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Research Article

The Experience of Accessing Physical Healthcare When You Have a Diagnosis of a 'Personality Disorder': A Systematic Review and Meta-Synthesis

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ABSTRACT

Living with a diagnosis of a personality disorder presents a host of significant physical health challenges. Specifically, those with personality disorders may face inequities in their experiences of physical healthcare in comparison to the general population. The aim of this review was to investigate the experiences and the potential barriers or facilitators those with personality disorders encounter when accessing physical healthcare. Three articles examining these experiences were included. Four meta-themes were identifies: a) General disregard from physical healthcare professionals, b) Identity and self-perception of personality disorder as a barrier to treatment, c) Stigma and lack of awareness around personality disorder in healthcare settings, d) Physical problems viewed through the lens of patient's personality disorder. Each of these themes highlighted the extensive barriers that individuals with personality disorders face when accessing physical healthcare. The findings suggest that people with personality disorders largely have negative experiences when attempting to access physical health care. No facilitators to accessing physical healthcare were identified within the existing qualitative literature. These findings present implications for future healthcare policies and suggest that there is a greater need for specialist training for healthcare professionals in managing the physical problems that individuals with personality disorders present with in healthcare settings. The scarcity of qualitative research in this area indicates that further research is needed in this area to explore these experiences in greater depth.

Keywords: Personality disorder; Physical healthcare; Healthcare; Physical problems; Access; Barriers; Experiences; General practice; Hospital

INTRODUCTION

Personality disorders are a debilitating mental health disorder characterised by patterns of disturbances in identity, affect and interpersonal relationships. Globally, there is a prevalence rate of 7.8% for personality disorders. Whilst personality disorders often have high comorbidity with other mental disorders, they are also associated with a range of adverse physical health problems such as cardiovascular disease, chronic pain, fatigue, respiratory disease, immunodeficiency problems arthritis and obesity. The problems associated with physical health in those with a personality disorder can have a significant impact upon these individuals and have resulted in a life expectancy of 18 years less in those that do suffer, compared to the general population.

The reduced life expectancy seen in those with personality disorders is also present in other mental health disorders, such as schizophrenia. The disparities in physical health between those with mental health problems and those without mental health problems may be the result of several factors including lifestyle factors, medication and barriers to care. Individuals with psychosis and depression are likely to smoke at a higher rate and exercise less, compared to those in the general population. Each of these factors contributes significantly to poorer physical health and further increases the risk of developing physical health conditions. These trends are also seen in individuals with

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personality disorders and therefore contribute towards the reduced life expectancy within this population.

One of the inequities in the quality of physical healthcare that is faced by individuals with mental health problems is less effective screening for diseases like cancer. This may be a result of general healthcare staff being less informed about the complex interplay between physical and mental health and the specific challenges relating to drug interactions and treatment difficulties as a consequence of the patients' psychiatric symptoms. Furthermore, limited screening time available to healthcare providers might mean that mental health problems are prioritised. These problems are magnified by the practical and financial burden that patients face through having to attend separate medical providers for their mental and physical healthcare [1].

Stigma and prejudice are also barriers faced in accessing physical health care by individuals with serious mental illness. Specifically, these barriers to access can be perpetuated by factors such as suboptimal therapeutic relationships and treatment discontinuation as a result of the stigma and prejudice those with serious mental illness face. There is also evidence to suggest that the level of attention these individuals receive is linked to the extent to which their healthcare providers 'like' them. Individuals with personality disorders tend to be exposed to stigma that is greater of that than other mental disorders. This stigmatisation can negatively influence the way in which health practitioners react to the behaviours and symptoms characterised by personality disorders with behaviours being perceived as purposeful misbehaviour as opposed to real experiences of the disorder. This can subsequently lead to a diagnostic overshadowing of physical illnesses that accompany the disorder. This is especially concerning given that around 40% of those within secondary care services suffer from at least one personality disorder and a large majority of sufferers tend to fall through the gap between primary and secondary care services meaning they often rely on emergency departments in times of crisis.

