPD in primary care may be linked to difficulties in the patient-GP relationship. One of the central features of BPD is instability of mood, cognition and behaviour often played out within an interpersonal context. This poses significant challenges to

those involved in the delivery of health care (Devens, 2007; Nowlis, 1990; Searight, 1992) particularly if the diagnosis is not explicit. An absence of appropriate relationships and social interactions in early life means that the patient with BPD may not have an awareness of appropriate boundaries within social relationships, (Nowlis, 1990); they may be over familiar and increasingly intimate, evoking uncomfortable responses (Nowlis, 1990; Searight, 1992). Individuals with BPD can find contradictory experiences difficult to process and in order to manage this may use a defence mechanism of "splitting" where they perceive themselves as being *"all good"* or *"all bad"*. This view of the self can rapidly change and extend beyond the self to opinions about others including health care providers. This can be confusing for a GP who may at one consultation find themselves idolised then at a later appointment devalued (Nowlis, 1990; Searight, 1992).

Despite these documented difficulties and their impact on health outcomes there is little empirical evidence on the impact of BPD out-with specialist mental health services. Having a greater understanding of the issues pertaining to BPD will benefit both patients and GPs resulting in improved management. An outline of some of the studies that have been carried out looking at Personality Disorders in primary care are listed in table 2 below.

Table 2: Prevalence of PD and BPD in Primary Care

Authors	Population	Personality Diagnosis	Measures	Main findings
Casey & Tyrer, (1990)	358 Patients >15 yrs presenting to GP with conspicuous psychiatric morbidity	All personality disorders	Personality Assessment Schedule (PAS) Social Function Schedule (SFS) Michigan Alcoholism Screening Test (MAST) Present State Examination (PSE) Separate GP and researcher psychiatric diagnosis using ICD- 9	28% of patients received diagnosis of PD using the PAS Poor agreement between GP and Psychiatric ratings Greater proportion of PD in urban practice Social adjustment affected by more than just PD. Mental disorder had greater effect.
Sansone & Sansone (1996)	194 female patients aged between 17 and 52years attending non emergency medical care at a health maintenance organisation (HMO)	Borderline Personality Disorder	Borderline personality sub scale of the Personality Diagnostic Questionnaire – Revised (PDQ-R) Self-Harm Inventory (SHI)	20% reported symptoms of BPD. These patients significantly higher use of health care including telephone and physician contacts The SHI showed no association with health care utilization No difference in the number of GPs that patients attended Implications for health care costs for those attending with BPD symptoms
Hueston, Mainous & Schilling (1996)	93 patients attending GP practice	All personality disorders	Structured Clinical Inventory for DSM III Axis II (SCID – II).	25% BPD Those classed as high risk had lowered functional status,

			Short Form -36 (SF-36)	increased risk of depression and/or alcohol misuse and reported lower levels of satisfaction with their care.
			Beck Depression Inventory (BDI)	
			CAGE alcohol use questionnaire	Demographics and socio economic differences were not attributable to these differences.
			RAND Patient satisfaction Questionnaire – adapted version	Borderline, schizoid and dependent PDs associated with higher degrees of functional impairment and even greater risk for depression and alcohol misuse.
Sansone, Wiederman & Sansone (1998)	116 women attending HMO	Borderline Personality Disorder	PDQ-R	20% BPD
			SHI	Experience of trauma and Borderline personality symptomatology predictive of increased health care usage albeit to a lesser degree than in psychiatric settings
			Trauma Questionnaire	
			Demographic Questionnaire	
			Review of medical records for previous year	Referrals to specialist physicians not associated with trauma or BPD symptomatology
				BPD symtomatology associated with increased physician visits.
Parsons, (1997)	965 primary care patients	BPD	Borderline Index of the Diagnostic Interview Schedule	18% BPD in primary care

Moran, Jenkins, Tylee et al., (2000)	303 consecutive attendees at 4 GP practices	All Personality Disorders	Demographic Questionnaire GHQ – 12 SF – 36 (physical subscale) Self-report of persistent physical and/or psychological problems over previous 12 months Informant Based Standardised Assessment of Personality (SAP) from ICD 10 and DSM IV	Overall prevalence rate of 24% Many met criteria for more than one PD Higher rate of psychiatric morbidity, particularly for Cluster B More likely to attend on an emergency basis and to report previous psychiatric morbidity
Moran et al. (2001)	1year follow up of 303 attendees from 2000 study	All Personality Disorders	GHQ -12 SF – 36 Physical subscale Structured Personality Assessment (SAP) List of Threatening Experiences Questionnaire Brief Client Satisfaction Questionnaire GP rating of PD GP self report of attitudes	Ratings on the SAP was predictive of attendance at GP and fewer referrals to secondary care Little agreement between GP ratings and SAP. GP ratings (27/%) associated with higher prescription rates for psychotropic medication Those rated as having a PD by GP were perceived to be less compliant with treatment, more stressful to manage and less likeable
Gross, Olfson, Gameroff,	218 consecutive adult primary care attendees	All personality disorders	SCID II CIDI	6% met criteria for BPD, 4 times higher than community prevalence

Shea, Feder, Fuentes, Lantigua, Weissman, (2002)			self report physical and emotional health measures Patient Health Questionnaire Patient Care Evaluation of Mental Disorder Mini –International Neuropsychiatric Interview – psychotic symptoms sub section Sheehan Disability Scale – family life/home responsibilities subscale and social life sub scale admissions, prescriptions and mental health treatments Records review	BPD patients had one or more psychotic symptoms twice the rate for other psychiatric diagnosis and 7 x higher than controls 50% of BPD group had current auditory/visual hallucinations 21% expressed self-harming behaviour and suicidal ideation BPD group reported feelings of emptiness, rapid mood changes, impulsivity and intense interpersonal relationships Less than half considered by GP as having "active or ongoing emotional or mental problems" BPD lower self perceived physical and emotional health than controls and poorer psychosocial functioning. Individuals with BPD made significantly fewer visits then people with other psychiatric diagnoses or controls.

Prevalence rates for all PDs in primary care ranges between 24 percent and 28 percent, considerably higher than the estimated 10 per cent in the community (Alwin et al., 2006). Only four studies have reported rates for BPD and again rates are considerably higher than the estimated community prevalence rates of one to two per cent (Torgersen et al., 2001). Variance maybe attributed to the different measures used. As a consequence of the different methodologies and populations sampled one must interpret these findings with a degree of caution. There are however some relevant findings that are outlined below.

Those with Personality disorders, specifically BPD report poorer psychosocial functioning (Gross, Olfson, Gameroff et al., 2000; Hueston, Mainous & Schilling, 1996), higher rates of psychiatric morbidity (Gross, Olfson, Gameroff et al., 2000; Moran, Jenkins, Tylee et al., 2000) and emotional problems i.e. depression and anxiety (Gross, Olfson, Gameroff et al., 2002; Hueston, Mainous & Schilling, 1996).

Reports of patterns of health care use are contradictory. Moran et al., (2000) reported that patients were more likely to attend GP practices in crisis. Sansone, Weiderman & Sansone (1998) reported an association between higher levels of BPD symptomatology assessed by the SHI and PDQ with more face to face visits and telephone consultations with GPs. Gross et al., (2002) however found that despite reporting poorer psychosocial functioning, significant self harm and current psychotic symptoms those who met DSM IV criteria for BPD visited GPs less frequently than those patients with other or no psychiatric diagnosis.

Two studies reported GP ratings of PDs and agreement between Psychiatric and GP ratings were poor (Casey & Tyrer, 1990). In the Moran et al study (2001) GPs rated 27% of patients as having a personality disorder. This was associated with higher rates of physical and psychiatric morbidity at baseline (Moran et al., 2001). GPs were inclined to rate patients as having a personality disorder if they were perceived to be less compliant, more stressful to manage and less likeable of patients. Moran et al (2001) suggest that high rates of PD as assessed by GPs in comparison to rates derived through structured assessments support the view of a diagnosis of personality disorder being used by practitioners as a pejorative term that is based on patient characteristics and consulting patterns rather than a true representation of personality constructs (Moran et al. 2001).

1.6.1. GPs as Gatekeepers

GPs act as the gatekeepers to mental health services (Nowlis, 1990) and there are a number of influences on referral patterns. Ward (2004) has suggested that GPs are more comfortable and skilled at managing patients with Axis I disorders such as depression, anxiety and schizophrenia in primary care but are more likely to refer patients with BPD to specialist services to manage active self harm and suicidal ideation. Within the general population, Hjortdahl & Borchgrevink (1991) reported that patients who were well known by their doctor were twice as likely to be referred on to other services as those patients whom the GP felt they had less knowledge about. Considering that individuals with BPD may attend their GP less frequently (Gross et al., 2002) GPs may have less opportunity to get to know these patients and this may influence the likelihood of referrals to other services.

Conversely, it is possible that prior knowledge about a BPD diagnosis may influence referral onto other services, either increasing referrals because of concerns about management or active gate keeping for those considered not worthy of specialist services or, as Moran et al (2001), suggest assumptions regarding the treatability of personality disorders where GPs will refer for mental health problems but not personality disorders. Always conscious of possible abandonment, an individual with a diagnosis of BPD may become angry and hostile if they consider a referral to other services as a sign of rejection by the GP, which may make GPs less inclined to make referrals to other services (Searight, 1992).

Although GPs are not in the position to provided ongoing psychotherapy an important task for GPs is to establish rapport and build and maintain empathic working relationships with patients (Gross et al., 2002). There is growing evidence that how a GP manages a patient's treatment and care is linked to their perceptions of that patient, and will have important implications for health outcomes (Street, Gordon & Haidet, 2007; Gerbert, 1984).

1.6.2 Gaps in the literature

As outlined in previous sections there is an extensive literature on PDs focused on aetiology, outcome and more recently treatment approaches. As Nehls (1999) comments, little attention has been paid to the views of individuals with a diagnosis of BPD. Most studies have instead asked staff working in specialist health services about their views. Findings from these studies indicate that individuals with PDs including BPD are perceived as manipulative, less deserving of treatment, difficult to manage and the least liked of patients (Gallop, Lancee & Garfinkle, 1989; Haigh, 2006; Lewis & Appleby, 1988; Markham & Trower, 2003; Salmon et al., 1981; Webb & McMurran, 2007).

These perceptions may be understood within a historical context when initially PDs were not considered to be a mental illness. Kendell (2002) has suggested that the majority of clinicians continue to support this view and as a consequence individuals are seen as being in control of their behaviour and therefore blameworthy. Having a diagnosis of BPD is recognised as being associated with far greater stigma than any other psychiatric diagnosis (Haigh, 2006; Kane, 2006). Such pejorative attitudes are known to impact on a person's level of distress where others' negative attitudes become internalised to the extent that the person believes these to be true, worsening the already fragile sense of self (Horn, Johnstone & Brooke, 2007). Qualitative research carried out with people with a diagnosis of BPD has indicated, however, that the detrimental effects of stigma can be overcome through experiencing supportive and helpful relationships where the professional looks beyond the label of BPD (Fallon, 2003; Haigh, 2006; Nehls, 1999).

Research has shown that individuals with BPD sometimes struggle in navigating their way through services and have reported difficulties in their health care relationships, (Fallon, 2003; Nehls, 1999). Indeed having a diagnosis has often been used as a reason to exclude people from services (Horn et al., 2007). Problems in accessing services may also extend beyond specialist mental health services. Below are quotes taken from studies asking about experience of having a BPD diagnosis where the participants mentioned encounters with GPs:

"My GP who wanted to give me more pills and get me out the door as soon as possible…" p172 Haigh (2006)

"When I go in to see my GP I feel like I get blown off a lot…not taken seriously…just curt two- or three word answers, cutting me off, and then, you know, out the door really fast" p288 Nehls (1999).

In 2003, Castillo published a book of findings of a large scale study that explored the experiences of 50 individuals with a diagnosis of Personality Disorder. To report the full findings of the study which included chapters on experiences and poetry and narratives from the fifty participants is beyond the scope of this thesis. Some of the reported findings are however relevant for example when asked about other services respondents were positive, 60 per cent stated they found their GP to be *"very helpful"* or *"helpful"*. The study was a broad account of people's experience of personality disorders and in some ways this limited the in depth analysis that could be conducted. For example, although extensive narratives were included in the publication, no attempt was made at qualitative analysis. As with many studies, the sample was mixed and therefore implications for individual personality disorders, such as BPD, were not explored.

Webb & McMurran (2008) explored the views of seven women with BPD about a new DBT specialist service. Using a Qualitative Delphi Survey method participants were asked their views of services received prior to and throughout their contact with the new service that included attendance at GPs. Overall five statements relating to experience of GP services were supported by four or more of the participants. GPs were described as *"helpful", "good"* and *"understanding"*. Statements were not all positive however. Participants stated that GPs *"misunderstood the level crisis"* and *"never had enough time"*.

There are number of limitations in this study. The Delphi study methodology employed consisted of two rounds. Round one, where participants were asked open questions about their contact with services and round two, where participants were asked to rate a selection of statements taken from round one as to how much they agreed with each. Firstly, arbitrary cut off points for agreement and disagreement

are questionable. Participants were said to have reached a consensus when four or more made the same ratings. This meant that if only three agreed or disagreed their views were not considered. The salience of experiences may have been no less important for those individuals who rated statements as only *"some of the time" versus "half of the time" or "all of the time"*. Webb & McMurran (2008) conclude that GPs may need to consider how they offer services to this patient group and that improvement in referrals and integrated service delivery across would be enhanced by listening to the voices of patients. As they did not go on to explore what it was that made GPs helpful and understanding and how they could improve their understanding of crises how this would be achieved is not clear.

Whilst clinical anecdotes and research may suggest that relationships between individuals with BPD and GPs may be compromised it appears that no one has asked individuals with a diagnosis of BPD specifically about the experiences of contact with GPs. Inherent to the diagnosis of BPD are interpersonal difficulties which make it more difficult to assess and treat the person. Due to difficulties in establishing and maintaining relationships, people with a diagnosis of BPD can present a significant challenge to those involved in their care (Nehls, 1999; Paris, 2005). One must acknowledge that due to the unique complex and unpredictable nature of their presentation, these individuals will pose particular issues that GPs will need to manage.

This section has outlined some of the reasons that personality disorders should be on the agenda of primary care services given their impact on health care utilisation, health outcome and patient satisfaction. There is a significant overlap between mental health and physical health problems making it more difficult for GPs to ascertain the underlying cause of a person's presentation (Bennett & Kerr, 2006). It is therefore important to gain a better understanding of the patterns of health care utilization given the implications for the treatment of other co-existing mental and physical health problems (Reich & Vasile, 1993).

1.7. Aims

The aim of the current study is to explore the experiences of individuals with a BPD diagnosis in their contact with GPs.

CHAPTER TWO

METHODS

2.1. Design

The research used Interpretative Phenomenological Analysis (IPA), founded on the principles outlined by Smith, (1996) and Smith & Osborn (2003). IPA is grounded within a phenomenological background. This philosophical school of research is concerned with how individuals gain knowledge about the world (Willig, 2001). Moreover, phenomenology asserts that knowing is inextricably linked to experiencing. It is not possible to gain knowledge without the experience of perceiving and interacting with the phenomenon that is presented to us (Willig, 2001).

IPA affords an account of the unique perspective of the individual. In using an idiographic approach, the aim is not to produce an objective statement of truth; instead through detailed interpretative analysis it aspires to reach an understanding of each individual's experiences and how that individual makes sense of their unique worldview, (Coyle, 2007; Horn et al., 2007; Smith & Osborn, 2003).

IPA is interpretative because it acknowledges that it is never possible to fully access the psychological world of the individual. Instead what is produced is an interpretation of individual experience through the interaction between researcher and participant that will unavoidably be biased by the researcher's own beliefs and experiences (Willig, 2001). IPA also draws on a hermeneutics approach. In essence, the researcher is making sense of the participants experience whilst the individual themselves attempts to attach meaning to their own experience (Smith & Osborn, 2003; Willig, 2001). Through this double hermeneutics, the researcher not only attempts to capture the meanings that underpin individual experience but through the interpretative process can adopt a questioning stance that may elicit information that that the participant may not consciously be aware of (Smith & Osborn, 2003).

Willig (2001) argues that a phenomenological approach can be used to explore any human experience. IPA has been used extensively both in health and clinical psychology and indeed with individuals with a diagnosis of BPD (Horn et al. 2007; Nehls, 1999). IPA was considered the most suitable approach in this study as the

research question was not to construct a theory but instead aimed to explore the experiences of individuals with a diagnosis of BPD of going to see their GP. Given that there is sparse literature in this area IPA was considered the most appropriate methodology as it is recommended for initial exploratory work. IPA is an idiographic approach and in linking back to the personality literature, in reflects the views of idiographic theorists such as Allport who emphasised the importance of individuals' unique qualities and experiences (Allen, 2006). Gaining an understanding of people's experience of GP services using an IPA approach is an invaluable tool in health care reform (Nehls, 1999). Given the complexity of the BPD diagnosis using a qualitative approach would allow a more in-depth exploration of each person's individual experience that quantative measures would not be able to capture.

2.2 Participants

Unlike quantitative research that favours random sampling, IPA relies on purposeful sampling in order to achieve as homogenous a sample as possible (Smith & Eatough, 2007). As the researcher was interested in the experience of contact with GPs in the context of having a diagnosis of BPD the study exclusively recruited participants who had this diagnosis as confirmed by their psychiatrist. Participants all attended one of four CMHTs within the area in which the researcher was working. All had a diagnosis of BPD and had ongoing contact with the CMHTs.

2.2.1 Sample size

Power calculations are not necessary for qualitative research. There is no 'correct' sample size as there are both advantages and disadvantages to small and large samples. Whilst a small sample may facilitate a more in-depth interpretation and analysis of each discourse it may limit the range of experiences to be explored. Larger samples may generate far greater themes; however the richness and individual experiences may be lost (Smith & Osborn, 2003). Although sample sizes vary, Smith & Eatough (2007) recommend that a sample size of between six and eight is suitable for postgraduate research. The principle of sampling to saturation was also used to determine sample size. Using this principle, recruitment stops when it

becomes clear from interviews that no further themes are likely to emerge. A total of eleven patients were interviewed, thus allowing an in-depth exploration of experiences whilst remaining manageable within the time constraints (Smith & Eatough, 2007).

2.3 Ethical considerations

An ethical application was submitted to both the local NHS Research and Development Department and the Medical Research Ethics Committee in November 2007. A favourable opinion was granted in January 2008 (see Appendix 1) and the main considerations are discussed below.

2.3.1 Consent

A transparent and democratic process must be followed when including individuals in research who may be considered vulnerable as a result of their psychiatric diagnosis (Tee & Lathlean, 2004). With respect to individuals with a diagnosis of BPD, Dew (2007) recommends that consent be obtained by persons not directly involved in the individual's ongoing care and time allowed out-with the clinic setting before deciding whether to take part. These recommendations take into account some of the core features of a diagnosis of BPD in particular fear of real or imagined abandonment, impulsivity and interpersonal difficulties. It is acknowledged that these diagnostic features may bias an individual's motivation for participating in research (Dew 2007).