Previous systematic reviews have examined the experiences of accessing physical healthcare in people with serious mental illness and found that there are various barriers to these individuals receiving quality healthcare which include factors relating to the individual patients, the healthcare professionals treating them and the system as a whole. Systemic factors included diagnostic overshadowing from healthcare professionals, misunderstanding of the lived experiences that those with mental illness face and miscommunication and a lack of communication among healthcare providers. Factors such as effective communication and family support have been found to facilitate access to physical healthcare. The extent to which these barriers or facilitators presented themselves might be influenced by the expectations of the individual patients. These previous systematic reviews are limited by their focus on people who have psychosis or bipolar disorder.

The current model of healthcare may also exacerbate the problems faced by those with personality disorders and serious mental illness. The fragmented nature of the current model means that patients often have to visit a number of different healthcare providers for their appointments and treatment. This has been shown to create a barrier to healthcare as patients tend to feel overwhelmed by the number of appointments they have to attend, especially when they have other life commitments. There have therefore been calls for an integrated healthcare model, in which patients can attend multiple appointments for different health problems, at the same healthcare provider. The integration of physical and mental healthcare has the potential to provide patients with multidisciplinary meetings, greater care coordination and more person-centred care. This may help to facilitate the access of physical healthcare in individuals with personality disorders and improve their overall experience of healthcare [2].

This review will aim to address the research gaps highlighted by investigating the experiences individuals with personality disorders encounter when accessing healthcare for physical illnesses and whether there are any distinct barriers or facilitators they face when gaining such access.

The questions that this systematic review aims to address are:

- What are the experiences of people diagnosed with a 'personality disorder' in accessing healthcare for physical illness?
- What are the barriers and facilitators to accessing physical healthcare for people with a diagnosis of 'personality disorders'?

MATERIALS AND METHODS

Overview

The review was registered prospectively with the PROSPERO database (ID: CRD42023444868). This enables enhanced transparency in the reporting of syntheses within qualitative research. To ensure transparent reporting of the systematic review, the PRISMA checklist was used.

Search strategy

For this review, 'physical healthcare' was defined using an adapted version of the definition used by Happell and colleagues; it focused on 'health providers that supply patients and clients with clinical services such as screening and consultations on a range of medical issues' [3].

Multiple search terms, both MESH and textual, were formed from test searches and expert advice from a librarian at University College London (UCL). Search terms (and their truncated variants) related to the research questions were organised through the use of the SPIDER tool. These terms were organised into four conceptual areas and are presented in Figure 1.

exp. Personality disorders OR personality disorder* OR complex emotional needs OR CEN

AND

access* OR barrier* OR obstacle* OR hinder* OR facilitator* OR stigma*

AND

healthcare OR health care OR physical illness* OR physical disorder* OR physical disease* OR physical impairment* OR physical abnormalit* OR disabilit* OR physical health OR chronic physical health OR long-term physical health OR long term physical health

Figure 1: Search terms using SPIDER tool.

Seven health science databases were searched during July 2023: Medline, CINAHL, PsychInfo, Embase, Emcare, Web of Science and PsycEXTRA. Searches were not limited by date or by language. Grey literature was also searched for using eTHOS and Google to find additional resources including dissertations, government reports and non-peer reviewed publications.

Inclusion and exclusion criteria

Studies were included if 1) Participants were 18 years or above, with a formal diagnosis of a personality disorder using the DSM, ICD or trained clinician, 2) They included service users', carers or mental health professionals' perspectives of an individual's experience of accessing healthcare for physical illness in those with a personality disorder, 3) Were set in primary, secondary or tertiary health care, including but not limited to, general practitioner surgeries, hospital wards and emergency rooms, 4) They included personality disorders among a broader definition of serious mental illness but only if they specifically separated data for personality disorders within their data in comparison to other illnesses such as psychosis, schizophrenia or bipolar disorder, 5) Were qualitative papers, which reported primary qualitative data through methodologies including ethnographies, one to one interviews, focus groups or participatory action research and survey studies which provided analyses of responses to open ended questions. Mixed method studies were also included if the qualitative aspect of the study met the inclusion criteria of this systematic review.