Taking these recommendations into account, participants were approached by a member of their clinical team who provided them with the information sheet. Written consent was however obtained by the researcher who was not involved in their care prior to the interview and GPs were informed by letter of their patients' decision to participate (see Appendices 2 & 3).

Consent is a dynamic process and one that should be regularly reviewed (Orb, Eisenhauer & Wynaden, 2000). By virtue of employing IPA methodology it is not possible to know in advance what topics may be discussed therefore the researcher

regularly checked throughout the interview that participants were comfortable to continue. From the outset, it was made explicit that participants could withdraw at anytime, without reason and with no impact on their continued care. Of the eleven interviews conducted no one asked to withdraw from the study.

2.3.2. Confidentiality

In order to protect individuals' confidentiality and anonymity, names were replaced by pseudonyms and recordings were only listened to by the researcher. All identifiable information was removed at the stage of transcription so that those who may have access to the transcripts for purpose of analysis would not be able to identify individuals. Whilst direct quotes were used in the final report, again these were anonymised. This process followed the principle of beneficence as outlined by Orb and colleagues (2000) which promotes the well being of participants and avoiding harm that may occur by revealing identities of participants.

2.4 Procedure

2.4.1 Recruitment

Recruitment began in February 2008. Psychiatrists and Clinical Psychologists working across the four CMHTs were asked to identify individuals with a confirmed diagnosis of BPD based on the inclusion and exclusion criteria (see appendix 4). As the research was carried out within the General Adult Psychiatry service then all participants would be aged between 16 and 65 years. As it is not possible to predict what will be discussed within each interview, it was possible that participants may become distressed whilst recalling difficult events (Orb et al., 2000). Continuing contact with the CHMTs ensured that any further support that may have been required would be readily and immediately available without the need for a referral to another service. The availability of the team "duty worker" provided further immediate and specialist support if required. Participants were included if they had or were continuing to engage in deliberate self harm. Self harm is a common coping strategy and should be differentiated from suicidal intent. A core feature of BPD the exclude this group would have limited recruitment to the study. Individuals were excluded from the recruitment process if they had been discharged from inpatient

admission within the proceeding four weeks. A recent study by the reported that Personality Disorder accounted for only 11 per cent of suicides following psychiatric admission and that completed suicide was likely to occur within the first three weeks post discharge (Appleby, 2006). Inpatients were also excluded from the study as their compromised mental health may have impacted on their ability to provide informed consent.

Patients meeting the criteria were provided with an information sheet outlining the rationale of the research and what their participation would involve (see Appendix 5). Those who were interested were then asked to contact the researcher to discuss any questions/concerns and to arrange a time for the interview. An additional independent contact was included on the information sheet that could offer impartial advice to potential participants.

2.5 Data Collection

2.5.1 Interview Schedule

Constructing the interview schedule allows the researcher to set the scene, introducing the main topic to be discussed. This process is particularly useful when researching sensitive topics as it allows the researcher to consider the phrasing of questions and include questions that may address particular themes that they anticipate may be relevant.

Smith & Osborn (2003) encouraged the use of assumption free, open-ended questions that use everyday language. At times however, questions may be too open and it may be necessary to provide prompts. These prompts are more explicit and allow the researcher to explore a particular experience in more detail (Smith & Eatough, 2007). Using a related technique of funnelling allows the interview to move from the exploration of broader topics to the more specific. Beginning with more general questions however allows the participant to interpret them as they wish, thus minimising the risk of the researcher influencing the course of the interview.

The interview schedule is designed as a guide; the researcher need not stick faithfully to the order of questions or may decide to omit some. This iterative process allows an open discussion, encouraging the participant to talk with minimal prompting. This flexibility enables the participant to discuss issues that they consider important that the researcher may not have anticipated and otherwise have missed (Smith & Osborn, 2003; Smith & Eatough 2007).

Based on the existent literature and the consideration of possible themes to emerge, the researcher constructed the interview schedule found in Appendix 6.

2.5.2 Interviews

IPA can use a number of different mediums by which to gather information for the purpose of analysis including written and video diaries, and observations within the natural environment. The most common method of data collection however is the semi structured interview (Smith & Osborn 2003). Interviews took place within the CMHT where the participant usually attended. As participants were not reimbursed for any travel expenses, interviews were scheduled, wherever possible to coincide with a routine clinic appointment.

IPA interviews can be lengthy and cover emotive material therefore it was important at the beginning of the interview to put the participant at ease building rapport and a sense of trust. Part of this process involved asking general questions which allowed the collection of basic demographic information such as age, and marital status. Interviews lasted on average 40 minutes with participants allowed to take breaks as and when required. A pilot interview was conducted in order to trial the interview schedule and refine if necessary. Following the interview, the participant provided feedback that was very positive, in particular they stated that asking them to think back to their last visit made it easier to think about their experiences and gave them something "to hang" their narrative on. Following analysis it was decided to incorporate this pilot interview into the main study due to the richness of the narrative.

In addition to the interviews, the researcher kept reflective notes, documenting additional information that they considered being important including their own thoughts and feelings that could be used in the stages of analysis.

2.6. Data Analysis

Interviews were completed by the end of May 2008 and analysis took place in June 2008. All interviews were recorded using a digital voice recorder and were then transcribed verbatim. Data analysis followed the stages set out by Smith & Osborn (2003) a schematic representation of which can be in figure 1 below:

Stage 1- Free Textual Analysis

Researcher reads and re reads transcription to immerse themselves within the text

Researcher makes notes of salient points, features of speech and cross references with reflective notes from each interview.

Stage 2 – Identifying Themes

Focus shifts from preliminary note taking to a more in-depth analysis applying psychological concepts to make sense of the meaning held within each individual's account.

At this stage emerging themes are identified

Although an interpretative process it is critical at this stage that care is taken to remain true to the original text

Stage 3 – Data Reduction

Themes are brought together under naturally occurring "clusters"

Based on the concepts expressed by the identified themes the cluster is given a title called a "super ordinate theme"

At this stage, initial emerging themes may be omitted due to a lack of supporting evidence.

Stage 4 - Table of themes

A final table of super ordinate themes alongside the sub themes that compose it is constructed representing key points of the narratives.

Illustrative quotes from the text are used to ground themes within the text.

Stages 1-4 are repeated in a cyclical process emerging themes from subsequent interviews are referenced against earlier themes and either incorporated into existing themes or new themes are created. This ensures that each individual account is not lost.
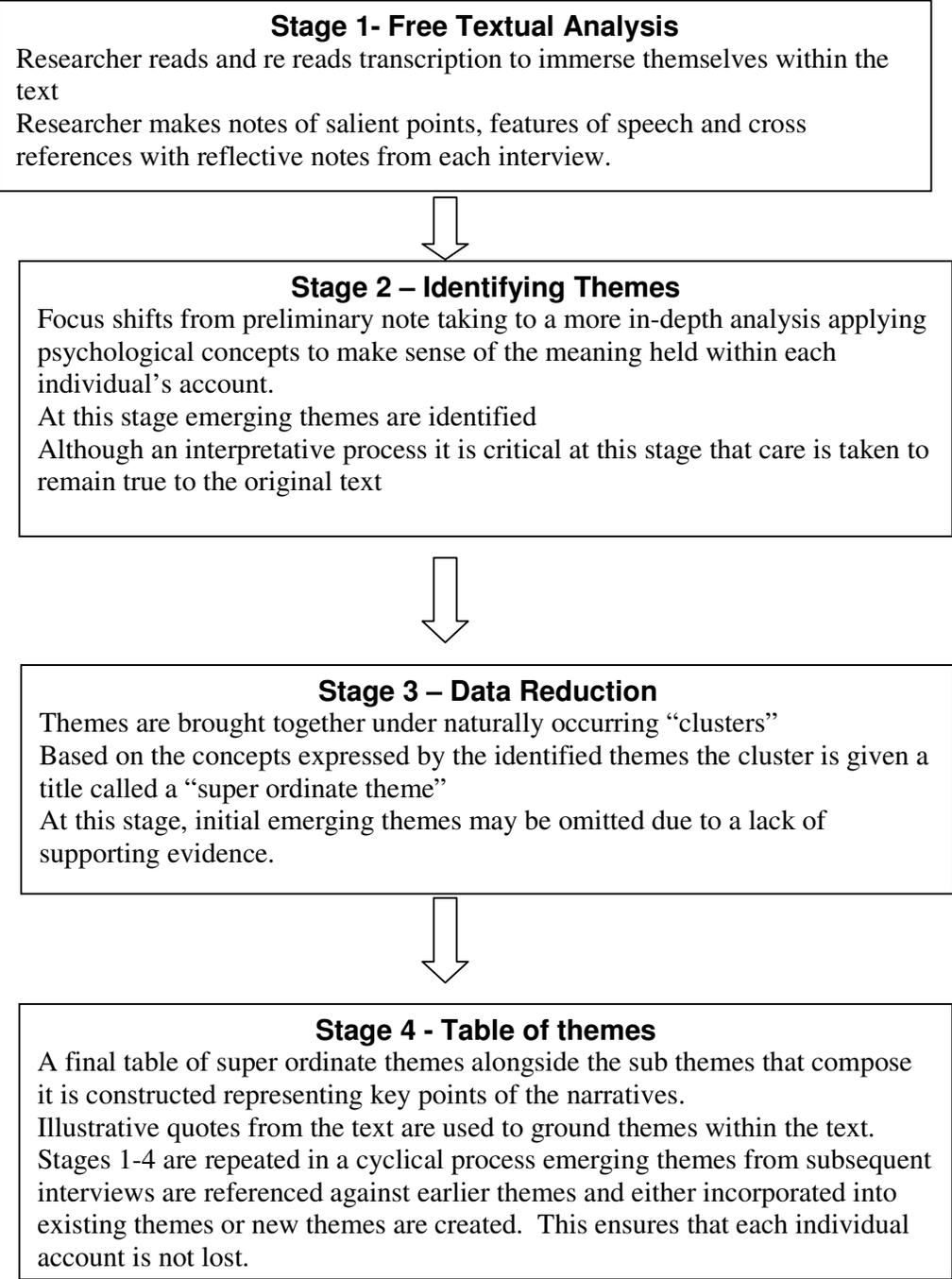
Figure 1: Schematic Representation of analytic process (adapted from Smith & Osborn, 2003)

2.7. Quality Control

Yardley (2000) has outlined a number of principles that underpin good quality research. These are sensitivity to context, Commitment, Rigour, Transparency, Coherence, Impact and Importance and are discussed below.

2.7.1. Sensitivity to Context

Any research needs to be placed within a context and the findings of the current study were looked at within the context of the existent literature that had used similar methodology or which had looked at the same topic. This was carried out at the analysis stage once themes had been identified. Identifying where findings corroborate with earlier studies can add further evidence and perhaps more importantly differences can be even more informative perhaps developing new understandings of the topic (Coyle, 2007).

The researcher must also be aware of the context within which the interviews take place. In this study participants were interviewed in a clinic setting. This posed specific issues concerning both the participants and the researcher's expectations of the encounter. Qualitative interviews are very different to clinical interviews where the clinician may be more likely to direct the topic of conversation, ask more questions and where boundaries are more rigid. To try and overcome this difficulty the researcher adopted a more informal approach, talking a little about themselves and offered some refreshments in order to make the participant feel more at ease and to distinguish the interview from a routine clinical appointment.

2.7.2. Commitment

The researcher conducted a comprehensive review of the literature and through clinical practice had gained an understanding of working with this patient group. The researcher also attended national PD conferences, attending specific workshops relating to BPD. Interviews were transcribed by the researcher demonstrating further commitment to the research process. The researcher also attended regular qualitative

seminars held within the university department where they were able to discuss with other researchers the different stages of analysis and themes as they emerged.

2.7.3. Rigour

All data was analysed by the researcher as outlined above. Emerging themes were identified and through a circular process emerging themes from subsequent interviews were either incorporated into the earlier themes or added as new themes to maintain an idiographic account. Once initial analysis was conducted the software package Nvivo (©1999-2002 QSR International Pty. Ltd) was used to help with the coding and organisation of data affording the researcher more time to reflect on themes allowing an more in depth analysis. An example of a coded transcript is included in Appendix 9.

2.7.4. Validity

In addition to academic and clinical supervisors, two independent members of university staff trained in qualitative methodology reviewed initial exploratory coding. Throughout the further stages of analysis the researcher regularly consulted with one of these independent advisors, working in the Scottish Primary care Mental Health Research and Development programme. Again in addition to academic and clinical supervisors they were able to review super ordinate and related sub themes having viewed transcripts and N Vivo coding. They were also involved in reviewing the final report to ensure the accuracy of themes.

Four of the participants were also involved in reviewing super ordinate and sub themes. A process referred to as member checking (Mays and Pope, 2000). The reader is also an integral part of the validation process. In the results section below extracts from original transcripts are used to illustrate themes. Whilst some extract may be lengthy this sets the quotes within a context, allowing the reader to see where each theme has emerged, adding to the transparency of the analytical process.

2.8. Role of the researcher

A post-modernist approach, IPA acknowledges the unique role of the researcher where the outcome is a product of the interaction between the participants and researcher (Smith & Osborn, 2003). Analysis involves the researcher immersing themselves within the text to take an insider's perspective. To achieve this, the researcher becomes and integral part of the research process, bringing his/her own opinions and biases to the interpretative process. There were a number of reasons why I had decided to conduct my research with this population. Working as a Trainee Clinical Psychologist at the time of carrying out the research I had worked for 12 months in a CMHT. I therefore had experience of working clinically with individuals with a diagnosis of BPD and had been exposed to attitudes of staff who frequently discussed patients with "personality" problems.

My mother works as a GP receptionist in a small rural practice and I had very good relationships with the GPs for whom she worked. Aware of my training I was frequently asked by them how to deal with "difficult" patients as they felt unsure what and how they could improve their service to individuals with mental health problems. GPs having acknowledged there were difficulties in such consultations made me questions if patients felt the same about their visits. I considered this to be an important area that required further investigation and decided to ask patients themselves.

CHAPTER 3

RESULTS

3. Results

In this chapter the findings of the study are described. Sample characteristics for each participant are described in Table 3 below. **Pseudonyms have been used throughout to protect individual's identities**.

Table 3: Sample Characteristics

	Age	Diagnosis	Marital status
Alison	39	BPD & Severe depression (in remission)	Single
Anne-Marie	36	BPD & Depression	Single
Louise	37	BPD & Depression	Co habiting
Phil	32	BPD & Depression	Single
Lynsey	38	BPD, Anorexia nervosa (in remission)	Single
Mhairi	22	BPD & Depression	Single
Susie	63	BPD & Depression	Single
Lee	42	BPD	Cohabiting
Yvonne	60	BPD & Schizophrenia	Married
Joanne	33	BPD & Depression	Single
Mary	43	BPD & Anorexia Nervosa (in remission)	Separated

Five super-ordinate themes were identified; Experience of Having a BPD Diagnosis, Perceptions of GPs, Invalidating Experiences, Sense of Self and What Works Well. Each super-ordinate theme and their corresponding sub themes are illustrated in Figure 2 below. All super-ordinate themes were discussed by each participant however there was a degree of variation in sub themes. A summary table of participants' individual themes can be found in Appendix 7 alongside the transcription notation and example of coded transcript (Appendices 8 & 9 respectively). Individual super ordinate themes will be introduced along with related sub themes. Anonomised extracts from original transcripts will be used to illustrate each theme.
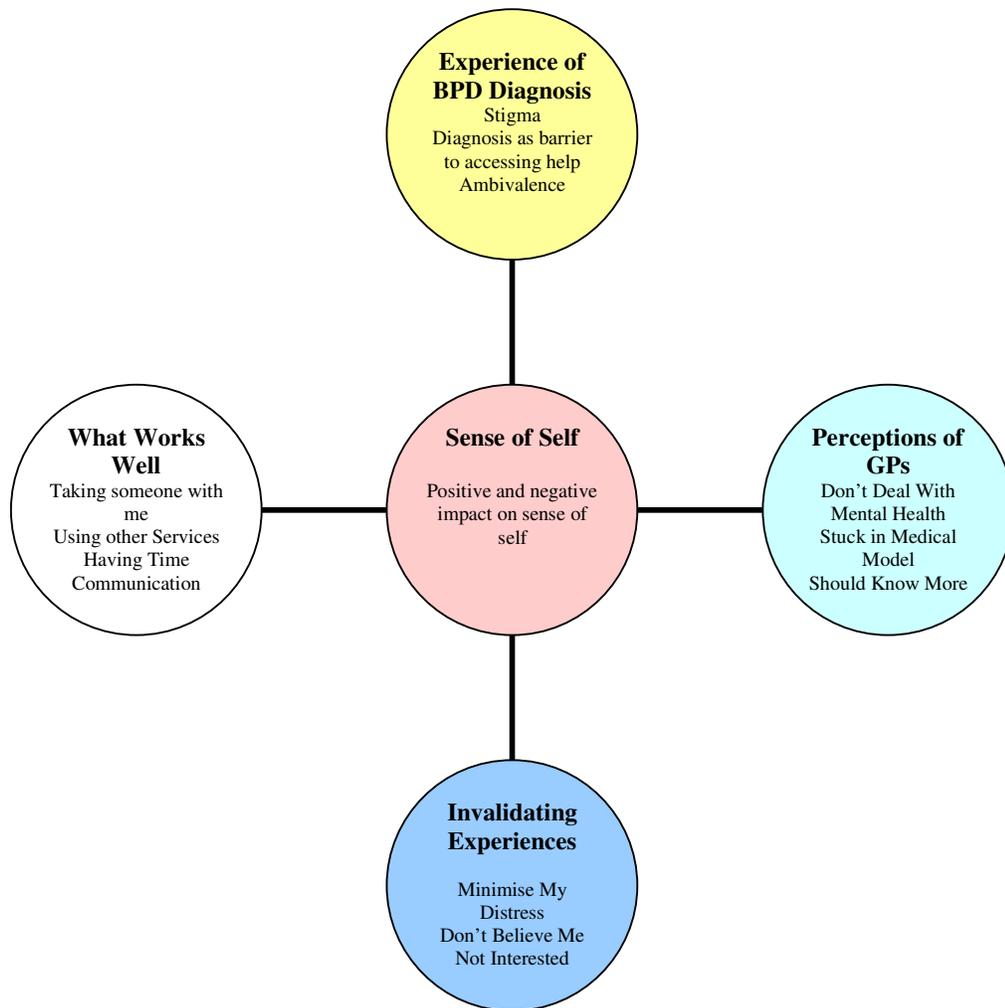
Figure 2: Schematic representation of Themes

3.1. Experience of Having a BPD Diagnosis

All participants described living with a diagnosis of BPD and the impact this had on their interactions with GPs. In this section the sub themes of *Stigma Associated with BPD Diagnosis*, the *Perceived Role of the Diagnosis in Being a Barrier to Help* and *Ambivalence Towards Diagnosis* are discussed.