Papers were excluded if they 1) Involved individuals who showed personality disorder traits but had not received a diagnosis, 2) Included participants with serious mental illness but did not include personality disorders, 3) Were studies set in mental health services unless they encompassed data on accessing physical health care, 4) Quantitative studies or secondary research such as theoretical reviews. Quantitative studies were excluded as this review intended to focus upon the rich and complex experiences of individuals that qualitative research provides.

Screening and data extraction

Duplicate papers that appeared on more than one database were removed before screening. Appropriate data was imported to and stored in the systematic review management software, Covidence. Titles, abstracts were screened independently by the lead author (CC). Full texts were retrieved and assessed against the eligibility criteria. The reference lists of the retrieved papers were further scrutinised for any additional eligible studies. Ten percent of full-texts were reviewed by a second reviewer (OK). Disagreements were resolved through discussion between both reviewers. Inter-rater agreement for full text screening was 100%. The following data was extracted from all included papers author; publication year and country; sample size; participant characteristics (e.g., age, gender, ethnicity, type of personality disorder); type of analysis used and emerging themes. Authors were contacted by email to request further information if their publication lacked the detail necessary for complete extraction or if data was missing that was relevant to the systematic review or analysis [4].

Critical appraisal

The Critical Appraisal Skills Programme (CASP) qualitative checklist was used to assess quality in order to increase the trustworthiness of the review, as recommended by Cochrane. This tool consists of a series of ten questions addressing the trustworthiness and transferability of qualitative papers. The CASP does not use a scoring system but suggests that if the first two questions cannot be answered with 'yes', the evidence may be of low quality. These two questions relate to whether the review addresses a clearly focused question and if the authors searched for the right type of papers. The quality of retrieved papers was assessed independently by the lead author and ten percent of these were assessed by the second reviewer. Any discrepancies between the reviewers were resolved by discussion. Whilst some papers were likely to offer richer narratives than others, studies were not excluded based upon the quality of their methodology used. Critical appraisal was then integrated into the data synthesis.

The Authority, Accuracy, Coverage, Objectivity, Date and Significance checklist (AACODS) were used to assess quality of grey literature. This tool appraises the quality of different variables such as author(s) qualifications, accuracy of the given information, the scope of the work, the objectivity of the content, timeliness of the publication and the relevance of the content in relation to the research question. The AACODS does not use a scoring system and so requires the appraiser to form an overall evaluation of the Grey literature material based upon a checklist.

Meta-synthesis

A thematic synthesis of the data was carried out by the lead researcher (CC). Analysis was based upon the principles of meta-synthesis techniques outlined by Sandelowski and colleagues and followed the guidelines set out by Thomas and Harden for conducting a thematic synthesis [5].

The stages of this process included:

- **Line by line coding:** In this stage I re-read and thematically coded the results and discussion sections of the included articles and extracted relevant quotations and author interpretations to NVivo 14.
- **The formation of ordered constructs:** First order constructs referred to direct participant quotes reported within retrieved papers. Second order constructs were defined as the authors' interpretations of participants' quotes that were conveyed through themes found within both the results and discussion sections of retrieved papers. Finally, synthesised constructs emerging from the analysis of both first and second order constructs formed third order constructs.

- **The development of descriptive themes:** Constructs were reviewed to see how themes contrasted and compared to one another across papers. Second order constructs were carefully reviewed to help facilitate the formation of third order constructs which accurately encompassed the various themes across the reviewed studies. This led to the development of initial descriptive themes.
- **The generation of analytical themes:** Descriptive themes were then carefully compared and contrasted and finally synthesised to produce analytical themes.

Whilst Thomas and Harden's guidelines highlighted that meta-syntheses were distinguishable from meta-ethnographies in that they do not use third order constructs to go beyond the original content of original studies, it was deemed appropriate to combine the principles of each of these in order to infer barriers and facilitators to accessing physical healthcare in individuals with personality disorders. This enabled the emergence of more abstract and analytical themes resulting from initial descriptive themes and through an iterative process led to a set of themes that accurately portrayed these inferred barriers and facilitators and implications in healthcare development.