3.1.1. Stigma Associated with BPD Diagnosis

All participants talked about believing that GPs held negative attitudes and prejudices toward them as result of their BPD diagnosis. The participants described how having a diagnosis was associated with a pejorative label. As a consequence participants felt that they were immediately disadvantaged as they either did not get the opportunity to discuss why they were attending the GP or when they did GPs had already made treatment decisions based on their BPD diagnosis. These experiences left many participants feeling angry, both at themselves for having put themselves in that position and at the GPs for failing to listen to them and failing to see the person behind the label.

> Extract 1
> It's like I've been judged before I've even told them what's wrong. They've already labelled you they've already looked at your medication and they've already decided that they're not going to treat you for what you're there for. And I come out so angry at myself for even, "why did you bother going?", because they can't see past that that's all they can see in you.
>
> Lynsey (Lines 380-384)

As a consequence of such stigma and its' associated label a number talked of how they felt GPs were afraid of them, thinking that they posed a danger to themselves and others and how this made them feel upset and ashamed. The use of the word "*mortally*" in the following extract underlines the extent to how much Yvonne despaired being labelled as dangerous based on negative assumptions related to her BPD diagnosis.

51

Y. Well it makes me feel like "oh my god I've got mental health problems and they're putting a label on us". I've said to my partner "Oh god they think I'm gonna hit them".
I. What impact does that have?
Y. It's terrible, it really is. Do you think that?
I. Mmmm that's what a lot of people have said
Y. I do I think I'm labelled and I just <u>mortally</u> hate it.

Yvonne (Lines 171-184)
(Lines Suppressed 174-180)

Being labelled was considered to have influenced health care and GP interactions. Participants described how having a diagnosis affected not only access to health care but some felt that their diagnosis had an impact on how their care was delivered, often with a perceived lack of decency and dignity. Alison compared her diagnosis with being an *"…alcy, druggy, scumbag"* reflecting her belief that she shared equal status with these other prejudiced groups.

Extract 3
Yeah I think there needs to be more awareness in general practice I think there ((sighs)) huh yeah I mean just even basic, basic things like talking to somebody like a human being. Not you know, like, OK they might be, you know, an alcy, druggy, scum bag whatever, you know, homeless you know but see the person as a person and they deserve the best services for them and I do often feel, think often very second class….

Alison (Lines 553-560)

3.1.2. The Perceived Role of the Diagnosis in Being a Barrier to Help.

All participants stated their diagnosis had been a barrier to accessing health care. Many described how they had to justify their attendance at their GP, as it was not enough to be ill but they also had to say what they expected the GP to do and why they warranted the GPs help.

> Extract 4
> It's like all the time you've got to be explaining why you've gone. Not the symptoms you've got but you've got to also explain why you've come! You know you can't just be ill. But when you say the symptoms you've got its like "and... so?"
>
> Lynsey (Lines 230-233)

Many had the experience of having gone to the GP and not receiving a proper medical assessment, instead they were told just to leave it to see if things got better. This had a significant impact on how participants felt about themselves. Participants often described how they felt they were a nuisance and did not deserve to be at the GP practice.

> Extract 5
> Well you'll go in and they'll say "come in and have a seat" they'll sit down and say "What can I do for you today?" and I'll say… well the last one was about the numbness in my hand and they ask "how did it happen?" and I explained how it happened and they said "We'll leave it for a couple of weeks and if it's still the same come back and see me". Which I thought was quite poor.
> *I. And what did you expect would happen when you went?*
> L. What did I expect?
> *I. Yea.h*
> L. I did expect him to look and go through where the numbness and all that was but it wasn't the case.
> *I. Right ok, how did that make your feel?*
> L. It makes you feel like you shouldn't be there, you shouldn't be there asking them things, you shouldn't be there, you shouldn't even be at appointments. That's what it makes me feel…
>
> Lee (Lines 111-130)

Joanne described how she had gone to see her GP very distressed, looking for some advice. She talked of how she felt the GP had scolded her for attending and inferred that there were other people in the practice with physical problems who were in

genuine need of treatment. Note how she attributed the GPs response as a consequence of the GP having a bad day.

> Extract 6
> When I was back at home there was one doctor I went to and I said "I don't know what to do" and they started…I don't know, they must have had a really bad day and they started saying "I don't want to hear this drivel, there's patients out there who have cancer". And they were going on about people having cancer and heart attacks and "you should be happy with your life, just get a grip on yourself". So that was a bad experience so it was.
>
> Joanne (Lines 103-108)

Many participants who self harmed described how they felt the GPs response had made them feel that they did not deserve treatment because their injuries had been self-inflicted.

> Extract 7
> Feeling…feeling like they're not wanting to treat you, you've done it yourself so em -em - em you just have to look at the consequences of doing it. "Why should we help you when you've done it yourself and there are other people who really need our help who haven't done anything to hurt themselves" you know "it wasn't their fault that they broke their leg".
>
> Anne-Marie (Lines 674-678)

3.1.3. Ambivalence towards Diagnosis

A number of participants had mixed feelings about their diagnosis. At times individuals were fully aligned to the label yet also made attempts to distance themselves from those with the same diagnosis. Whilst all participants talked explicitly about having the BPD diagnosis many also referred to co occurring mental health issues such as depression. This may be because participants did not receive treatment from their GP for BPD but there was also a sense that this reflected a desire to distance themselves from the BPD label aware of the associated negative perceptions.

Participants frequently aligned themselves to the label when wanting recognition for their achievements or when this entitled them to accessing support, for example from CMHTs but often they distanced themselves when the label and associated negative stereotypes were considered a barrier to accessing health care. This was illustrated by participants stating that whilst they acknowledged some people did fit the stereotype they did not.

> Extract 8
> P. Like I said you know you get a lot of people who do sort of play the system and stuff like that you know whatever, you know and time wasters and such maybe I don't know I'm not trying to sound too nasty with that one, hypochondriacs and stuff like that or I think that's the right word,
> *I. Yeah*
> P. Yeah that's cool. But obviously yeah I think that's the way they feel sometimes you know its like either that or they see you as a time waster or they just don't understand or want to understand.
> Phil (Lines 88-96)

Others talked more explicitly about the lack of understanding about BPD and how having a diagnosis overshadowed their appointment even when attending for physical health problems. In the following extract Lynsey states at times the label is not needed or indeed wanted, particularly when it was seen as a barrier to accessing health care.

> Extract 9
> but I just think its misleading borderline personality I really don't think they know what it entails and how it can be sometimes for the person and they don't appreciate that but when you're there not with that you should be treated like anyone else.
> Lynsey (Lines 370-372)

For some, switching alignment with the diagnosis was an unconscious process that was evident in the use of language throughout their narrative. Notice how Alison switches pronouns within a few sentences. She begins by using "we" but then refer to "the ones.....help them". She aligns herself with the marginalized group however when requesting help switches pronouns perhaps because she felt unable to ask for help for herself.

But I, you know well have we no got any moral fibre or any you know self control or you know the ability to go "right yeah I'm giving up smoking and that's great". I'm… I'm trying to lose weight and things like that and get a bit fitter I mean everyone is ratting farting about going "Oh yes exercise, exercise is great oooh yeah exercise great for your mental health" well why don't they actually do something about it? Why don't they target people, the ones with mental health problems and help them improve, you know, their health status.

Alison (Lines 259-273)

One interpretation of participants' reluctance to completely abandon the label was the belief expressed in a minority of narratives that in some ways having a BPD diagnosis should entitle them to having more time as their needs were more complex and arguably more important than other people's difficulties.

Extract 11
And I know that mental health problems can take a bit more time than physical problems but that's just part and parcel and I think there should be a facility for that, for people, because it's not something you can explain in five minutes you know how your feeling if you know what I mean?

Anne Marie (Lines 53-56)

Many participants acknowledged that GPs were busy and that they had other patients to see however participants described how their needs were more important due to the desperation and seriousness of their situation. Notice in the following extracts that whilst Alison and Lee acknowledged GPs were busy there was a sense that their needs should take priority, they could not wait *"trying to explain the wait"* and GPs should make an extra effort *"it would be nice to get a call"*.

Extract 12
So when your phoning ok, you know so possibly Friday just before a public holiday etc etc everybody and their auntie is wanting to see the GPs but trying to explain the wait or how you feel in yourself and that you think you need help and things like that.

Alison (Lines 44-49)

Extract 13
and I know that there are loads of people who are ill and that and I do respect that but when things like that come to light it would be nice to get a call from a GP to say "right we need to speak about this and see how we could sort this out".

Lee (Lines 209-212)

3.2. Perceptions of GPs

This theme reflected the beliefs participants had about their GPs. Some of the sub themes described the attributions made by participants in order to understand the responses of GPs whilst others were general impression about GP practice. In this section the sub themes, *GPs Don't Deal with Mental Health*, *GPs Stuck in Medical Model*, and *GPs Should Know more About Mental Health* are discussed.

3.2.1. GPs Don't Deal with Mental Health

This was a strong theme to emerge from the narratives where participants described that when attending for issues relating to BPD they felt that GPs did not consider this to be within their remit and participants were frequently told to go to specialist services instead. Not all participants however had regular contact with specialist services or had an assigned CPN which made this difficult. Participants also felt that GPs *should* deal with these problems as they are the first contact for many individuals.

> Extract 14
> Like em "I can't help you", it's like "we'll help you with your physical illness but mental health services will help you with your mental illness". So basically don't go near your GP if you've got a mental illness got to the specialist services.
>
> Anne-Marie (Lines 614-617)

> Extract 15
> P. Like I said through the experience of my doctors it's always it's what I've come to expect you know. Unless you've got something sort of broken limbs or you appendicitis or whatever, or this that and the other all that sort of crap or whatever you know something medical or surgical whatever I think that's where their main sort of interests, well not interests but their main sort of thing lies.
>
> Phil (Lines: 68-77)

> Extract 16
> But it was just the fact that they just ((sighs)) …another particular doctor and they have retired as well but they were a locum and they were great on the physical side, they were the sort of doctor who would draw you a diagram ((laughs)). But they were absolutely bloody useless when it came to anything to do with mental health and I avoided them like the plague, whereas my mum had physical problems and she swore by this GP and thought they were great and my sister loved them as well. Cause if you went in with a physical problem they would explain it all to you but anything to do with mood or anything and they were quite short and off-hand.
>
> Mary (Lines 93-99)

This was in contrast to when participants attended for physical health problems. Many described how they found it was easier to attend the GP for physical health problems because they had been able to describe their difficulties, which fitted in a medical model where the GP was comfortable in their role. The GP was therefore able to do something practically even if they could not 'cure' the physical problem. Having their concerns acknowledged and being taken seriously had made their attendance a much better experience. Across the narratives there was a distinction made between attending for physical health problems and problems related to their BPD diagnosis.

Extract 17
I. You mentioned before about a difference from perhaps when you go for a physical health problem compared to a mental health problem?
A. Ha Ha like going for laryngitis I mean the doctor was able to shine the torch down my throat have a wee look have a wee feel round my neck and that and go "Aye that's laryngitis" and even though they were able to say "there's nothing you can do about it you just like has to run its course" erm and they said "obviously try and not talk to much try and rest your voice you know they were happy they'd made a diagnosis and they did give information. I was quite happy I'd walked away with an idea about what was going on and sort of things and you know I was like "ka-ching done" nicely boxed up and away you go.

Alison (Lines 435-443)

Extract 18
I. And I know you said you mostly go for mental health problems but have there been times when you have gone for physical things and is there a difference?
P. Well like I said it's been a few years just been it'd like I said, I've just know it to be a bit more different like I said you know its not like laying in the back of their chair writing the prescription it's like right let's have a listen to your heart lets give you a bit of an MOT sort of thing you know you know it's that sort of side of things obviously maybe if you have got the flu or a chest infection en that's what they do they listen to your chest and take you blood pressure and blah blah blah but obviously with depression or whatever you can't check someone's chest or whatever or check out somebody's blood pressure or whatever cause you don't need it depression don't really sort of create a fever but obviously their approaches have been different you know on how they've dealt with things.

Phil (Lines 416-438)

3.2.2. GPs Stuck In a Medical Model

This was a strong theme emerging within the participants' narratives that GPs stuck rigidly to the medical model and there was a clear sense that GPs viewed medication as the only thing they could offer.

> Extract 19
> The first time when I moved here I had been diagnosed with depression and I'd been going with little niggly things and the doctor started asking me questions and I started bawling my eyes out and then they sort of said about Prozac and I sort of like said I'd give it a go. I did try it for a month and a half but it was upsetting me more the fact that I was constantly having to pee and I think it was because of dry mouth and I wasn't used to it drinking that much but after a while I just said "Look, I can't take this" and the other one was just the same but anyway then I come back and said "look this antidepressant doesn't work" and by this time I was at another practice and they said "well there's nothing I can do if you don't take your anti depressants"
>
> Joanne (Lines 84-92)

Others believed that GPs used medication to reduce the amount of time they spent in consultations with them, often having written the prescription before they had even had the opportunity to discuss their current problems and were reluctant to enter into a conversation with them. This again reinforced their feelings of rejection.

> Extract 20
> I know they've got a high level of responsibilities for their job but it just feels like they don't want to take the time. My view is that they get the money and that's it. Give tablets out willy-nilly. It's easier to give the patient the tablet than sit and have a conversation with them. The tablet will sort the problem that's what I see.
>
> Lee (Lines 226-230)

> Extract 21
> but like I said it's never been along the lines of you know sort of "How are you feeling?" you know "Are you feeling low?" you know that's taking an interest it's just like "Well lets give you some more medication".
>
> Phil (Lines 297-299)

A minority however did not consider this a problem as they had strong beliefs that medication was what was managing their symptoms. One participant, Louise, had in the past been refused any medication as a consequence of her BPD diagnosis so the fact that she was now prescribed medication was welcomed.

> Extract 22
> L: Compared to here, these people here are a lot lot better, I've had more help in the past five years here compared to there. They said medication wasn't the answer, I had to live with it, you know, that sort of stuff, it's your choice at the end of the day
> *I: And how did that make you feel? What does it mean to you having that?*
> L: You mean just now? ((Smiles)). Great, that you know that I can go to my GP and tell them how I was feeling and they would change my medication over, they would put my medication up.
>
> Louise (Lines 104-115)

3.2.3. GPs Should Know More About Mental Health

There was a clear sense across the narratives that GPs lacked a basic awareness in mental health, in particularly how to respond to self-harm and acute distress. This theme is related to the above sub theme, *GPs Don't Deal with Mental Health* perhaps due to a lack of understanding or not appreciating the difficulties for individuals with a BPD diagnosis.

> Extract 23
> I actually feel that GPs need to be educated more on mental health because as you well know doctors choose what field obviously they go into as they're studying. Now obviously, a doctor that's going to be a surgeon or a GP or whatever they're not wanting to go into Mental Health [Mmm Hmm] so they maybe don't really want to deal with mental health problems, issues. And I just feel that they should be educated more in mental health issues because I don't feel that, I mean they talk about em people in general not understanding about mental health problems but I feel that one of the main things like the GP doesn't understand what people can be going through. Well they maybe do understand but they don't come across with the right approach you know when people present to them with a problem.
>
> Anne-Marie (Lines 147-152)

Extract 24
M. I can't think there's not been that many times cause usually I just go through the psychiatrist here.
I. And is that good that you don't have to go to the GPs?
M. ((Laughs)) Yeah. People here know what they're talking about
I. Right OK so did you get that feeling from the GPs that they didn't really understand or?
M. Yeah
I. Apart from them saying to you oh it's just a phase, was there any other way in which they didn't understand?
M. Well it was just the fact that maybe mental or psychiatric problems can happen to younger people it doesn't just happen to you in your thirties.

Mhairi (Lines221-234)

Extract 25
P. You know obviously I was sort of not diagnosed until a year and a bit ago obviously you know, you know, you know, I dunno, I'm not 100% sure how it works you know. I don't think they've got a great understanding really you know…But I dunno you know there are obviously reasons for it you can speculate all you want and sort make up you own sort of thing
I. And do you have an idea?
P. Like I said they maybe really are busy and stuff like that you know it's not there, they either become lazy or you know not wanting to know mental health sort of side of things you know like I say I don't think there's a great deal of people, doctors that want or have any major of knowledge depression and stuff like that.

Phil (Lines 87-100)

Whilst many of the participants acknowledged that there were specialist services to deal specifically with their mental health many believed that this should be part of a GPs role also as they are often the first contact when people are having difficulties. Moreover participants said although they recognised were busy they felt that GPs had a duty of care and in not having knowledge about mental health they were failing in that duty.

Extract 26
Sometimes I feel abnormal. Like I'm just another sad statistic on this earth. That's what it feels like. Just feel like that people who have mental health problems "Well we're no the people who deal with it so this is how we'll deal with it. We'll see you for a couple of minutes get your tablets then out the door. And I do understand there is people for like here [CMHT] but what are GPs for? What are they there for?

Lee (Lines 419-424)

Extract 27

och I mean I know must be hugely frustrating working with somebody trying to help somebody you know if you can't see you know the fruits of your labour ((laughs)) but the thing is don't go into that line of work if you can't do that it doesn't help.

<div align="right">Alison (Lines 413-417)</div>

Extract 28

But obviously being a doctor, you know I do understand that it is busy and it is stressful and stuff like that and like I said you know but in someway there is still no excuse you know. I mean like I say I used to work in care and stuff like that you know I used to work with you know autistic, Downs syndrome and everything like that you know you know you know if I didn't take care and report what I was doing or what they were doing to themselves or stuff like that I would be in the shit you know.

<div align="right">Phil (Lines 395-403)</div>

3.3. Invalidating Experiences

Invalidating Experiences was a major theme that was evident in all of the narratives. There was an overwhelming sense that GPs had invalidated their experiences. All participants described instances where they felt their experiences had been dismissed by GPs. Here the sub themes, *GPs Minimise my Distress*, *GPs Don't Believe Me* and *GPs are Not Interested* are discussed.

3.3.1. GPs Minimise my Distress

Many participants often tried to get by with the help of friends or family. They felt that GPs thought they were overreacting and that they should get on with things on their own. As a consequence, all described going to their GP as a last resort particularly for mental health problems.

Extract 29

It just gets depressing sometimes and you know when I run out of pills its like "oh no I've got to get to the doctors".

<div align="right">Phil (Lines 427-328)</div>

Extract 30

so even like, just going to the GPs surgery, basically with a gun to my head.

<div align="right">Alison (Lines 490-491)</div>

Those who could no longer cope had contacted their GP at times of crisis and had felt patronised by the GPs response. In the following extract a friend of the participant had contacted the GP to request a home visit. The participant had felt very low, had a history of self-harm and the GP had told them to go and have a bath. The participant described how they felt so angry with the GP who had made them feel that they were over reacting. Humour was a coping strategy that they used to deal with their disbelief and anger.

Extract 31
A. I was once told in response to telling them how horrendous I was feeling I was once told to run myself a bath a nice hot bath and have a lovely cup of tea, chamomile tea.
I. And that was your GP?
A. That was the advice. I mean even I was angry at that point and said "you will never get back in my house" ((laughs)). Oohh that really incensed me at the time.
I. And had that been a home visit?
A. Aye
I. Can you tell me more a bit more about that it sounds like something that was quite difficult?
A. ((Sighs)). Like that not doing awful well, and eh yeah these two people sat in my house and give me this patronising rubbish which I recognised it as such so tried to kind of end the meeting as quickly as possible and yes the upshot was that I was to have a bath a nice warm bath candles and everything and a cup of chamomile tea. I didn't even like or have chamomile in the house ((laughs)) I had a bath! I was so gob smacked that even I thought "oh that's just gr-ea-t"!