Reflexivity

Reflexivity is a practice which ensures rigor and quality in the analysis of the work of a researcher. This process helps to determine the integrity and trustworthiness of the research in relation to the researcher's subjective role and interests. This is particularly important in qualitative research as it relies upon the subjective interpretation of various findings. There was diversity in the genders (one male, three female) and cultural backgrounds of the researchers who conducted this study. There was also variation in the career stages of those involved. SR is an Associate Professor at the University College London (UCL), UK. ST is a PhD student at the UCL. OK, who acted as the second reviewer within this study, is an MSc student at UCL.

Inevitably, my own personal views and ideas will have influenced the coding of the included studies and the synthesis of these findings (CC). Although i have not had experience within a clinical role, my ambition of becoming a qualified clinical psychologist means that I have a vested interest in the experiences of individuals with mental health problems and subsequently the potential of improving these experiences in a manner that benefits both the individual, the community and my own personal aspirations of helping those that require help. My current position as an MSc student has only furthered my interest in the lived experiences of individuals suffering from mental health disorders, as prior to that my interests were more service-led. The analysis process has also been shaped by the focus on my research question being on the 'accesses to physical healthcare. My own experiences of accessing physical healthcare have been mixed but the poorer experiences stick out more in my mind and I hold the belief that the overall quality of healthcare, physical or mental is very poor within the UK. I therefore considered this to be an important area and believed that for individuals with personality disorders, this particularly required greater investigation and it was therefore important to explore their own experiences of accessing physical healthcare [6].

RESULTS

The initial search identified a total of 3341 results with this reducing to 2184 after duplicates were removed. Titles and abstracts were screened. One hundred and eight papers were retrieved assessed for eligibility *via* the inclusion criteria of this review. Of these, three met the eligibility criteria and underwent full-text screening. All three of these papers were included in the meta-synthesis. A review of the reference list of included papers yielded no additional papers. Reasons for exclusion of papers are illustrated in the PRIMSA diagram in Figure 2.

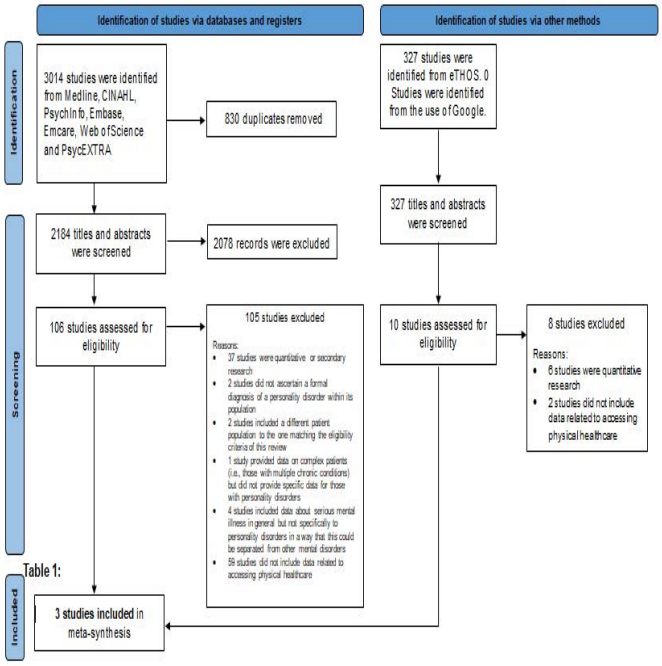

Figure 2: PRIMSA diagram.

Study characteristics are summarised in Table 1. All three studies were conducted in the US or UK. Sample sizes ranged from 11 to 30 with a large majority of participants identifying as female. The age range of participants was between 18 and 65 years, although age was not stated in one study. Studies mostly included people with borderline personality disorder. Results from each study arose solely from interviews conducted with service users. One study conducted interviews with mental health liaison professionals but the results from this did not pertain to the access of physical healthcare so were not included in this study's meta-synthesis. Physical health conditions included bowel problems, bladder problems, tumours, eye problems, urinary problems, short-term and chronic pain, infections and suspected pulmonary embolisms. Participants were recruited *via* social media or through healthcare settings including Clinical Mental Health Teams (CMHT), crisis intervention services, outpatient mental health clinics and acute psychiatric units. Physical healthcare settings included General Practices (GP), general hospitals and nursing care [7].