Alison (Lines 623-649)

Extract 32
L. It's the way they come across to you "Oh it will be OK in a couple of days things will sort themselves out" and that's the attitude you get all the time
I. And what's going through your mind when they're saying that?
L. Do you honestly know what I'm thinking? You honestly don't know what I'm thinking…what's going through my head. You don't…just…. do you understand what I'm trying to say what I'm trying to tell you here?! ((Laughs)).

Lee (lines 330-337)

These experiences were not confined to mental health problems. In the following extract the participant had suffered a miscarriage but the GP minimised her desire to grieve for her child. One may speculate as to the reasons why the GP responded in the way that they did however it may be that they made an assumption that the participant would not be able to cope with the emotional impact.

> Extract 33
> L. Em, Well I've been like pregnant three times. Em I miscarried,
> *I. I'm sorry*
> L. That's ok I lost my baby at six months. And then I've got my other child but they live with their grandparent through my illness. So em one GP came out and said "well it's only a baby you've lost". This is the sort of way… (4)... that's what he came out with.
> <div align="right">Louise (Lines 174-180)</div>

Many participants had changed GPs in an attempt to get a better response. This however was not always successful. Mhairi had changed her GP as she felt she was not being listened to and was told her problems were just part of adolescence. Mhairi described how she felt she was made to feel a nuisance and that nothing was really wrong with her. She was understandably upset and confused because she was really struggling to cope. Having made the decision to change GPs however the response was just the same.

> Extract 34
> *I. So you changed doctors?*
> M. Yeah they were kind of the same as well.
> *I. How were they the same?*
> M. Just their general attitude towards you and that wasn't good.
> *I. Can you tell me a little bit more about what their attitude was like?*
> M. Quite dismissive, I mean I think they didn't believe ya, that kind of thing.
> *I. Did they come out and say that? what made you think...?*
> M. Just the way they implied it or like I was just going through a phase and stuff like that like you would just get over it.
>
> <div align="right">Mhairi (Lines 65-80)</div>

3.3.2. GPs Don't Believe Me

When attending the GP all participants described how on many occasions they felt that their GP did not believe them. This theme was particularly rich in the narratives of those participants who frequently engaged in self-harm. Participants often did not attend the GPs after having self harmed due to shame and concerns about how the GP would respond. Often participants described how it was at the insistence of friends or family that they attended and when they eventually did so their perceptions was that their GP did not care about what had happened. As a consequence GPs failed as to the reason why they had overdosed. There was an overall sense that GPs viewed this as attention seeking and/or manipulative. Self-harm had often been in response to feelings of not being able to cope or feeling very low in mood, they felt there was nothing to live for.

Extract 35
I. And going along looking for help when you are that age and realising that you know that there's something not right here and going for help and not getting that, what's the impact of that?
M. Just hopeless like there's nothing you can do but kill yourself.
I. And have you attempted to take your own life?
M. Yeah
I. And have you gone to the GPs about that specifically?
M. Not really I've seen psychiatrists in the hospital like the next day or whatever. Nothing really at the GP apart from the first time then I got referred here after that…. I wasn't coping at college or anything. Everything in my head was too much so then I took an overdose and then I was in hospital for a week and then I went to see the GP and quite like…I dunno I can't think of the word they didn't really take it serious again I don't think.
I. What did they say or didn't they say that make you think that?
M. I felt like they thought that I was just acting out or whatever.

Mhairi (Lines 232-272)
(Lines suppressed 246-253)

Extract 36
P. I've probably lost count and probably don't even want to try and remember how many times I have sort of OD'd and not done anything about it and obviously I'd go and tell the GP and that sometimes and stuff but I said sometimes it just seems they look at you and yeah not interested sort of thing that's what I felt anyway.
I. Yeah and that's important how that makes you think about yourself how did that affect you?
P. Well you know like I said, you know, its like, you know, its not to get attention or whatever you know I'm not sort of screaming down the phone to get an ambulance you know five minutes after taking the pills it's not a form of attention seeking or anything like that.

Phil (Lines 214-226)

GPs did not discuss the issues that had prompted the self-harm and participants felt they were no further forward in getting they support they felt they needed. More concerning, many stated that it gave them further reason to kill themselves. In the following extract Lynsey had gone to the GP to ask for some medication to help her sleep. With support from her family, she had been trying to manage for the previous week but had started to experience hallucinations. Because the GP thought she was attention seeking she was not given any medication and told to return in two weeks. This had near fatal consequences for Lynsey who as a result of feeling that she had not been listened to and that nobody cared what happened to her, attempted to hang herself and was subsequently admitted to hospital having then cut her throat. Lynsey felt that had her GP taken the time to listen to her at the earlier appointment then perhaps a hospital admission may not have been necessary.

Extract 37
Well before I had mega problems, mega, mega I would never go for anything to do with my illness. There was one time when I did have to go and I took my mum with me, because you have to someone with you, you have to someone with you because…and em the GP we were both [my mum and I] in tears I hadn't slept in six nights or days I was beginning to see things out the corner of my eye, you know sleep deprivation. My mum was crying and they said "Go away and come back in two weeks when I've contacted your consultant". So I went home and tied a rope round my neck but my mum was trying to phone, she got the police and they kicked the door in and resuscitated me and the same GP came along and sectioned me and said "I thought you were just putting it on for attention" and I was so angry. The police were in the house so I went to the toilet and got a razor and cut my neck, got my artery ended up in hospital for nine months and all I wanted was some Lorazepam to help me sleep.

Lynsey (Lines 47-58)

Those participants who had been given the opportunity to talk about their problems with their GP found that they did not believe what they were saying. For many their experience had been that the GP had asked them if they were lying or had asked others to confirm their account. Again a sense of disbelief and anger was evident in the narratives. Participants stated that often the last thing they wanted was attention and their experiences were so distressing that they could not comprehend why any one would lie about such things.

Extract 38

 Well when they asked a question one day about what it was like when you were getting – I can't think of the word – they wanted to know how it felt going through the - what do you call it I can't think at the moment – just didn't believe us when I told them how it felt when I was going through the nightmares over and over again and what it felt like and what my reactions were and the answers I gave they didn't believe us. And one of them came back the following week and admitted that she didn't believe us. She actually went to someone else and asked them what I meant by what I said and it turned out yes, that I was telling the truth, I mean what is the point in lying?

<div align="right">Susie (Lines 168-175)</div>

Extract 39

the trouble is you know like I said for most of my life I've had ODs and stuff like that so it should be in my medical records anyway saying that I have the tendency to OD or self harm or stuff like that you know and you know obviously you know it took a fair while for my them to get my records but I obviously told them you know obviously when I first joined the surgery exactly how everything was and about overdoses and stuff like that overdoses that I never went to hospital for just laid up at home after them for a couple of days you know I went through a phase of having sort of like eight overdoses in about four months or whatever you know and it was like (spoken in a dismissive tone) "oh well we'll just wait for your medical records to come here" and stuff like that and it was just crap.
I. And what was the effect of that?
P. Well you know, it just sounded like they didn't believe us! You know it was like you know "oh you know we need to have your medical records here and that you know so we can see for ourselves"

<div align="right">Phil (Lines 155-168)</div>

Again because of their BPD diagnosis many participants described how they felt that their GP had not believed what they had presented with and failed to carry out a proper examination. In the following extract Yvonne had to make an appointment with another GP before she was admitted to hospital for severe burns to her tongue, mouth and throat as a result of an accident.

Extract 40

Y. My whole mouth, my tongue was all pure white and em they took us into the hospital and it was all burnt in here and down here ((points inside of mouth)). So they gave me steroids and antibiotics, I was in there for four days.
I. But what did the first doctor say?
Y. I don't think the other GP believed us! When I showed the second doctor they said "Oh you should be in hospital, we'll get you an ambulance and take you straight up there".   So they phoned my CPN and they said "I thought you would have to go in" cause I'd showed them my mouth. And eh they said "Why did you not go to the doctor?" and I said "I did but it was a waste of time".

<div align="right">Yvonne (Lines 141-155)</div>

Prejudice also extended to family members where some participants had been asked if they were imagining their child's symptoms.

> Extract 41
> They think I'm imagining it's happening, and I'm like "well yeah he's been sent home from school, he's got quite a high temperature and…" but sometimes they say, "is this really happening?"

<div align="right">Lynsey (Lines 209-211)</div>

3.3.4. GPs Not Interested

Many participants described how GPs in addition to not being interested in their mental health problems; more importantly felt that GPs were not interested in them as a patient, regardless of why they were attending. As a consequence, participants described how they found it difficult to establish relationships with their GP. Note the comparison made by Alison between physical and mental health problems. Her perception regarding the lack of interest has been attributed to her BPD diagnosis.

> Extract 42
> I think because they've seen me over and over and over again, it almost like well somebody else with a long physical well a long term health problem I think over the years with experience get better because GPs get to know them and how to help them and what's appropriate and what's not what works and what doesn't. Or like how I used to feel, which was that I didn't think they were all that interested you know.

<div align="right">Alison (Lines 364-371)</div>

This theme was further evidenced by the difficulties expressed in a number of narratives that even when attending for physical problems they had felt dismissed or their problems were attributed to their mental health as illustrated in Lynsey's narrative below.

Extract 43

L. You could be explaining what's wrong, cause I've got a problem with my bowel but I could be speaking to the wall cause they say "Phone your psychiatrist when you get home" and I'm like but what can a psychiatrist do about my bowel?! You know or…I had really I was referred to gynae before I got pregnant and obviously when I got pregnant eh I stopped the, I didn't have to go but then I lost the baby and for three years after that I was going to the doctors I'm still having it now, a period every week and one time I bled for 16 weeks in a row and I went to the doctor and they told me to phone my CPN or psychiatrist cause "I think it's stressed induced"!!! ((Laughs)). And for about the last year and a bit I've just put up with it and stopped going cause I was going to them quite a lot cause it was so draining and so…and they said it's your psychiatric, every time so she'd take a swab but when you phoned up there was no results cause they hadn't actually sent it away! And I just thought, is this really happening, you know. You just thought, they haven't even sent it away, they went to the bother of taking the swab but they never even sent it away.
I. And what's the effect of that?
L. I just feel "why should I go?" and if there's anything really wrong "well they're not going to bother anyway" so… I've even stopped going for my smears cause I think what will they say, "Oh just phone your psychiatrist!!"

Lynsey (Lines 150-169)

Such responses from GPs often meant that some participants avoided their GP altogether for physical health problems and as a consequence the physical health of these individuals had often been compromised as evidenced in the following extracts.

Extract 44

I: So even with physical things you still think they might not believe you?
S: I was really lucky last year, I had to get 2 ops and one of them was for I had a tumour in my womb and it was actually about 14/15 inches when they took it out. I think part of that was my fault because although I had quite severe pain there I wouldn't go and say to them and if it hadn't shown up when I had a scan on my kidney I probably wouldn't be here now. So this is it. I think in some ways I think I'm being stupid but in other ways I couldn't see any way round it.
I: So are you ok to talk about that?
S: Yeah, ok at the moment
I: Well, let me know if you don't want to. Thinking back to that time when you were in that pain what was it that was making it difficult to go to the GP?
S: I don't know I was that swollen, just swollen all over but there was nothing I could do to get rid of it. I think I knew deep down at the time that something was really wrong but was also worried about going to see them and ordinarily I probably would have waited months and months to see them but it just so happened that I was in the hospital when they discovered this but it was that big in the end that they couldn't get it in the one picture.

Susie (Lines 216-241)

Other participants felt that they were a nuisance to their GPs based on the GP's body language such as tapping pens on the desk or looking at their watch.

> Extract 45
> *I. And again how do you know they're listening to you that sounds silly, I'm full of silly questions but you've said a few times that it's the fact that they listen to you that make the experience good, so how do you know they're actually listening?*
> M. Well you can just tell by their body language if they're looking at you or if they're sitting there looking at their papers and tapping their pen on the desk and stuff like that so… It's like they can't wait to get on to the next one then the next one so they can get home, that's how it feels
> *I. And how is that?*
> M. Just like they're no' that bothered.
>
> Mhairi (Lines 187-207)
> (Suppressed lines 194-201)

> Extract 46
> I find some GPs don't they don't take the time to get to know about you they just basically sign the prescription and see you on their way, you know, they're more worried about the clock ticking away than your problems really.
>
> Anne-Marie (Lines 50-53)

As a consequence of such invalidating experiences all participants described how their situation often got to crisis point whereby they became so distressed at not being able to access help that they self harmed or attempted to take their own life. Only then was there any response from GPs that subsequently reinforced the self harm behaviour. Ironically this had the potential to reinforce existing beliefs that these individuals are attention seeking, subsequently reinforcing existing negative attitudes and perpetuating somewhat unsatisfactory interactions between GPs and their patients with a BPD diagnosis.

> Extract 47
> L. you know it go to the point where I overdosed about 67 times.   Just for help struggling I would end up going to the bridge you know and being silly as they would say (laughs wryly).
> *I. Are you Ok talking about this?*
> L. Yeah I'm fine it was it was the police that helped me more you know the negotiators. You know just , it was hard I just was so … I don't know how to explain it , just so distressed, so negative thoughts I just I was just wanting help and I just wanted people to listen and I felt that was the only way to do it. I mean that was my only way of saying like "I'm I'm I'm getting desperate now and I'm really needing help" and that was the only times I would get it was going to that drastic measure.
>
> Louise (Lines 225-23).

Disappointingly, participants said that having felt driven to such extreme behaviour often improvement in GPs response was short lived that left them worrying about whether they would end up in another crisis.

> Extract 48
> it got lax again after they like they did what ever they did they thought "well lets get back to they way we normally do" just hand you a prescription when you come in or give you a sick note or whatever you know (pretend to write a prescription). And like I said it took an overdose and a complaint for them to get off their arse and actually do something. You know, be nice, be serious about things you know you know but like I said little bits they've done have helped in some ways but I think they could have dealt with a lot more things in a lot more better way. But that's my opinion it doesn't mean it counts does it?!

<div align="right">Phil (Lines 189-197)</div>

3.4. Sense of Self

It was clear throughout all of the interviews that participants' sense of self was embedded within their GP experience. The interactions between the GP and the participants had a powerful influence as to how participants viewed themselves. In this section the themes *GP Response Having a Negative Impact on Sense of Self* and *GP Response Having a Positive Impact on Sense of Self* are introduced.

3.4.1. GP Response Having a Negative Impact on Sense of Self

Inherent in BPD is a fragile and fragmented sense of self that has developed through invalidating early experiences. As a consequence of such experiences participants already believed that they were unwanted and that nobody cared what happened to them. For many, consultations with the GP were a re-enactment of these early experiences that reinforced an already damaged sense of self. Many participants had attended GPs following self-harm and had felt that their GPs had not taken them seriously. Phil clearly believes that the GP was in a position to help him but indeed made a choice not to. Phil's perception served to reinforce his existing sense of worthlessness and confirmed to Phil that maybe he should take his own life.

Extract 49
So like I said you can't sort of rationalise it, but like I said not being not taken seriously, you know? If you can't get help from people that can help you then where can you get help from? That's the way it sort of feels sometimes and yeah that's maybe some of the reasons why I have sort of taken overdoses because it's like asking for help and no one's really sort of there that can help you, will help you, or want to.
I. And what's that like?
P. Well, like I say it does kind of drag you down obviously and stuff like that you feel you're unwanted you know, it's, you know, you know like I said it confirms your own ideas that you are unwanted you know you do sort of… it gives you extra reason to top yourself. Like I said it's.. you know it just makes you feel all upset and just makes you feel like you know like it's the truth of the fact that you're not worth being in, on this planet sometimes.

<div align="right">Phil (Lines 243-257)</div>

In the following extract Lee described abusive and invalidating early experiences. Having made an appointment struggling to cope she felt she was not listened to which reinforced her feelings of worthlessness. Note how Lee is at pains to say that it was not her fault she was put into care, further evidence that she was concerned about being viewed as bad.

Extract 50
When I was fourteen I was physically and mentally tortured by my mother. No telling a lie, I was only twelve, just out of care. <u>Through no fault of my own</u> I was 18 months when I got put into care and I got to leave the home when I was twelve and it was like my mother never wanted me back home. And I was the youngest of my family at the time so I was the last one to be taken out of the home and it felt like I wasn't wanted so I ended up physically and mentally tortured by her. Locked away in a room for a week, not being able to eat, going to the toilet, having to go to the toilet out the window and things like that. Eh then running… eventually when I got out the room I went to Social Work to tell them what happened. The state I was in; my head was cut open, swollen, my legs were black and blue and I was told "just go back to your mum, things will be fine". These kind of things stick in your mind and seeing it happen again when people don't take the time to listen to you it just kind of puts you back into that being worthless again it's just sometimes it's just the way GPs are. You go and see them and it's like "right there's the prescription away you go"; it just puts you back down that same road.

<div align="right">Lee (Lines 460-473)</div>

Some believed that there was no point going to see their GP at all because they were not worth treating which often meant that their physical health was compromised.

> Extract 51
> L. It would have to be really really bad where I couldn't get in touch with somebody else but it's usually just physical things and eh there's usually always, always something said that it's to do with your psychiatric and you come away feeling so….that you just never, never want to go back again.
> *I. Are you able to tell me more about that?*
> L. I usually feel…well I don't really like myself it's obvious, I don't think much of myself and it's obvious they think the same, like I'm not worth helping with different things.
>
> Lynsey (Lines 70-83)

> Extract 52
> I just find the GP thing quite difficult, overwhelmingly difficult experience and I tend to – well my eye contact is not good and my worry is that they just think I'm a pain in the teeth ((Laughs)). So I avoid going so I've had umpteen reminders because I've got a coil fitted that is a 5 year coil and it's been in for 7 and I still haven't done anything about that and I keep getting reminders about that and I avoid going. So I do find it quite difficult like when I had that chest infection I should have gone back for a respiratory check, which I didn't go back for that either. So I'm not wonderful at going to the GP in the first place.
>
> Mary (Lines 22-30)

Others had gone to the GP and as a consequence of the consultation had left feeling that nobody cared what happened to them which left many feeling worthless. Others were conscious of the power differentials and had described feeling chastised at appointments. In the following extract Mhairi attended her GP after discharge from hospital and stated that she felt the GP was making an example of her in front of their student. Mhairi had felt that they were being told off for her 'bad' behaviour and she described the impact that had on how she felt about herself.

> Extract 53
> Just makes you feel as though you're a bit of crap under their shoe and they can treat you however they like because they're the doctor. That's how they came across to me. That's because he was the doctor and had their student there. I just felt they were showing off in front of them… Like the way they were talking to me after what I'd done and I'd been put in the hospital and he was just like undermining it just being rude and horrible, he just made me feel that big (squeezes fingers together), like I was nothing.
>
> Mhairi (Lines 116-129)
> (suppressed lines 120-126)

The impact of the GPs disregard for participant's distress and the perception that GPs could help them but were choosing not too engendered a sense of worthlessness and despondency. As a consequence many felt that they would be better off dead.

> Extract 54
> *I. If you can think back to that time what kind of thoughts were going through your head, any feelings in your body?*
> A. Well thing is I was suicidal at the time; it was so dangerous em because they could have killed me basically if you want to put it bluntly. They could well I'm not saying they could have killed me but they could have caused me to kill myself.
> *I. Because you were feeling?*
> A. mmhmm if my mum hadn't been there I might have…
> *I. Right, Ok, so having your mum with you was a good thing?*
> A. Yeah I mean we don't live together or anything but my mum was with me at the doctors that night cause like I say I was in hysterics and to come away with something like that "what do you want me to do for you?".
> *I. How did that make you feel about yourself?*
> A. Worthless.
> *I. It sounds a silly question but to help me get an understanding to get in your shoes if you like, what's that worthless feeling like , what does it mean to you?*
> A. Just like that I'm a blob and who's just walking about and nobody cares or notices how I feel or em willing to help me stop these things really.
>
> Anne-Marie (Lines 155-180)

3.4.2. GP Response Having a Positive Impact on Sense of Self.

For many participants the GP taking time to listen and validate their concerns had a powerful and positive impact on their sense of self. What is striking about these narratives was that participants were grateful for any sign of interest as most of the time they felt extremely isolated. They did not expect huge gestures but for many just the GP taking time to listen or even a handshake had been important. Alison noted how important it was for her that a new GP had read her notes and taken time to introduce themselves and shake her hand.

Extract 55
A: It was actually quite a good ((laughs)) response um as I say it was a new GP to the practice so we had never met before so they actually made a point of saying "Hi I'm Dr so and so I'm new here" and you know and they were looking on the screen so they knew things about me so they didn't just like open you know, like they didn't just like press the button and I came in and they went "yes what d'ya want?" sort of thing ((Laughs)), you know, they actually made a point of saying…
I: *And that made you feel?*
A: Yeah, good, good, yeah it was like "Oh I'm worthy of a handshake, Oh god I've not had that in a long time" ((laughs)). It's daft how important these things are.

Alison *(*Lines 94-108)

Having regular contact with the same GP was also something that participants valued. The fact that this was done spontaneously with out having to ask was also positive. Often it was not important whether the GP agreed or said the right thing but that they listened and validated that person's experience. Note also that Anne-Marie feels that her real, inner self is hidden inside and that this can only be unlocked through the interaction with others.

Extract 56
I. *What makes them spot on?*
A. Well they basically do what you want them to do. You know you go in you ask them a question they give you an answer. It might not be the answer you want to hear but at least they're giving you an answer you know and maybe show a bit of sympathy where its needed a bit of compassion where its needed or and I never asked to see the doctor cause it started off it was every two weeks it was couple of times. I never asked them to do that it was them that instigated that you know. "I'll see you in three weeks right; I'll see you every month". So I felt good about that, I thought they're taking an interest in me I feel like someone's actually taking an interest out with the mental health support that I'm getting.
I. *And how did that make you feel knowing that someone is interested in you as a person?*
A. It gives me hope that I'm still in here ((points to self)) and I'm going to get back to the way I was and that people do like me 'cause I think everybody hates me, you know, that's just another problem that I've got. And it's just an amazing feeling when someone shows you that bit of compassion cause it makes you feel that person cares about me, you know? I mean, I know doctors have got to care and all the rest of it. I mean I don't want everybody to care about me, I mean life's life, but just to show that bit of care can make all the difference especially to someone who's feeling the way I feel.

Anne-Marie (Lines 835-845)

Many participants felt guilty at having taken up a GPs time and believed that they did not deserve treatment. To have the GP say acknowledge that their need are equally important than others again had a positive impact.

> Extract 57
> S: Well, she'll sit there like if I go to the surgery however long it takes and even if she comes out here and I always feel guilty about that, thinking that there's somebody else waiting on her that needs her more than I do - but it's probably not strictly true – well that's what she keeps saying anyway that it's not true.
> *I: So she's actually said to you – so have you said to her about it?*
> S: Yeah, she says that I'm entitled to treatment just the same as everybody else but I don't always see it like that I just back myself into a corner and that's the way I am.
> I: Right, well, having her say that you are entitled to treatment the same as everyone else what impact does that have on you?
>
> S: It has a really good effect, it really does.
>
> <div align="right">Susie (Lines 81-94)</div>

3.5. What Works Well

Most participants were able to report some positive experiences of going to see their GP. This varied depending on individual GP and many stated that often it was difficult to get an appointment with this GP because of their popularity. This super ordinate theme illustrates that despite the many complexities associated with providing health care to this population, most participants could describe things that they believed worked well. This theme is sub divided into what the individual does well and what service responses worked well. Within this superordinate theme the sub themes of *Taking Someone with Me*, *Use of Specialist Services*, *Having Time* and *Communication Between Services* are discussed.

3.5.1. Taking Someone with Me

This theme reflected how a number of participants asked either a friend or relative to attend the GP with them as a consequence of previous invalidating experiences. This appeared to serve two distinct functions. For some participants the friend or relative assumed the role of interpreter due to their difficulties in verbally expressing their presenting problems particularly at times of crisis when they are needing extra support.

> Extract 58
> *I. So your mum had gone with you to see the GP that time and was that useful to have somebody with you?*
> M. Yeah
> *I: What was good about having your mum there with you?*
> M. She was able to explain things cause if it was up to me I wouldn't have gone cause I just couldn't speak to anybody and she was able to say how like what I was feeling and that and how things led up to what happened.
>
> Mhairi (Lines 287-298)

For other participants friends or relatives acted as an advocate. In these situations the participants had felt confident in explaining their problems however due to prior visits where they had not been taken seriously the friend or relative was there to verify their accounts and they felt the GP would have to respond.

> Extract 59
> Cause if I go on my own, I don't get to speak really I don't get a chance to explain what's going on they're just like, "Oh that'll be the medication you're on". But I felt that if I took someone with me then they would at least listen to what the problem was.
>
> Lynsey (Lines 67-73)

> Extract 60
> but I do tend to take somebody with me when I go to the GP. Not necessary to argue my case as it were but kind of, you know, safety in numbers, totally.
>
> Alison (Lines 16-19)

3.5.2. Using Other Services

This was a common theme across the majority of participants' narratives. For many they preferred to access help from other services such as specialist mental health teams or out of hours services. The majority of participants talked of the invaluable support they received from their CPN who they would often approach alongside other professionals in the CMHTs rather than make an appointment with their GP.

> Extract 61
> I'm lucky I've got a very good relationship like with my consultant
> psychiatrist and that and my CPN so a lot of the time where people would
> be going to their GPs I often short circuit that system and come here
> instead (right OK) you know for a mental health specific problem.
>
> Alison (Lines 50-53)

> Extract 62
> But if I feel like, I've got a support worker and I look to them, I'd rather
> look to them than the doctor, so I would cause I get more of a feedback and
> I get more help. From the doctor it's just like brushed under the carpet
>
> Lee (Lines 156- 159)

Many participants described how they waited to contact out of hours services rather than go to their own GP. Many described how even when in considerable pain or distress they would prefer to wait until the surgery was closed to get in touch with out of hours services.

> Extract 63
> I ended up starting to phone NHS 24 because I got the right level of care
> from them the compassion and somebody I felt was actually listening to
> what I was saying and they ended up putting me on to their on call CPN so
> that was my way of getting around what I class as a bad system in a GP's
> surgery.
>
> Anne-Marie (Lines 132-136)

Lynsey was the only participant who said she would not approach out of hours as she stated they responded similarly to her GP.

> Extract 64
> I wouldn't now, now that I'm back in contact with CPN and that I wouldn't go to a GP with that and I would never, never, never call an out of hours doctor, never because I've had that much hassle with them and my mum says that she would never ever phone and out of hours GP. She would sit on me all night rather than phone!
>
> Lynsey (Lines 485-489)

3.5.3. Having time

Having time with the GP was considered most helpful. Many described finding it difficult to explain their problems in short appointment times and for those who had been given double appointments described them as invaluable. For those who had not had this experience this was one of the most important things that they would like to see changed. A number of participants described how they had a regular review with their GP which engendered a sense of the GP taking an interest in them and as discussed above this had a positive impact on how they viewed themselves. Again, participants did not expect GPs to agree with them but just acknowledge how things were for them at that time. In the following extracts Joanne and Anne Marie described having a regular review with their GP. This appeared to serve a number of purposes. For Joanne, she was able to deal with the practicalities of getting her prescription and having a double appointment meant that she felt less pressured thus making it easier for her to explain her feelings.

> Extract 65
> J: I actually see them once a month to get my prescription but we also have a bit of a chat as well so they actually make double appointments which is quite good cause it means I get stuff of my chest until the next time
> *I. And what does it mean them giving you that extra time?*
> J. It just, I don't feel that stressed when I go em and I know like even if they don't completely agree they'll listen and say "Well this is the way I see it" and it's easier that way cause they're to the point.
>
> Joanne (Lines 148-157)

Extract 66

Well like I say I'm due to see my GP next week. I'll have to phone up and make an appointment and this is me er going to see them for a monthly visit at the moment just so they can keep an eye on me em it's just giving me a bit of faith and trust in the system again because I sort of lost that cause it was getting to the point where it was the hospital or nothing ((mm hmm)) there was no middle man you know em and I felt like I mean a GP isn't there just to hand out prescriptions, they do an awful lot more, I mean you know that. GPs aren't there, I mean a GP would hate it if I said "all you're there to do is hand out prescriptions" they do so much more things but for, for some reason I felt they weren't willing to do it for me at my old surgery but here, totally different.

Anne-Marie (Lines 240-249).

For others, GPs setting aside to time to listen and enquire about things beyond the practicalities of medication and medical lines had a positive impact. We can see however how Susie still struggles to accept that she is worthy of treatment but their GP not rushing them makes seeking help a little easier.

Extract 67

S: Well, she'll sit there like if I go to the surgery however long it takes and even if she comes out here and I always feel guilty about that thinks that there's somebody else waiting on her that needs her more than I do - but it's probably not strictly true – well that's what she keeps saying anyway that it's not true.
I: *So she's actually said to you – so have you said to her about it?*
S. Yeah, she says that I'm entitled to treatment just the same as everybody else but I don't always see it like that I just back myself into a corner and that's the way I am.

Susie (lines 81-94)

Extract 68

P. Yeah the GP I have at the moment is quite cool you know I think they're beginning to obviously you know beginning to build a sort of relationship now whatever and last time it was sort of going in you know obviously they asked how I was and that sort of taking an interest and that you know, you know my mum got diagnosed with lung cancer a couple of months ago
I. *I'm sorry*
P. Oh no don't worry about it, it's a bit of a head mess but obviously asking about that, asking about her, and you know how I sort of feel , coping with it and stuff like that you know em obviously gave me a prescription for medication and stuff like that em I think at that time I had to sort of get a sick note for the job centre you know you know and after that's done just a brief sort of chat about how I feel you know you know asking if I'm still going to the gym and still doing sort of sport activities that side of things so generally along that sort of lines you know, you know.

Phil (Lines 13-27).

3.5.4. Communication Between Services.

Another important theme to emerge from the narratives was communication between services. As discussed above many participants used a variety of services including CMHTs and out of hours services. Whilst there were benefits to this many felt that there was a lack of communication that made them feel vulnerable as their perception was that nobody wanted to take responsibility for them. A number of participants believed that difficulties with GPs were often attributed to a lack of communication between services whereby GPs were not aware if there had been any particular problems. This often meant that participants had to try and explain to GPs how they were feeling which they often found it difficult to do.   If clearer lines of communication were available particularly if there were crises then this would make attendance easier as the individual would not have to try and explain to the GP. A further function of improved communication would again reinforce the validity of individuals' difficulties as many felt they needed to have another person explain their difficulties in order to be taken seriously.

> Extract 69
> A. That's one thing they don't really get enough, get enough information. GPs don't, I feel, get enough information from the mental health services about your condition well I don't know well from what I see it's basically "blah blah blah" and that's it. They don't go into great detail if there's any problems or so I mean my GP my old GP did say that and they actually ended up getting a lot of information from my mum and so I feel that GPs don't get enough information from mental services just about the whole kit and caboodle really, you know the pass the parcel.
> *I. And what does that mean for you then if they're not getting that information?*
> A. Well it makes me feel like I'm going there and they're not really realising how bad things are for me sometimes and em I find it quite hard sometimes to put across my feelings because I'm always worried that they think I'm just being a hypochondriac you know so em, so I find that quite hard um, you know, I just feel it would be better if they had more information, em, em, more updates even, not so much more information but maybe more updates which I know would cause a lot more paperwork and that but even, I mean, there's all these computer links nowadays so I don't see why they can't just e mail a computer link that somebody can then just put it in my file.
>
> Anne-Marie (Lines 15-34).

In stark contrast when services communicated with one another the participants said they felt more at ease, and felt that people actually cared what happened to them. For many, communication between the Psychiatrist and GP had meant that there was clear a plan in place if they became unwell. Lynsey described the relief at having had this recorded in her Advanced Statement. This had made it easier for her to attend the GP, as before she had been concerned that she would admitted to hospital.

> Extract 70
> Yeah they've asked my Consultant if they can, if I go to them quite distressed if they can give me a once only as required medication so that it means it doesn't need hospital so that they can give me the as required medication once off and that hopefully will help and they'll monitor you and we've got that down in writing so that's really good cause I've wanted that all along to save sending you to assessment for me just to be able to go to the GP and say look I'm having an awful time just now I think once off of an as required would help and we've finally got it. Just that GP though so I don't know what will happen with the other ones. It was just them I spoke to. We discussed that in hospital and I had to discuss it with them when I went for my first prescription when I came out and they said they was more than willing and they thought that was the best thing for me rather than put me in hospital all the time for just a wee bit of a crisis or just a few bad days. They would gladly see me daily and give me one. So I'm more than delighted about that.
>
> Lynsey (Lines 333-349)

Many participants said that they found it helpful to have their CPN liaise with the GP about their medication and to have others involved in their care seek referral to other services. Having such systems in place alleviated some of the reluctance they had to attend the GP based on the perceptions they had.

> Extract 71
> I just phone my CPN to get some tablets sorted out. They fax it over to the GPs and three hours later I get the tablets, that's how it works.
>
> Yvonne (Lines 189-195)

> Extract 72
> There is a support worker at the hospital so you can go through her and she sort of basically chats up your GP gets what's needed a referral or whatever and you turn up at whatever clinic
>
> Alison (Lines 304-306)

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3.6. Relationships Between Themes

Through analysis of the data it is possible to identity tentative links between themes. The super ordinate theme *Sense of Self* would appear to be central to participants' experience of contact with GPs where the GP response had a significant impact on how participants viewed themselves. This influenced how individuals navigated their way through the health care system. The sub ordinate themes *Taking Someone With Me* and *Using Other Services* outlines the strategies that participants used to get their needs met based on their negative perceptions of GPs and their prior invalidating experiences. This being the first study to examine such interactions only tentative links between themes can be suggested. Section 5.5. outlines further research that may add to the understandings of the current study.

CHAPTER 4

REFLECTIONS

4. Reflections

The following section discusses each of the themes and relates the findings of the current study to the existing literature. The final two sections describe participants' reflections on themes and the researcher's own reflections on conducting the research.

4.1. Reflections on Experience of Having a BPD Diagnosis

The emerging theme of *Stigma Associated with a BPD Diagnosis* was rich throughout all participants' narratives. People with BPD have been described as one of the most stigmatised groups in society (Haigh 2006; Kane 2006). As a consequence in addition to coping with their diagnosis they frequently have to deal with negative attitudes and stereotypes (Penn & Wykes, 2003). The stigma attached to BPD is widely acknowledged and across the narratives there was a strong sense that this was something participants were concerned about and, indeed, all reported having had first hand experience of. There are two main forms of stigma; overt (enacted) discrimination and perceived (subjective) stigma (Dinos, Stevens, Serfaty et al., 2004; Green et al., 2003). Some suggest that such stigmatising attitudes are by virtue of the diagnosis itself (Charland 2006; Sadler & Fulford, 2006), where in order to satisfy diagnostic criteria, the individuals' behaviour is judged against social and cultural norms. Individuals diagnosed with BPD are therefore regarded as immoral and blameworthy (Charland, 2006; Sadler & Fulford, 2006).

The media also plays a powerful role in shaping and reinforcing negative stereotypes of individuals with mental health problems, particularly those with personality disorders (Haigh 2006; Sieff, 2003). Media coverage of mental health is overwhelmingly negative, portraying sensationalist images and stories, which perpetuate the stereotypes of people with a diagnosis of personality disorder as dangerous and violent individuals (Sieff, 2003). The introduction of the term Dangerous and Severe Personality Disorders (DSPD) in a government consultation paper also fuelled images people with any personality disorder as dangerous individuals (Haigh, 2006).

Being labelled is a theme that has emerged in many studies looking at the effects of stigma, particularly in mental health. In an IPA study, Nehls (1999) asked 30 women about their experience of living with a diagnosis of BPD. Whilst participants were comfortable with their diagnosis they abhorred the associated label as it had the potential to exclude individuals from services (Horn et al., 2007; Nehls, 1999). Green et al (2003) also reported that individuals with mental health problems found that being labelled entitled others to treat them in a derogatory manner. Kriesman & Strauss (1989) suggested that in receiving the diagnosis an individuals' identity becomes overshadowed and they become the "borderline".

The theme *The Perceived Role of the Diagnosis in being a Barrier to Help* is similar to the findings of a focus group carried out with individuals with a personality disorder (Haigh, 2006) and other qualitative studies that looked at the effects of diagnosis (Horn et al., 2007; Nehls 1999). These studies corroborate the findings of the current study where individuals with a BPD diagnosis are acutely aware of the negative perceptions of staff and therapeutic nihilism. Often the BPD diagnosis had meant that individuals were excluded from services and many felt that this was intentional (Horn et al. 2007; Nehls, 1999). This was similar to the beliefs of participants in the current study where individuals believed GPs could help them but were choosing not to. The recent policy document, "Personality Disorder No Longer a Diagnosis of Exclusion" (NIMHE 2003a) has attempted to readdress the imbalance of service provision to this population yet it appears that there still needs to be a significant amount of education in order to shift attitudes for real world changes to take place.

Individuals can use a number of mechanisms to counter the effects of stigma. Research has shown that causal attributions of discrimination are protective of self image. Those who attribute rejecting experiences to others prejudiced attitudes are less likely to internalise the stigma thereby protecting their perception of themselves (Major, Kaiser & McCoy, 2003). This was evident in extract 6 where Joanne attributed the GPs outburst to a "bad day".

Goffman (1963) proposed that individuals who are ambivalent about their stigma frequently switch between aligning themselves with those sharing the stigma and distancing themselves to become more like the 'normal'. This is most likely to occur when trying to distance the self from unflattering stereotypes (Goffman, 1963). This can be seen in the current study within the theme *Ambivalence Towards Diagnosis* as expressed by a minority of participants for example Phil in extract 8.