Table 1: Study characteristics are summarized.

Study	Country and setting	Participant demographics and diagnoses (n)	Analysis	Themes
Nehls	America; Crisis intervention service of a community mental health centre, an outpatient mental health clinic and an acute psychiatric unit	30 economically disadvantaged adult women who were receiving care in public mental healthcare settings Ethnicity not stated Age not stated-implied 18 and above DSM-III-R or DSM-IV criteria for a diagnosis of borderline personality disorder	Interpretive phenomenology and multistage data analysis	One main theme was identified: 'Living with a label'
Campbell	Scotland Four local Clinical Mental Health Teams (CMHT)	11 participants Gender and ethnicity not stated 40 years (range 22-63 years) Diagnosis of borderline personality disorder by psychiatrist	Interpretative phenomenological analysis	Three main themes and four sub-themes related to the experiences of accessing physical healthcare: 'Experience of having a BPD diagnosis' with the sub-themes of 'The perceived role of the diagnosis in being a barrier to help' and 'Ambivalence towards diagnosis'; 'Invalidating experiences' with the sub-theme of 'GP's not interested' and 'Sense of self' with the sub-theme of 'GP response having a negative impact on sense of self'
Sharda	England; Telephone interviews and electronic mail interviews	12 participants with an NHS hospital admission within the last two years 11 participants were female 1 participant was male Ethnicity was not stated Mean age not stated (range: 18-65 years)	Framework analysis	Two main themes were identified: 'Workforce; Knowledge, understanding, skills, and discriminatory practice in the general hospital' and 'Service delivery; missed care and treatment'

	Diagnosis of a personality disorder *via* a clinician or a career of someone meeting the above criteria

Quality appraisal

The use of the CASP and AACODS appraisal tools indicated that the quality of studies were consistently of medium to high quality when assessing each study using the criteria for each tool. All three studies appropriately used qualitative methodology, utilised a suitable research design and presented clear research aims. Appropriate data collection methods were used and clear findings were described in all studies. Each paper provided adequate information to determine the analysis of their data was rigorous and that they had used an appropriate recruitment strategy. Two studies sufficiently described their process of ethical approval and their consent process and adequately considered reflexivity and the possible role that the authors may have played in analysis process but the third study did not. See Tables 2 and 3 in the appendices for full appraisal ratings [8].

Table 2: CASP appraisal of included studies.

CASP statement	Nehls
Was there a clear statement of the aims of the research?	Research aimed to generate knowledge and an understanding of what is unique about living with the diagnosis of borderline personality disorder
Is a qualitative methodology appropriate?	Qualitative methodology was appropriate in order to interpret the unique and subjective experiences of individuals living with a diagnosis of borderline personality disorder
Was the research design appropriate to address the aims of the research?	Explanation of use of interpretive phenomenology with an account of why this method was chosen to address the research aims
Was the recruitment strategy appropriate to the aims of the research?	Targeted diagnosis based selection. No indication of how the number of participants was determined
Was the data collected in a way that addressed the research issue?	Individual, private interviews conducted by author or research associated at an agreed place and time and recorded via audiotape. Interviews began with the same question and were intended to prompt a conversation about the experiences of living with a diagnosis of borderline personality disorder. Interviews were terminated at the point in which participants indicated they had nothing more to share
Has the relationship between researcher and participants been adequately considered?	Author's role and potential bias or influence not acknowledged in report
Have ethical issues been taken into consideration?	Description of informed consent forms but no description of ethical approval or consent process
Was the data analysis sufficiently rigorous?	In depth step-by-step description of the analysis process and discussion of how researchers interpreted texts and developed themes and common meanings
Is there a clear statement of findings?	Presentation of themes and supporting quotations in relation to research aims
How valuable is the research?	Description of how other populations can learn from this research and how it may contribute to new directions in mental health care

Table 3: AACODS appraisal of included studies from a grey literature search.