4.2. Reflections on Perceptions of GPs

Participants in this study stated that they believed GPs were reluctant to venture out with the medical model where often the prescription of medication dominated consultations. In the current study participants contrasted their experiences of attending for physical health problems which they often felt were dealt with better because they fitted neatly into the medical model. This theme also emerged in another qualitative study where individuals with BPD were asked about their experiences of psychiatric services (Fallon, 2003). In the study individuals with a diagnosis of BPD explained how nursing staff, particularly in acute settings were comfortable in their medical role, providing medication and dealing with physical consequences of self harm but were not willing to discuss motivation for self harm or participants' distress. As a consequence many avoided contact with individuals leading to further feelings of rejection and alienation.

As discussed in Chapter One, there is emerging evidence for the treatability of associated BPD symptoms by both pharmacological and psychological treatments in particular that some pharmacological treatments demonstrate some efficacy in the management of the core features of BPD such as emotional regulation and impulsive behaviour. It is likely that GPs will share some of the responsibility in managing such medication and considering the participants in the current study viewed the prescription of medication as further evidence of GPs disinterest in them, GPs may have to consider how to do this in a way that is not seen as rejecting by the patient.

Professionals, encouraged by the evidence for treatability and desperate to make headway and effect change may experience a certain degree of difficulty in establishing and maintaining therapeutic relationships however as individuals with BPD often just want to be accepted as they are.

The theme *GPs Don't Deal with Mental Health* is particularly important if we take the view of some participants that GPs do not want to deal with physical health problems either if the patient has a diagnosis of BPD. There is considerable debate as to who should be responsible for the physical health care of individuals with a mental illness. Whilst some have argued that psychiatrists would be better placed to provide both mental and physical health care in a recent study contact with GPs were indeed valued and important to patients with a psychotic illness (Beescroft, Becker, Griffiths et al., 2007). In addition to managing co morbid problems GPs are the gatekeepers to specialist services such as psychological therapies and a fialire to take the time to listen and understand the patients' problems then they may mean that individuals may not be able to access appropriate services.

The theme *GPs Should Know More About Mental Health* reflected participants' lack of confidence in GPs. There was a sense that GPs readily accepted stereotypes and this served as a barrier to hearing what the patient was attending for. Similar to the findings of other studies participants felt that this made it more difficult to have a meaningful consultation (Fallon, 2003; Nehls, 1999). It is now recognised that individuals with personality disorder are at the interface of many services and that their mental health problems are likely to impact on both health and social care. The National Institute for Mental Health in England (NIMHE, 2003b) has proposed that introducing a 'Skills Escalator" address this problem that will increase awareness that not only will help to dispel of the myths surrounding personality disorders and also be the impetus for improved service delivery (Kane, 2006). The narratives in the current study demonstrate that lack of awareness is something that participants are aware of and would welcome GPs getting further training.

4.3. Reflections on Invalidating Experiences

Webb & McMurran (2008) stated that GPs were perceived as not having time and underestimating distress. The narratives of all participants would appear to support these findings whilst at the same time providing more detailed evidence of this. The theme *GPs Don't Believe Me* is similar to extensive literature that showed mental health professionals regarded individuals with BPD as manipulative, attention seeking and indeed less deserving of treatment (Deans & Meocevic, 2006; Lewis & Appleby, 1988; Markham & Trower, 2003). Moreover it has been shown that BPD in particular is subject to more critical attitudes when compared to other diagnoses including schizophrenia and depression (Markham, 2003; Markham & Trower, 2003). The findings in the current study suggest that participants feel GPs shared similar views that influenced their consultation.

This theme also echoed the findings of other qualitative studies where self-harm was perceived as manipulative (Fallon, 2003; Nehls, 1999). Considerable debate exists as to the meaning and function of manipulation which is beyond the scope of this thesis. Suffice to say that there is a body of thought that asserts that manipulation is a common strategy used to gain personal goals and in accepting this view one must also accept that society therefore judges individuals with BPD against higher and arguably unrealistic standards (Bowers, 2003; Potter, 2006).

Bowers (2003) has provided a working definition of manipulation and proposes that it involves three main components; the behaviour is planned, there is disregard of concern for others and that it involves deception. Self harm is frequently cited as manipulative (Bowers, 2003) in that it evokes uncomfortable responses in those working with them and patients described as "difficult" are those who engage in this behaviour (Gallop, Lancee & Shugar, 1993). A comprehensive understanding of the function of self harm has yet to be reached and often appears paradoxical in its nature (Bowers, 2003; Stanley & Brodsky, 2005). Participants argued that control was a feature of self harm but the function for the individual self harm was to control emotional states rather than to be used as a ploy to control professionals (Nehls, 1999). Participants in other qualitative studies felt that such attitudes acted as a

barrier to professionals understand the underlying motivation of self harm which was often to alleviate emotional distress and as a consequence they were denied help when at their most vulnerable (Fallon, 2003; Nehls, 1999). For a number of participants in this study they described how at the time, they really wanted to die. If self harm is indeed manipulative then one would expect that individuals present to health care services looking for help. The findings of the current study however and that of other qualitative studies (Fallon, 2003) would suggest the contrary, where self harm is often an impulsive act and not disclosed due to feelings of guilt and embarrassment.

Participants in the current study felt that GPs could be both insulting and patronising. Dinos et al., (2004) studied the effects of stigma associated with mental illness and reported that non psychotic disorders including personality disorders and affective disorders worried more about patronising attitudes than those with a psychotic illness. In the earlier focus group individuals with personality disorder also felt subject to patronising attitudes, (Haigh, 2006).

The theme *GPs Not Interested* was expressed by all participants who stated that they believed GPs were not interested and many used GPs' body language such as lack of eye contact, looking at papers etc as evidence of this. Whilst there were some concrete examples of overt discrimination most of the narratives reflected perceived stigma as evidenced by the language used such as impression feelings etc yet it such experiences that are thought to be most damaging (Green et al. 2003). Green et al. (2003) have suggested that people who have a high level of perceived stigma become so sensitive to the possible discriminatory behaviour of others that looking at a watch or computer that would normally be regarded as innocuous behaviour becomes evidence of rejection. In the Horn et al (2007) study individuals said that they felt rejected by virtue of their diagnosis. The authors suggested that this led to a cycle of rejection whereby in turn individuals with BPD reject services. This reinforced ideas of individuals being manipulative and difficult (Horn et al., 2007). In the current study, statements such as *"you will never get back in my home"*; *"in fact I told them*

to get out", in response to perceived rejection, would appear to corroborate these findings.

The findings of the current study would also suggest that as a consequence of invalidating experiences participants often went to their GP as a last resort if they could not get help from anywhere else. This supports the findings of Moran et al (2001) who stated that individuals with a PD diagnosis were more likely to attend on an emergency basis. Patterns of health care for people with a diagnosis of BPD in primary care are as yet unclear although recent research suggests that individuals with BPD attend their GP less than those with other psychiatric diagnoses and those with no mental heath problems (Gross et al., 2002). The findings of the current study may provide an explanation for non attendance that includes feared rejection and levels of perceived stigma. This would support the findings of Dinos et al., (2004) who found that perceived stigma resulted in individuals withdrawing from others and avoidance of help seeking. Participants in the current study also felt that their physical problems were attributed to their mental health and as a consequence they avoided their GP. As a number of participants had deteriorating medical conditions that should have regular review by their GP, it is possible that their physical health needs are thus compromised.

For many years individuals with BPD have been excluded from psychiatric services and denied treatment. Whether as a result of overt or perceived stigma for some participants in the current study they believed this was also true of physical health care. Systems of health care require that the individual presents to the GP and explain their problem. For some this is easily done as physical problems as seen to be easier to explain. Fear of rejection and discrimination is however a significant barrier in help seeking behaviour (Dinos et al., 2004) and was evident in a number of the narratives in this study. GPs will need to consider how to delivery services to this group of people that may require a more active role of the GP. As this is a reason that has received very little attention in the literature one can only speculate. It is however an area requiring further research due to the possible impact on individual's physical health.

4.4. Reflections on Sense of Self

There was a strong sense that participants' sense of self is inextricably linked to the interactions with others, in this case their GP. This had both positive and negative consequences. Inherent in BPD is a fragile and fragmented sense of self that has developed through invalidating early experiences. For many, consultations with the GP were a re-enactment of these early experiences that reinforced an already damaged sense of self. Linking to the theme *Experience of Having a BPD Diagnosis*, making external attributions to explain rejecting experiences meant that the sense of self was protected. For example, when Joanne attributed the GP's response to them having a bad day. Making external attributions i.e. attributing rejecting experiences to the discriminatory behaviour of others is acknowledged as protecting self esteem (Major, Kaiser & McCoy, 2003). Most participants in this study however made internal attributions in the sense that unpleasant experiences were attributed to the self rather then blamed on other people's prejudiced attitudes.

Social construction theories assert that a sense of self and identity is determined through interactions with others (Burr, 1995). Such interactions can have potentially negative consequences. Through continuous exposure either overt or perceived stigma in social encounters results in negative attitudes and moral judgements become internalised (Green, Hayes, Dickinson et al., 2003). Such internalised stigma is recognised as having a deleterious effect on identity and self esteem. Links, Struening, Neese-Todd et al., (2001) used measures of self esteem, symptoms of depression and two measures of perceived stigma to assess the impact of stigma on self esteem. The results demonstrated that higher levels of perceived stigma were significantly associated with low self-esteem. Every individual exists within a society that shares a common belief system about what is acceptable and unacceptable behaviour. When diagnosed with BPD then not only does society hold negative attitudes but so too, as a member of that society, does the affected individual, leading to a degree of self hatred and loathing (Green et al., 2003).

The theme, *GPs response having a positive impact on sense of self* is similar to the findings of earlier studies. Qualitative research carried out with people with a

diagnosis of BPD has indicated that the detrimental effects of stigma can be overcome through experiencing supportive and helpful relationships where the professional looks beyond the label of BPD (Fallon, 2003; Haigh, 2006; Nehls, 1999). These positive encounters extended beyond a transient mood state having made a considerable influence on how the individual thought about themselves. Unfortunately, due to the many negative assumptions associated with BPD many people avoid having contact with these individuals.

4.5. Reflections on What Works Well.

Taking someone with me and *using other services* were two strategies that people used to get their needs met. In the current study participants described seeking help from other services, most often specialist mental health and out of hours services, as a result of unsatisfactory GP encounters. This provides an alternative explanation for the reported higher use of specialist mental health services (Bender et al., 2001) historically attributed to help seeking, demanding and attention seeking characteristics associated with the BPD diagnosis (Bender et al., 2001; Tyrer et al., 2003). If this were true, then we would expect this to be replicated across all levels of health care. In fact the opposite appears to be the case in primary care as evidenced by the findings of Gross et al. (2002) and the narratives in the current study.

Across the narratives participants appreciated having a variety of services that they could access. It is possible that having an option of services to go to may serve as an emotional buffer to invalidating experiences. Due to the effects of internalised stigma individuals may feel they are a nuisance and not deserving of treatment and having an option of where to get help from may make them feel less of a burden on any one particular service. Due to the paucity of research in this area investigating how individuals with BPD navigate their way through services is warranted. Whilst Fallon (2003) examined the experience of psychiatric services it would be useful to look at how people accessed services across all tiers of health care.

Integrated services that are flexible and work well together is something that all participants wanted and had benefited those who had experience of it. There was a desire for GPs to take into account a wider perspective. This is indeed something that is valued in other studies when individuals were asked about their experience of the BPD diagnosis and psychiatric services (Fallon, 2003; Nehls, 1999). The sub-theme *Having Time* described GPs giving time and listening to participants about issues other than medication. This was a sentiment that has been echoed in a number of studies (Haigh, 2006; Fallon, 2003; Nehls, 1999). The importance of this was reinforced by the voices of other participants in the current study who had not had such experiences when they said they would like an opportunity to talk more at length. One reason why this may not happen could be due to different expectations of the GPs and their patients. GPs are trained and practice in a model where they are expected to diagnose, treat, and cure symptoms. Faced in a consultation with someone who cannot clearly explain their symptoms or where there is no clear treatment plan may be especially challenging for some GPs. As a consequence they may avoid contact with such patients, often by referring them to specialist mental health services. Burns (2006) has noted that referrals to CMHTs often reflected difficulties GPs had in managing difficult consultations as opposed to individuals requiring active treatment.

Participants in the current study have suggested that all they want is to be listened to and to have their difficulties validated. This supports the findings of other studies where participants stated they did not want therapy just for people to listen which in itself was thought to be therapeutic, (Fallon, 2003; Nehls, 1999). Goffman (1963) has suggested that negative stereotypes can be overcome through the increasing closeness of interactions with one another developing empathy, trust and recognition of the person behind the stereotype. We already know from the literature however that staff are likely to avoid interactions leaving a therapeutic stalemate (Haigh, 2006; Nehls, 1999). The current study adds weight to this argument as there is evidence that when people do look beyond the stereotypes it can have a positive impact on an individuals' sense of self. The current study provides examples that this does happen in pockets of practice and is highly valued.

4.6. Participant Reflections

As outlined in Chapter 2, participants played an important role in the validation of themes. Following analysis the researcher met with four participants (Anne-Marie, Susie, Lee and Yvonne) to look over the emerging themes and to get feedback. All reported that they believed the super-ordinate themes were an accurate reflection of their experience of their contact with GPs. Although they reported being saddened that this was a common experience they overwhelmingly stated that it helped to know that others shared similar experiences. This may have had an effect on their own levels of internalised stigma if they started to make external attributions about their personal invalidating experiences. This proved to be a very emotional time for both the researcher and participants. All participants thanked the researcher for giving the opportunity to have their voices heard which was extremely humbling for the researcher.

4.9. Researcher reflections

IPA acknowledges that interpretations of individual experiences are biased by the researcher's own opinions, beliefs and personal experiences and those narratives are the product of researcher and participant interaction (Smith & Osborn, 2003). In order to monitor my own biases that may affect interpretation of the research data I kept a diary, noting my reflections throughout the research process.

There were rich accounts across all of the narratives describing the stigma associated with a having a BPD diagnosis. Participants believed that people held negative attitudes and judgements about them and this is something that became very apparent to myself throughout the research process. Throughout the study I was struck by the negative attitudes I encountered throughout all stages of the research process. I was told I was brave, "mad" or both to be interviewing "those people". I was frequently told that my project would never get ethical approval and would it not be easier to ask GPs about their experience.

I'm feeling really angry, was at a meeting today with qualified and trainee clinical psychologists and when I presented my thesis proposal somebody said "Good Luck with that!" at which point a number of my colleagues laughed. Had I not already worked with this population I would be really worried about what I as letting myself in for. Really angry too and more determined to give a voice to these individuals.

Participants also discussed their perceptions that their diagnosis was a barrier to accessing help. Similarly I found that trying to conduct research in this area was overshadowed by the stereotypes and assumptions made about individuals with BPD. At the ethics panel I was asked whether talking to people with a diagnosis of BPD about difficult experiences may put them at risk of suicide. Again a lack of understanding about this diagnosis was a potential barrier to finding out the experiences of these people. I was asked whether I had considered the fact that as consequence of my study participants were likely to start putting in formal complaints about their GPs. Throughout the interviews the participants were balanced in their discussion and acknowledged that their interviews were only their opinion acknowledging that other people may not have the same experience.

Participants spoke of how GPs need to have more awareness of BPD and having been through the process of myself writing the introduction I could understand why people perhaps shy away from this topic. I was often very confused and overwhelmed. The following extract was taken from my reflective diary at the earlier stages of the research process:

Totally confused writing the introduction to my research and struggling with the definition of Personality Disorder. Everything seems so contradictory and that unnerves me. This lack of certainty is making it hard for me to be confident in what I'm writing down. Feel very overwhelmed, everything going on in my head – can't even sleep. I if can't make sense of this diagnosis, how can those receiving it find their way?

The recruitment process was very slow. Despite distributing the recruitment packs to Clinical Psychologists and Consultant Psychiatrists in early February, I did not carry out my first interview until the end if April. The following extract is taken from my diary when I was feeling very despondent and again frustrated about what I considered a lack of interest in this subject area.

No one recruited to the study either as yet, not one of the Consultants have even acknowledged receiving the recruitment packs. Am beginning to think that no one is really bothered or interested.

Carrying out the interviews and listening to such emotive narratives made me reflect on my own practice and I felt considerable pressure to do the narratives justice. The following extract was written after transcribing the first interview.

Felt very frustrated and confused. Reading over transcript think I may have missed things I should have explored in more detail… maybe they thought I was no better than their GP! The participant said "give an opening" and may be I didn't do this?

Throughout the transcribing process I found myself becoming increasingly upset listening to some of the experiences of participants, particularly when participants described issues of prejudice and stereotypes within the theme *Experience of Having a BPD Diagnosis*. I was particularly upset and angry when participant described being labelled and judged based on the pejorative label they had been given. This made me reflect on my own personal experiences about a close member of my family who had profound learning disabilities and had been admitted to hospital and died a few months later. During this time my family had to make a case why they should be given treatment. Noting down these personal reflections was invaluable during the interpretative process as I became very conscious that whilst I could not separate myself from my feelings I had to try and not let them influence my interpretation. The following extract is taken from my diary during the initial stages of analysis.

Feeling very unsettled and lots of thoughts going round in my head. Earlier on today whilst reading over a transcript I found myself becoming very tearful and upset. Brought back a lot of emotions from around the time when [   ] died. Having to justify their need for treatment to the extent of taking in videos to the hospital to prove they did have a quality of life, unlike the "vegetable" that one of the Consultants referred to them as. Making sure someone stayed with them on the ward, day and night, to make sure they received the right treatment. It's upsetting to think that after all these years I still feel I've let [   ] down, This is making me question who am I doing this for? Maybe in some ways I'm trying to make up for the things I felt I couldn't do for [   ].

Carrying out the study has made me reflect on how much I take things for granted. Whilst transcribing I had to attend my GP for what was later diagnosed as Carpal Tunnel Syndrome. As a consequence I was unable to write in my diary for a number of days but on reflection remembered feeling relieved that I had managed to get an

appointment for that afternoon and how reassured I was that the GPs would be able to 'fix' my problems. I never considered that my GP might not believe me or I would be not be taken seriously. It is difficult to understand how it must feel to be in either physical or emotional pain and not feel able to approach your GP, whether as a result of overt or perceived stigma.

CHAPTER 5

DISCUSSION AND CONCLUSIONS

5.1. Methodological Critique

It is important as a researcher to acknowledge both the strengths and weaknesses of the research as outlined in the sections below.

5.1.1. Limitations

The significant co morbidity in this population and heterogeneity of the BPD diagnosis meant that sample was heterogeneous. IPA suggests using a sample that is homogenous and it therefore it may be that a different methodology would have been more appropriate. IPA has however been used to explore the experiences of people living with a diagnosis of BPD (Horn et al., 2007; Nehls, 1999). The significant commonality of recurring themes apparent throughout the participant's narratives would suggest that IPA was suitable.

Qualitative methodologies rely on retrospective reports that are may biased by individual's perspective at that time (Coyle, 2007). In this study it is possible that narratives reflected the current relationship with their GPs. Yet even those participants who had recent positive experiences could vividly recall the details of previous experiences which were rich throughout all of the narratives. This is understandable given the impact of such negative encounters on perceived stigma and subsequent sense of self.