AACODS checklist	Campbell	Sharda
Authority	Author has professional qualifications and is associated with a reputable organisation. Paper has been cited by others and provides a detailed reference list	Author has professional qualifications and is associated with a reputable organisation. Has since had work published that has been cited by others. Study also provides a detailed reference list
Accuracy	Clearly defined research aim and stated methodology. Aim is met and methodology is adhered to. Peer review of accuracy of initial coding and developed themes. Well supported by documented references	Clearly defined research aims and stated methodology. Aims are met and methodology is adhered to. No indication that paper has been peer reviewed but is well supported by documented references
Coverage	Sample exclusively included participants with a diagnosis of borderline personality confirmed by their psychiatrist. Interviews were carried out in line with an interview schedule which was designed as a guide	Sample had clearly defined inclusion and exclusion criteria and interviews carried out were limited to a specific topic guide
Objectivity	Work extremely balanced with reflexivity considered. Standpoint of author very clear	Work extremely balanced with reflexivity considered. Standpoint of author very clear
Date	Clearly stated date that research was undertaken. Key contemporary material included in reference list	Clearly stated date that research was undertaken. Key contemporary material included in reference list
Significance	Meaningful research which enriches current research in this area	Meaningful research which enriches current research in this area

Meta-synthesis

Four meta-themes were identified with each containing a various number of relevant sub-themes. The meta themes identified included 'General disregard from physical healthcare professionals'; 'Identity and self-perception of personality disorder as a barrier to treatment'; 'Stigma and lack of awareness around personality disorder in healthcare settings' and 'Physical problems viewed through the lens of patients' personality disorder'. Each of the sub-themes is illustrated by apposite participant quotations and is discussed in further detail. There was no discussion of any facilitators to accessing physical healthcare within these findings.

Meta-theme 1: General disregard from physical healthcare professionals

The most common theme that emerged throughout the data related to a general disregard and display of ignorance on behalf of healthcare professionals towards the physical health problems of patients with personality disorders. Individuals with personality disorders commonly described instances in which their physical problems were not taken seriously as well as experiences of being cut-off from speaking when trying to explain their physical problem. These behaviours presented a significant barrier to individuals with personality disorders as they were unable to receive the treatment and care that they felt they needed to overcome their physical problems [9].

Physical problems are disregarded and overlooked: General Practitioner's (GP's) of patients seemed to determine the outcome of their patients referral prior to giving them the necessary time to explain their physical problems and this led patients to feeling underwhelmed with the care in which they received.

"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."

For others with a personality disorder, the disregard did not come at the time of the appointment but rather at a point in time in which patients were under the assumption they had been booked in for a follow-up appointment when this was not the case. Individuals with a personality disorder felt that healthcare professionals had a duty of care towards them and when this was ignored it caused these individuals to feel as though their personality disorder diagnosis had undermined their level of care.

"He had to write to them both again and say, you know, you said this woman needs a follow up appointment, yet you've taken her off the system."

Personality disorder acts as a barrier to a proper medical assessment: Other patients described times in which their personality disorder impeded their right to a proper and thorough medical assessment for the physical problem they displayed. For example, one patient was advised by their GP that

they should wait to see if their problem of hand numbness continued to persist and if it did that they should return to their GP. Patients felt underwhelmed by these types of responses from their GP's as they felt they should be receiving an assessment and potentially treatment for their problem. This provides added concern to the physical health for some of these patients, as it raises the possibility that their physical problems may worsen between the time of their first appointment and their returning visit to their GP if they felt that another appointment was required. This was the case for one individual with a personality disorder who did not have their eye properly examined by their doctor, leading them to have to visit A and E three weeks later [10].

"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."

''He didn't give me any time to talk. He just literally smiled at me patronising, told me that basically I don't really have a problem, that it wasn't really true. It wasn't really an issue, they didn't really need to have done any of this stuff and I don't actually need the drops because I'm completely fine sort of thing (...) Three weeks later this I ended up back in A and E"

Responsibility of GP's is shouldered onto individual's psychiatrist: Individuals with personality disorders also described instances in which they felt their GP's were passing on their physical healthcare responsibilities to psychiatrists who were not qualified to deal with their physical health problems. Those with personality disorders expressed feelings of being perplexed as a result of receiving advice that they should visit their psychiatrists for their physical problems as they knew that their psychiatrists would not be able to provide them with healthcare that was necessary to overcome their physical problems. This prevented one individual with a personality disorders from going to appointments for their smear tests as they expected that their GP would tell them to speak to their psychiatrist [11].