By virtue of using such a small sample generalisation of findings is limited. Similarly, the current study recruited from CMHTs that form the main stay of specialist mental health services. In order to address this issue it may have been useful to have recruited directly from GPs practice asking GPs to identify patients with a BPD diagnosis. Those not in contact with specialist services may have different experiences with their GP. Given that BPD is often undiagnosed in primary care as discussed in Chapter one then this would perhaps have yielded a more modest sample size.

Participants in this study had a co morbid mental illness diagnoses, in particular depression. It may be that participant's narratives reflected their experience of having a mental illness in general. The commonality of themes and the explicit references to the BPD diagnosis however would suggest that the narratives spoke more about the difficulties of BPD. Given the extensive co-morbidity in this population as outlined in chapter one, one may also argue that it is improbable to disentangle the co-existing diagnosis with the diagnosis of BPD.

5.1.2. Strengths

The current study has focused on BPD, a subject area that is frequently misunderstood and under represented in the research literature. Although other qualitative studies have looked at the experience of having a diagnosis and experience of specialist mental health services the current study is the first to the researcher's knowledge that has looked exclusively at the experience of individuals with BPD in their interactions with GPs.

Recruitment of eleven participants with a BPD diagnosis is one of the largest IPA studies conducted. This is a particular strength as this population are recognised as being hard to engage. As the data suggests perceived rejection influences future interactions and yet having not met the researcher before participants in this study felt comfortable to discuss very personal and emotive experiences.

Using a qualitative methodology was another strength of this study. Whilst quantitative methods may have been able to assess frequency and satisfaction of visits to GPs they would not have elicited such rich and meaningful data. BPD is a complex diagnosis and using a qualitative methodology allowed an exploration of the complexities of people's views that included ambivalence about the diagnosis and impact on sense of self. Qualitative methodologies are recognised as being ideally suited to explore sensitive topics with vulnerable populations (Murray, 2003).

The current study has enriched the understanding of health care patterns of use by individuals with BPD. Widely recognised as higher users of specialist mental health services that current study suggests that this may be as a consequence of a less than helpful response from services as opposed to maladaptive help seeking behaviour.

A further strength of the current study was the involvement of participants in reviewing the themes, referred to as member checking (Mays & Pope, 2000) that enhanced internal validity. Feedback was overwhelmingly positive as participants believed that whilst the study reflected all the narratives, throughout the emergent themes participants stated that their individual stories were preserved. Murray (2003) has suggested that taking part in qualitative research can be therapeutic to those participants. As discussed above the majority of participants had made internal attributions as to the cause of their experiences and that this had led to a significant degree of internalised stigma. Having reviewed the themes participants stated that it was a comfort to know that other people had similar experiences and they stated that they were beginning to think that perhaps their experiences had more to do with other people's attitudes. It is not only them.

5.2. Implications for Services

Overwhelmingly what participants wanted most was for someone to listen and validate their experiences. Due to the interpersonal conflict that characterises this disorder and the associated stigma this often does not happen. The conflicting expectations between GPs and their patients is also a significant barrier in having improved consultations. To overcome these issues increasing awareness for both patients and GPs would create a shared understanding and reaching an agreement of realistic expectations. Another way to address some of the issues raised in the current study would be to provide training for GPs at earlier stages in training about the BPD diagnosis and implications on the management of patients in primary care. The dissemination these findings would be a potential starting point. Already practical suggestions such as having regular, brief contact and asking patients the reason for their attendance right at the beginning of the consultation could overcome some of the difficulties highlighted in the current study. Services also need to

consider how to make the transition between different levels of care more seamless in order to minimise feelings of anxiety and vulnerability this engenders in patients.

5.3. Future Research

Whilst the current study has focused on the views of individuals with BPD, it would seem a natural progression to conduct a similar study asking GPs about their experience of working with these individuals to provide a balanced view. This would allow a comparison of patient and GP experience and to note any similarities and/or differences. A further possibility would be to conduct a quantative study actually looking at GP/BPD consultations using video recordings. This could be compared with other mental health groups those patients with no mental health problems to ascertain if there is indeed as real difference or perceived difficulties as a consequence of BPD schemata. Based on the findings of such studies training for both GP and BPD patients could be introduced aimed at improving the quality of consultations.

5.4. Conclusions

The current study has provided insight into the experiences of individuals in contact with GPs using an IPA methodology. A number of themes emerged that suggested a significant degree of perceived stigma amongst individuals that influenced their experience of GP consultations. Many believed that GPs held negative attitudes towards them as a result of their BPD diagnosis that influenced their response. Participant's described how they felt that GPs minimised their distress, thought they were attention seeking and did not believe them. This had a significant impact on participant's sense of self that led to feelings of worthlessness, hopelessness and despair. Attributions about GP responses included a lack interest in, and awareness of, the impact of BPD and a conflict of expectations between GPs and their patients. As a consequence participants relied on other services such as CMHTs and out of hours services and a number avoided their GPs altogether, which had an detrimental impact on their physical health.

Participants stated that what was most important was having experiences validated. Services working together and the GP spending time and listening to individuals was considered good practice and indeed had a positive impact on individuals' sense of self.

References

Allen, B.P. (2006). *Personality Theories. Development, Growth and Diversity*, fifth edition. Boston Allyn & Bacon.

Allport G. (1966). Traits Revisited. American Psychologist. Vol 21:1-10

Allport, G. (1937). Personality: A Psychological Interpretation. Cited in Allen, B.P.(Eds) (2006). *Personality Theories. Development, Growth and Diversity*, fifth edition. Boston Allyn & Bacon.

Alwin, N., Blackburn, R., Davidson, K., Hilton, M., Logan, C. & Shine, J. (2006). *Understanding Personality disorder: A Report by the British Psychological Society*. Leicester: British Psychological Society.

American Psychiatric Association (1980). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed). Washington DC: Author.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorder Text Revised* ((4th edition)), American Psychological Society, Washington, DC .

American Psychiatric Association (2001) Practice guideline for the treatment of patients with borderline personality disorders. *American Journal of Psychiatry*, Vol 168, 1-52

Appleby L. (Director of Inquiry) (2006) *Avoidable Deaths: Five year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.* Manchester: University of Manchester.

Asnaani, A., Chelminski, I., Young, D. & Zimmerman, M. (2007). Heterogeneity of Borderline Personality Disorder: Do the number of criteria make a difference?. *Journal of Personality Disorders*, Vol 21(6): 615-625.

Bateman A, Fonagy P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry*. Vol 156(10):1563-9.

Bateman A, Fonagy P. (2001). Treatment of Borderline Personality Disorder with Psychoanalytically oriented partial hospitalization: an 18-month follow-up. *American Journal of Psychiatry*, Vol 158 (1):36-42.

Bateman, A. & Fonagy, P. (2003). Health Service Utilization Costs for Borderline Personality Disorder Patients Treated with Psychoanalytically Orientated Partial Hospitalisation versus General Psychiatric Care. *American Journal of Psychiatry*, Vol 160: 169-171.

Bateman, A. & Tyrer, P. (2004). Drug Treatments for Personality Disorders. *Advances in Psychiatric Medicine*, Vol 10: 389-398.

Beck, A.T., Freeman, A., Davis,D. & Associates. (2004). *Cognitive Therapy of Personality Disorders. Second Edition.* New York: The Guildford Press

Becker, D. (1997). *Through the looking glass: Women and Borderline Personality Disorder*. Oxford: Westview Press.

Beescroft, N., Becker, T., Griffiths, G., Leese, M., Slade, M. & Thornicroft, G. (2001). Physical health care for people with severe mental illness: The role of the General Practitioner (GP). *Journal of Mental Health* Vol 10(1): 53-61.

Bender, A.E., Oldham, J.M., Bender, D.S., Dyck, I.R., Stout, R.L., Morey, L.C., Shea, M.T., Zanarini, M.C., Sanislow, C.A., Grilo, C.M., McGlashan, T.H. & Gunderson, J.G. (2005). Dimensional Representations of DSM IV Personality Disorders: Relationships to Functional Impairment. *American Journal of Psychiatry*, Vol 162(10): 1919-1925.

Bender, D.S., Dolan, R.T., Skodol, A.E., Sanislow, C.A., Dyck, I.R., McGlashan, T.H., Shea, M.T., Zanarini, M.C., Oldham, J.M. & Gunderson, J.G. (2001). Treatment Utilization by Patients with Personality Disorders. *The American Journal of Psychiatry,* Vol 158(2): 295-302.

Bennett, L. & Kerr, I.B. (2006). Personality Disorder in other Healthcare settings. In Sampson, M.J., McCubbin, R.A. & Tyrer, P. (Eds). *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide*. London:Wiley.

Bennett, L. (2006). Community Mental Health Teams and the Assessment of Personality Functioning. In Sampson, M.J., McCubbin, R.A. & Tyrer, P.(Eds) *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide.* London: Wiley.

Bernstein D.P. , Iscan, C. & Maser J. (2007). Opinions of Personality Disorder Experts Regarding the DSM IV Personality Disorders Classification System. *Journal of Personality Disorder* Vol 21(5): 536-551.

Binks CA, Fenton M, McCarthy L, Lee T, Adams CE, Duggan C. (2006). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD005652. DOI: 10.1002/14651858.CD005652.

Blackburn, R. (2006). What is Personality Disorder? In Sampson, M.J., McCubbin, R.A. & Tyrer, P.(Eds). *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide*. London:Wiley.

Blais, M.A., Hilsenroth, M.J. & Castlebury, F.D. (1997). Content Validity of the DSM IV Borderline and Narcissistic Personality Disorder Criteria Sets. *Comprehensive Psychiatry*, Vol 39(1): 31-37.

Blennerhassett, R.C. & O'Raghallaigh, J.W. (2005). Dialectical behaviour therapy in the treatment of borderline personality disorder. *British Journal of Psychiatry*, Vol 186: 278-280.

Bowers, L. (2003). Manipulation: description, identification ad ambiguity. *Journal of Psychiatric and Mental Health Nursing*, Vol 10: 323-328.

Burns, T. (2006). An introduction to Community Mental Health Teams (CMHTs): How Do They Relate to Patients with Personality Disorder In Sampson, M.J., McCubbin, R.A. & Tyrer, P.(Eds). *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide*. London:Wiley

Burr, V. (1995). *An introduction to Social Constructionism*. London: Routledge

Casey, P.R. & Tyrer, P. (1990). Personality Disorder and Psychiatric Illness in General Practice. *British Journal of Psychiatry*, Vol 156: 261-265.

Castillo, H. (2003). Personality Disorder: Temperament or Trauma? London: Jessica Kingsley Publishers: London.

Charland, L.C. (2006). Moral Nature of the DSM IV Cluster B Personality Disorders. *Journal of Personality Disorders*, Vol 20(2): 116-125.

Clark, D., Beck, A.T. & Alford, B.A. (1999). *Scientific Foundations of Cognitive Theory and Therapy of Depression*. New York: Wiley.

Clarkin, J.F., Levy, K.N., Lenzenweger, M.F., Kernberg, O.F., (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *The American Journal of Psychiatry*, Vol 164(6): 922-929.

Cloniger, C. R., Svrakic, D.M. & Przybeck, T.R. (1993). A Psychobiological Model of Temperament and Character, *Archives of General Psychiatry,* Vol 50: 975-990.

Coccaro, E.F. & Kavoussi, R.J. (1991). Biological and Pharmacological aspects of Borderline Personality Disorder. *Hospital and Community Psychiatry*, Vol 42:1029-1033.

Coid, J., Yand, M., Tyrer, P., Roberts, A. & Ullrich, S. (2006). Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry*, Vol 188:423-431.

Cooke, D. J. & Hart, S. D. (2004). Personality Disorders. In Johnstone, E.C., Cummingham, Owens, D., Lawrie, S.M., Sharpe, M. & Freeman, C.P.L. (Eds). *Comparison to Psychiatric Studies, 7ᵗʰ Edition.* London: Churchill Livingstone:Elsivier

Costa, P.T., Jr. & McCrae, R.R. (1992). The five-factor model of personality and its relevance to personality disorders. *Journal of Personality Disorders, 6(4),* 343-359.

Cottraux, J. & Blackburn, I. (2001). Cognitive Therapy. Livesley, J.W. (Ed). In *Handbook of Personality Disorders: Theory, Research, and Treatment.* New York: The Guildford Press

Coyle, A. (2007) Introduction to Qualitative Psychological Research. In Coyle, A. & Lyons, E. (Eds). *Analysing Qualitative Data in Psychology.,.* London: Sage

Davidson, K. (2000). *Cognitive therapy for personality disorders.* Oxford: Butterworth-Heinemann.

Davidson, K. (2008). Cognitive Behaviour Therapy for Personality Disorders. *Psychiatry*, Vol 7(3): 117-120.

Davidson, K., Norrie, J., Tyrer, P., Gumley, A., Tata, P., Murray, H. & Palmer, S. (2006). The effectiveness of Cognitive Behaviour Therapy for Borderline Personality Disorder: Results from the Borderline Personality study of Cognitive Therapy (BOSDCOT) Trial. *Journal of Personality Disorder*, Vol 20(5): 450-465.

Davidson, K.M. & Tyrer, P. (1996). Cognitive Therapy for anti social and borderline personality disorders: single case study series. *British Journal of Clinical Psychology*, Vol 35: 413-429.

Deans, C., & Meocevic, E. (2006). Attitudes of registered psychiatric nurses to patients diagnosed with borderline personality disorder. Mental Health Nursing, Vol 21(1): 43-49.

Department of Health (1999). Review of the Mental Health Act (1983). Report of the Expert Committee.

Devens, M. (2007). Personality Disorders. *Primary Care: Clinics in Office Practice*, Vol 34:623-640.

Dew, R. E. (2007). Informed consent for research in Borderline Personality Disorder. *Medical Ethics*, Vol 8(4).

Dinos, S., Stevens, S., Serfaty, M., Weichs, T., & King, M. (2004). Stigma: The feelings and experiences of 46 people with mental illness. *British Journal of Psychiatry*, Vol 184 (176-181).

Fallon, P. (2003). Travelling through the system: the lived experience of people with borderline personality disorder in contact with psychiatric services. *Journal of Psychiatric and Mental Health Nursing*, Vol 10: 393-400.

Feigenbaum, J. (2008). Dialectical Behaviour Therapy. *Psychiatry,* Vol 7(3): 112-115.

Ferguson, B. & Tyrer, P. (2000). History of the concept of personality disorder. In Tyrer, P. (eds)   *Personality Disorder: Diagnosis, Management and Course* (Second Edition. Oxford: Butterworth-Heinemann.

Fonagy, P. & Bateman, A. (2006).   Progress in the treatment of borderline personality disorder. *British Journal of Psychiatry*, Vol 188:1-3.

Fonagy, P., Bateman, A. (2008).   The Development of Borderline Personality Disorder: A Mentalizing Model. *Journal of Personality Disorders*, Vol 22(1): 4-21.

Fonagy, P., Gergely, G., Jurist, E.L. & Target, M. (2006). *Affect Regulation, Mentalization, and the Development of the Self.* London: Karnac Books.

Gallop, R. Lancee, W.J. & Garfinkel, P. (1989). How Nursing Staff respond to the label, Borderline Personality Disorder. *Hospital and Community Psychiatry*, Vol 40 (8) 815-819.

Gallop, R., Lancee, W. & Shugar, G. (1993). Residents' and Nurses' Perceptions of Difficult to Treat Short Stay Patients. *Hospital and Community Psychiatry*, Vol 44: 352-357.

Gerbert, B. (1984). Perceived Likeability and Competence of Simulated Patients: Influence on Physicians' Management Plans. *Social Sciences and Medicine*, Vol 18(12): 1053-1059.

Gleitman, H., Fridlund, A.J.& Reisberg (1999). *Psychology* Fifth Edition. New York: Norton

Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity.* Engelwood Cliffs, NJ: Prentice-Hall.

Green, G., Hayes, C., Dickinson, D., Whittaker ,A. & Gilheany, B. (2003). A mental health service users perspective of stigmatisation. *Journal of Mental Health*, Vol 12(3): 223-235.

Gross, R., Olfson, M., Gameroff, M., Shea, S., Feder, A., Fuentes, M., Lantigua, R. & Weissman., M.M. (2002). Borderline Personality Disorder in Primary Care. *Archives of Internal Medicine*, Vol 162: 53-60.

Gunderson, J.G., Hoffman, P.D., Steiner-Grossman, M.P.H. & Woodward, P. (2005). *Understanding and Treating Borderline Personality Disorder. A guide for Professionals and Families.* Washington: American Psychiatric Publishing.

Haigh R. (2006). People's experiences of having a Diagnosis of Personality Disorder. In Sampson, M.J., McCubbin, R.A. & Tyrer, P.(Eds). *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide.* London: Wiley.

Hayward, M. & Moran, P. (2008). Co morbidity of personality disorders and mental illnesses. *Psychiatry,* Vol 7 (3): 102-104.

Herman, JL, Perry, JC & van der Kolk, BA. (1989). Childhood Trauma in Borderline Personality Disorder. *American Journal of Psychiatry,* Vol 146(10): 1358-1359.

Hjortdahl, P., & Borchgrevink, C.F. (1991). Continuity of care : influence of general practitioners' knowledge about their patients on use of resources in consultation. *British Medical Journal*, Vol 303 (6811): 1181-1189.

Horn, N., Johnstone, L. & Brooke, S. (2007). Some service user perspectives on the diagnosis of Borderline Personality Disorder. *Journal of Mental Health*, Vol 16 (2): 255-269.

Hueston, W.J., Mainous, A.G. & Schilling, R. Patients with personality disorders: functional status, health care utilization, and satisfaction with care. *Journal of Family Practice*, Vol 42 (1): 54-60

Jang, K.L. & Vernon, P.A. (2001). Genetics. In Livesley, J.W. (Ed). *Handbook of Personality Disorders: Theory, Research, and Treatment.* New York: The Guildford Press.

Jarret, C. (2006). Understanding personality disorder. *The Psychologist, 19(7),* 402-404.

Jefferson, G (1984) *Transcript Notation*, in J. Heritage (eds), *Structures of Social Interaction*, New York: Cambridge University Press.

Kane, E. (2006). Personality Disorder: New Initiatives in staff training. In Sampson, M.J., McCubbin, R.A. & Tyrer, P.(Eds). *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide.* London: Wiley.

Kendell, R.E. (2002). The distinction between personality disorder and mental illness. *British Journal of Psychiatry*, Vol 180: 110-115.

Kreisman, J.J. & Straus, H. (1989). *I Hate You – don't leave me. Understanding the Borderline Personality.* New York: Harper Collins.

Lewis, G. & Appleby, L., (1988). Personality Disorder: The Patients Psychiatrists Dislike. *British Journal of Psychiatry*, Vol 153: 44-49.

Lieb, K., Zanarini, M.C., Schmahl, C., Linehan, M.M. & Bohus, M. (2004). Borderline Personality Disorder. *The Lancet*, Vol 364: 453-461.

Linehan MM, Armstrong HE, Suarez A, Allmon D, Heard HL. (1991). Cognitive-Behavioural Treatment of Chronically Parasuicidal Borderline Patients. *Archives of General Psychiatry*, Vol 48: 1060-4.

Linehan MM, Heard HL, Armstrong HE. (1993). Naturalistic Follow-up of a Behavioural Treatment for Chronically Parasuicidal Borderline Patients. *Archives of General Psychiatry*, Vol 50 (12):971-4.

Linehan MM. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Publications.

Linehan, M., Comtois,K.A. Murray,A.M., Brown, M.Z., Gallop, R.J., Heard, H.L., Korslund, K.E., Tutek, D.A., Reynolds, S.K., Lindenboim, N. (2006). Two-Year Randomized Controlled Trial and Follow-up of Dialectical Behaviour Therapy vs Therapy by Experts for Suicidal Behaviours and Borderline Personality Disorder. *Archives of General Psychiatry*, Vol 63: 757-766.

Link, B.J., Struening, E.L., Neese-Todd, S.,Asmussen, S. & Phelan, J.C. (2001). The consequences of stigma for the self-esteem of people with mental illness. *Psychiatric Services,* 52, 1621 – 1626.

Links, P.S., Steiner, M., Offord, D. & Eppell, A. (1988). Characteristics of borderline personality disorder: A Canadian Study. *Canadian Journal of Psychiatry*, Vol 33: 336-340.

Livesley, J.W. (2001). Conceptual and Taxonomic Issues. In *Handbook of Personality Disorders: Theory, Research, and Treatment*. Livesley, J.W. (Ed). New York: The Guildford Press.

Livesley, W.J., Jang., K.L. & Vernon, P.A. (1998). Phenotypic and genetic structure of traits delineating personality disorder. *Archives of General Psychiatry*, Vol 55: 941-948.

Livesley. J. (2007). A framework for Integrating Dimensional and Categorical Classifications of Personality Disorder. *Journal of Personality Disorders*, Vol 21(2): 199-224.

Lynam, D.R. & Widiger, T.A. (2001). Using the Five-Factor Model to Represent the DSM IV Personality Disorders: An Expert Consensus Approach. *Journal of Abnormal Psychology*, Vol 110(3): 401-412.

Major, B., Kasier, C.R., McCoy, S.K. (2003). It's not my fault: When and Why Attributions to Prejudice Protect Self-Esteem. *Personality and Social Psychology Bulletin,* Vol 29(6): 772-781.

Markham, D. & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours. *British Journal of Clinical Psychology*, Vol 42: 243-256

Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder: social rejection and dangerousness. *Journal of Mental Health* Vol 12 (6) : 595-612.

Markovitz, P. (2001). Pharmacotherapy. Livesley, J.W. (Ed). In *Handbook of Personality Disorders: Theory, Research, and Treatment*New York: The Guildford Press.

Matthews, G., & Deary, J. (1998). *Personality Traits*. London: Cambridge University Press

Mattia, J.I. & Zimmerman, M. (2001). Epidemiology. In Livesley, J.W. (Ed). *Handbook of Personality Disorders: Theory, Research, and Treatment*. New York: The Guildford Press

Mays, N. & Pope, C. (2000). Qualitative research in health care. Assessing Quality in Qualitative Research. *British Medical Journal*, Vol 320: 50-52.

McGlashan TH, Grilo CM, Skodol AE, Gunderson JG, Shea MT, Morey LC, Zanarini MC, Stout RL (2000): The Collaborative Longitudinal Personality Disorders Study: baseline Axis I/II and II/II diagnostic co-occurrence. *Acta Psychiatrica Scandinavica,* Vol 102:256–264.

Mental Welfare Commission. (2007). Not my problem. Summary Report from Our Investigations in Deficiencies into the Care and Treatment of Mr G. http://www.mwcscot.org.uk/web/FILES/Publications/Mr_G_Final.doc

Miller, J.D., Pilkonis, P.A. & Mulvey, E.P. (2006). Treatment Utilization and Satisfaction: Examining the Contributions of Axis II Psychopathology and the Five-Factor Model of Personality. *Journal of Personality Disorders*, Vol 20(4): 369-387.

Millon, T. Meagher, S.E. & Grossman, S.D.(2001). Theoretical Perspectives. In *Handbook of Personality Disorders: Theory, Research, and Treatment*. Livesley, J.W. (Ed). The Guildford Press: New York.

Mischel, W. (1968). *Personality & Assessmen*t. New York: Wiley

Moorey, J., Davidson, K., Evans, M. & Feigenbaum, J. (2006). Psychological Therapies for Personality Disorder. In *Personality Disorder and Community Mental*

Health Teams: A Practitioner's Guide. Sampson, M.J., McCubbin, R.A. & Tyrer, P.(Eds) London: Wiley.

Moran P, Jenkins R, Tylee A, Blizard R, Mann A. (2000). The prevalence of personality disorder among UK primary care attenders. *Acta Psychiatrica Scandinavica,* Vol 102: 52-57.

Moran, P., Rendu., A., Jenkins, R. Tylee, A. & Mann, A. (2001). The impact of personality disorder in UK primary care: a 1-year follow up of attenders. *Psychological Medicine*, Vol 31(8): 1447-1454.

Mullins-Sweatt, S.N. & Widiger, T.A. (2007). Millon's Dimensional Model of Personality Disorders: A Comparative Study. *Journal of Personality Disorders*, Vol 21(1): 42-57.

Murray, B.L. (2003). Qualitative research interviews:therapeutic benefits for the participant. *Journal of Psychiatric and Mental Health Nursing* **10**, 231–238

National Institute for Mental Health in England (2003a). Personality Disorder: No Longer a Diagnosis of Exclusion. London: Author.

National Institute for Mental Health in England (2003b). Breaking the Cycle of Rejection. The PErsolity Disorder Capabilites Framework. London: Author

Nehls, N. (1999). Borderline Personality Disorder: The Voices of Patients. *Research in Nursing & Health*, Vol 22: 285-293.

Newton-Howes, G. (2006). Pharmacotherapy and Personality Disorders. In Sampson, M.J., McCubbin, R.A. & Tyrer, P.(Eds). *Personality Disorder and Community Mental Health Teams: A Practitioner's Guide.* London: Wiley.

Nowlis, D.P. (1990). Borderline Personality Disorder in Primary Care. *The Journal of Family Practice*, Vol 30 (3): 329-335.

Nvivo (©1999-2002 QSR International Pty. Ltd).

Oldham, J.M. & Skodol, A.E. (2000). Charting the Future of Axis II. *Journal of Personality Disorders*, Vol 14(1): 17-29.

Oldham, J.M., Skodol, A.E., Kellman, H.D., Hyler, S.E., Doidge, N., Rosnick, L. & Gallaher, P.E. (1995). Comorbidity of Axis I and Axis II Disorders. American Journal of Psychiatry, Vol 152 (4): 571-578.

Orb, A., Eisenhauer, L., Wynaden, D. (2000). Ethics in Qualitative Research. *Journal of Nursing Scholarship*, Vol 33(1): 93-96.

Palmer, S., Davidson, K., Tyrer, P., Gumley, A., Tata, P., Norrie, ., Murray, H. & Seivewright, H. (2006). The cost effectiveness of Cognitive Behaviour Therapy for

Borderline Personality Disorder: Results from the BOSCOT Trial. *Journal of Personality Disorder* ,Vol 20(5): 466-481.

Paris, J. (2005) Borderline Personality Disorder. *Canadian Medical Association Journal.* Vol 172 (12) 1579- 1583.

Paris, J. (2007). The nature of Borderline Personality Disorder: Multiple dimensions, multiple symptoms but one category. *Journal of Personality Disorders*, Vol 21(5): 457-473.

Parsons S. (1997). The epidemiology and effects of borderline personality disorder in Participants primary health care. *Journal of Psychiatry and Ment Health Nurs.* 1997;4:145-146.

Penn, D.L. & Wykes, T. (2003). Stigma, discrimination & Mental Illness. *Journal of Mental Health*, Vol 12(3): 203-208.

Pilgrim, D. (2001). Disordered Personalities and Disordered Concepts. *Journal of Mental Health*, Vol 10(3): 253-365.

Plomin, R., DeFries, J. C., McClearn, G. E. & Rutter, M. (1997). *Behavioral Genetics*. New York: Freeman.

Potter, N.N. (2006).   What is Manipulative Behaviour, Anyway? *Journal of Personality Disorders*, Vol 20(2): 139-156.

Pukrop, R. & Krischer, M. (2005). Changing Views about Personality Disorders: Comment abut the Prospective Studies CIC, and MSAD. *Journal of Personality Disorders*, Vol 19(5): 563-572.

Putnam, K.M. & Silk, K.R. (2005). Emotional Dysregulation and the Development of Borderline Personality Disorder. *Development & Psychopathology*, Vol 17(4) : 899-925.

Reich, J.H. & Vasile, R.G. (1993). Effect of Personality Disorders on the treatment outcome of Axis I conditions: an update. *Journal of Mental Health and Disease*, Vol 181: 475-484.

Robins, C.J., Ivanoff, A.M. & Linehan, M.J. (2001).   Dialectical Behaviour Therapy. In Livesley, J.W. (Ed)*Handbook of Personality Disorders: Theory, Research, and Treatment*. New York: The Guildford Press.

Rutter, M. (1987). Temperament, personality and personality disorder. *British Journal of Psychiatry*, Vol 150: 443-458.

Ryder, A.G., Costa, P.T., & Bagby, M. (2007).   Evaluation of the SCID II Personality Disorder Traits fro DSM IV: Coherence, Discrimination, Relations with

General Personality Traits, and Functional Impairment. *Journal of Personality Disorders*, Vol 21(6): 626-637.

Sable, P. (1997). Attachment, detachment and borderline personality disorder. *Psychotherapy, 34,* 171-181.

Sadler, J.Z., & Fulford, B. (2006). Normative Warrant in Diagnostic Criteria: The case of DSM IV TR Personality Disorders. *Journal of Personality Disorders*, Vol 20(2): 170-180.

Sansone, R.A & Sansone, L.A. (1996). Borderline Personality Disorder and Health Care Utilization in a Primary Care Setting. *Southern Medical Journal,* Vol 89 (12): 1162-1167.

Sansone, R.A., Wiederman, M.W., Sansone, L.A. (1998). Borderline Personality Symtomatology, Experience of Multiple Types of Trauma, and Health Care Utilization Among Women in a Primary Care Setting. *Journal of Clinical Psychiatry*, Vol 59(3): 108-111.

Scheel, K., (2000). The Empirical Basis of Dialectical Behaviour Therapy. Summary, Critique and Implications. *Clinical Psychology: Science and Practice*, Vol 7: 68-87.

Scottish Executive (2006). Delivering For Mental Health. Author. http://www.scotland.gov.uk/Publications/2006/11/30164829/0

Scottish Executive (2003). The Scottish Health Survey. Summary of Key Findings. Author. http://www.scotland.gov.uk/Resource/Doc/924/0019811.pdf.

Searight, H.R. (1992). Borderline Personality Disorder: Diagnosis and Management in Primary Care. *The Journal of Family Practice*, Vol 34(5): 605-612.

Sieff, E. (2003). Media Frames of mental illness. The potential impact of negative frames. *Journal of Mental Health*, Vol 12(3): 259-270.

Simmons. D. (1992). Gender issues and Borderline Personality Disorders. *Archives of Psychiatric Nursing* Vol 6(4): 219-213.

Skodol, A.E. (2005). The Borderline Diagnosis. Concepts, Criteria, and Controversies. In Gunderson, J.G., Hoffman, P.D., Steiner-Grossman, M.P.H. & Woodward, P. (2005). *Understanding and Treating Borderline Personality Disorder. A guide for Professionals and Families.* Washington: American Psychiatric Publishing.

Skodol, A.E., Gunderson, J.G., Pfohl, B., Widiger, T.A., Livesley, J.W., & Siever, L.J. (2002). The borderline diagnosis I: psychopathology, co morbidity and personality structure. *Biological Psychiatry*, Vol 51(12): 936-950.

Skodol, A.E., Gunderson, J.G., Pfohl, B., Widiger, T.A., Livesley, J.W. & Siever, L.J. (2002). The borderline diagnosis I: psychopathology, co morbidity, and personality structure. *Biological Psychiatry*, Vol 51(12): 936-950.

Smith, J. A. & Eatough, V. (2007). In Coyle, A. & Lyons, E. (Eds). *Analysing Qualitative Data in Psychology* Sage:London.

Smith, J.A. & Osborn, M. (2003). Interpretative Phenomenological Analysis. In Smith J.A. (Eds) *Qualitative Psychology. A practical Guide to Research Methods.* Sage: London.

Smith, J.A. (1996). Beyond the Divide Between Cognition and Discourse: Using Interpretative Phenomenological Analysis in Health Psychology. *Psychology and Health*, Vol 11: 261-271.

Sperry, L. (1999). *Cognitive Behaviour Therapy of DSM- IV Personality Disorders. Highly Effective Interventions for the Most Common Personality Disorders.* London: Taylor & Francis.

Stanley, B., & Brodsky, B.S. (2005). Suicidal and Self –Injurious Behaviour in Borderline Personality Disorder. A Self-Regulation Model. In Gunderson, J.G., Hoffman, P.D., Steiner-Grossman, M.P.H. & Woodward, P. (Eds). *Understanding and Treating Borderline Personality Disorder. A guide for Professionals and Families.* Washington: American Psychiatric Publishing.

Stern, A. (1938). "Psychoanalytic Investigation of and Therapy in the Border Line Group of Neuroses". *Psychoanalytic Quarterly* Vol 7: 467-489.

Stern, D. N. (2002). *The Interpersonal World of the Infant: A View from Psychoanalysis and Development Psychology*. Basic Books.

Street, R.L. Jr., Gordon, H. & Haidet, P. (2007). Physician's communication and perceptions of patients: Is it how they look, how they talk, or is it just the doctor? *Social Science and Medicine* Vol 65: 586-598.

Tee, S.R., Lathlean, J.A., (2004). The ethics of conducting co-operative inquiry with vulnerable people. *Journal of Advanced Nursing*, Vol 47(5): 536-543.

Torgersen, S., Kringlen, E. & Cramer, V. (2001). The Prevalence of Personality Disorders in a Community Sample. *Archives in General Psychiatry*, Vol 58:590-596

Tyrer, J. & Seivewright ,H. (2008). Stable instability: the natural history of personality disorders. *Psychiatry*, Vol 7(3): 129-132.

Tyrer, P. & Duggan, C. (2008). NICE guidelines for the treatment of personality disorders. *Psychiatry*, Vol 7(3). : 109-111.

Tyrer, P. & Ferguson, B. (2000). Classification of personality disorder. In *Personality Disorder: Diagnosis, Management and Course* (Tyrer, P. eds) Second Edition. Oxford: Butterworth-Heinemann.

Tyrer, P. (2000). *Personality Disorder: Diagnosis, Management and Course*. Second Edition. Oxford: Butterworth Heinemann.

Tyrer, P. (2002). Practice guidelines for the Treatment of borderline personality disorder: A bridge too far? *Journal of Personality Disorders*, Vol 16(2):113-118.

Tyrer, P., Coombs, N., Ibrahim, F., Mathilakath, A., Bajaj, P., Ranger, M. Rao, B. & Din, R. (2007). Critical developments in the assessment of personality disorder. *British Journal of Psychiatry*, Vol 190(suppl 4): 51-59.

Tyrer, P., Mitchard, S., Methuen, C. & Ranger, M. (2003). Treatment Rejecting and Treatment Seeking Personality Disorders: Type R and Type S. *Journal of Personality Disorders*, Vol 17(3): 263-268.

Tyrer, P., Thomson, S., Schmidt, U., Jones, V. Knapp, M., Davison, K., Catalan, J, Airlie, J., Baxter, S. Byford., S. , Byrne, G., Cameron, S., Caplan, R., Cooper, S., Ferguson, B., Freeman, C., Frost, S., Godley, J., Greensheilds, J., Henderson, J., Holden, N., Keech, P., Kim, L., Logan, K. Manley, C., Macleod, A., Murphy, R., Patience, L., Ramsay, L., De Munroz, S., Scott, J., Seivewright, S.H., Sivakumar, K., Tata, P., Thornton, S., Ukoumunne, O.C., & Wessely, S. (2003). Randomized controlled trial of brief cognitive behaviour therapy versus treatment as usual in recurrent deliberate self-harm: the POPMACT study. *Psychological Medicine*, Vol 33, 969–976.

Tyrer. P. (1996) Co morbidity or consanguinity. *British Journal of Psychiatry*, Vol 168: 669-671.

Verheul, R., Van der Bosch, L.M.C., Koeter, W.J., de Ridder, M., A.J., Stijnen, T. & van der Brink, W.(2003). Dialectical behaviour therapy for women with borderline personality disorder12-month, randomised clinical trial in The Netherlands. *British Journal of Psychiatry*, Vol 182: 135-140.

Ward, R.K. (2004). Assessment and Management of Personality Disorders. *American Family Physician*, Vol 70(8): 1505-1512.

Webb, D. & McMurran M. (2008). A Delphi survey of patients' views of services for borderline personality disorder: A preliminary report. *Personality and Mental Health* Vol 2: 17-24.

Webb, D. & McMurran, M. (2007). Nursing staff attitudes to patients with personality disorders, *Personality and Mental Health*, Vol 1: 154-160.

Widiger, T.A. (2000). Personality Disorders in the 21st Century. *Journal of Personality Disorders*, Vol 14(1): 3-16.

Widiger, T.A. (2001). Official Classification Systems. In Livesley, J.W. (Ed). *Handbook of Personality Disorders: Theory, Research, and Treatment.* New York: The Guildford Press.

Widiger, T.A. (2005). Five Factor Model of Personality Disorder: integrating science and practice, Vol 39(1): 67-83.

Widiger, T.G. & Frances, A.J. (1989). Epidemiology, diagnosis and co morbidity of borderline personality disorder. *American Psychiatric Press Review of Psychiatry* Vol 8: 8-24.

Williams SJ, Calnan M. Key determinants of consumer satisfaction with general practice. *Family Practice* 1991; 8: 237-242.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method.* Buckingham: Open University Press.

World Health Organization. *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines.* Geneva: World Health Organization, 1992.

Yardley, L. (2000). 'Dilemmas in qualitative health research'. *Psychology and Health*, Vol 15: 215-228

Zanarini MC, Gunderson JG, Marino MF, Schwartz EO, Frankenburg FR. (1989) Childhood experiences of borderline patients. *Comprehensive Psychiatry, Vol* 30**:** 18–25.

Zanarini, M.C., Frankenburg, F.R., Dubo, E.D., Sickel, A.E., Trikha, A., Levin, A. *et al.* (1998). Axis I comorbidity of borderline personality disorder. *American Journal of Psychiatry, 155,* 1733-1739.

Zanarini, M.C., Frankenburg, F.R., Hennen, J., Reich, D.B. & Silk, K.R. (2004). Axis I co morbidity in patients with borderline personality disorder: 6-year follow up and prediction of time to remission. *American Journal of Psychiatry*, Vol 161: 2108-2114.