"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?!"

"I've even stopped going for my smears cause I think what will they say, 'Oh just phone your psychiatrist!!'"

Meta-theme 2: Identity and self-perception of personality disorder as a barrier to treatment

Another theme that appeared throughout the studies related to how the individuals identified with the label of a personality disorder and how they thought this effected the perception that healthcare professionals had of them.

Fear and embarrassment about disclosure of personality disorder: Some individuals described the shame and embarrassment they had of their personality diagnosis. This led to a feeling of fearfulness that their healthcare professionals would find out about their personality diagnosis.

"I was too embarrassed to admit my BPD diagnosis, worried if my physical symptoms would be explained away as some sort of attention seeking."

Concerns about being seen as a problem by their GP: Individuals with personality disorders also described their concerns with communicating with their GP and how this prevented them from accessing healthcare for their physical problems. One patient described how they found the experience of a GP appointment overwhelming and this led to them receiving a number of appointment reminders as they did not attend their initial appointment. However, this individual did not provide any information on the reasons they felt they had concerns about being seen as a problem by their GP.

"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".

Meta-theme 3: Stigma and lack of awareness around personality disorder in healthcare settings

The experiences those with personality disorders faced when accessing physical healthcare were also influenced by the enormous stigma that individuals with personality disorders experience within healthcare settings. This was a theme that emerged consistently throughout the data when individuals with personality disorders described their experiences of healthcare for their physical problems. This stigma presented a significant barrier in the access of physical healthcare for those with personality disorders as healthcare professionals were often ill equipped in understanding the psychological and behavioural symptoms of personality disorders and the effect these symptoms may have on their physical health and approach to physical healthcare. These individuals felt that this often led to insufficient levels of physical care.

Lack of understanding around the meaning of personality disorder: One of the issues that were highlighted by those with personality disorders was that healthcare professionals did not seem to be fully informed about the psychological symptoms of personality disorders and so were not fully equipped to deal with the issues that were presented to them. This led to these individuals feeling as though they were not treated equally and with the same attention and care compared to those presenting with similar physical problems but who did not have a diagnosis of a personality disorder.

"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."

Health professionals fail to realise the connection between physical and mental health: More generally, healthcare professionals appeared to lack the necessary education regarding

the relationship between mental and physical health. This was more relevant to those suffering from pain with professionals failing to recognise that pain could often be the cause of mental symptoms such as suicidal thoughts, rather than their personality disorder.

"I was admitted due to severe abdominal pain linked to a urology problem and I have a long term indwelling catheter fitted due to urinary frequency problems. The increased pain was also fuelling my suicidal thoughts."

Distrust and belittlement due to personality disorder diagnosis: Stigmatisation of individuals with personality disorders created the perception that there was a lack of trust on behalf of healthcare professionals towards them. This was displayed though behaviours that individual with personality disorders found condescending and patronising. For example, some patients described having to suddenly be under 24/7 security watch despite stating that they had acted in a peaceful and civil manner throughout the course of their treatment. There were also times in which individuals with personality disorders faced experiences in which nurses put them under close observation to ensure they were not negatively disrupting their blood transfusion process. As a result, patients had the perception that nurses felt justified in making healthcare decisions that denigrated them [12].

"A nurse i've encountered previously did the handover and, seemingly as a result of whatever was said, they refused to put in the cannula until the last minute and put me on one-to-one observations with a staff member while I received treatment, on the basis that they "wanted to guarantee blood was going in, not being taken back out!" This, in spite of having received blood transfusions cooperatively and peacefully twice in preceding weeks, with no such observations."

Meta-theme 4: Physical problems viewed through the lens of patients' personality disorder

Having a diagnosis of a personality disorder meant that patients often felt as though they were seen by healthcare professionals as no more than their personality disorder and their autonomy and individuality was stripped away as a result of this.

Diagnostic overshadowing experienced as a result of personality disorder diagnosis: Patients described instances in which it was evident they were attending appointments for a physical problem, but their doctor continued to make their appointment relevant only in relation to their personality disorder.

"I would like my doctors to be able to understand that I'm there for my eye. That any psychiatric diagnosis I have has literally got nothing to do with it whatsoever."

This diagnostic overshadowing also occurred for serious physical health problems such as suspected pulmonary embolisms. Moreover, the assumption that patients had made their appointment for their personality disorder appeared to arise prior to the patient's arrival [13].

"I said I'm not here because of my mental health, I'm here because of suspected Pulmonary Embolism (PE)."

Pain not taken seriously due to personality disorder diagnosis: Other patients spoke of experiences where despite their overt distress, their healthcare professionals displayed a level of apathy that resulted in barriers to treatment and relief of their pain.

"I was so unhappy and so distressed and so scared and I was in so much pain, you know. Nobody was helping me, they wouldn't give me any pain relief."

Extra justification needed for GP appointment: Similarly, patients described times in which they perceived that it was unjustifiable to have made their appointment solely for the reasons of illness. Those with personality disorders felt that they had to provide exhaustive explanations for why they needed their appointment and the reasons that this required treatment from their GP, which was contrary to the healthcare experience in which they were hoping for.

"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 it's like "and... so?"

DISCUSSION

Main findings

This systematic review explored the experiences of accessing physical healthcare in individuals with personality disorder and the potential barriers and facilitators these individuals might face within these experiences. The experiences of people with personality disorders when accessing healthcare for their physical health was overwhelmingly negative. Many of these individuals described the consistent disregard and diminishment of their physical health problems by healthcare professionals and how this acted as a barrier to acquiring a thorough medical assessment and treatment when necessary. Another barrier faced by individuals when accessing physical healthcare concerned the self-perception these individuals had in relation to their personality disorder diagnosis. This was heavily intertwined with their approach to accessing physical healthcare and this negatively affected the quality of physical healthcare they received. These difficulties with self-identity were compounded by the significant stigma that is associated with personality disorders. This presented another significant barrier to the access of physical healthcare as healthcare professionals often responded flippantly to the physical problems of those with a personality disorder. Another barrier individual with personality disorders faced when accessing physical healthcare related to the diagnostic overshadowing of these individual's physical problems. There was a sense that healthcare professionals were often unable to view the individual throughout a lens that did not involve their personality disorder, despite the effort of patients in keeping their diagnosis irrelevant and separate to their physical health problems. There were no facilitators identified in the three studies included within our meta synthesis [14].

Findings in context of other research

Existing literature has already highlighted the significant barriers that those with serious mental illness face when attempting to access physical healthcare. This study, however, provides a unique picture of what these experiences involve specifically for those with personality disorders. The findings of this study suggest that an amalgamation of factors relating to the self-identity of individuals with personality disorders, the stigma they face and the systemic factors that cause healthcare professionals to overlook these patients, combine to present barriers to physical healthcare that are specific for this population, in comparison to populations with other serious mental illnesses [15].

Previous qualitative studies investigating the experiences of individuals with serious mental illness and the views of their careers and healthcare professionals in relation to accessing physical healthcare have demonstrated that there is often a severe lack of understanding from healthcare professionals regarding the connection between mental and physical health. Evidence has shown that the stigmatization of those with serious mental illness has presented a significant barrier to the accessibility of physical healthcare services for these individuals. Patients with serious mental illness have previously described experiences of being left feeling unheard or having experienced diagnostic overshadowing, with their physical health problems justified solely through the perspective of their mental illness. Each of these themes was also present among the experiences of individuals with personality disorders in the majority of studies included in this meta synthesis [16].

The theme relating to general disregard from healthcare professionals that emerged in this meta-analysis aligns with previous findings which have indicated that those with serious mental illnesses often face disrespect, harsh responses and rude attitudes from healthcare professionals. However, there has been evidence which has indicated that populations that do not suffer from mental health problems also face these experiences. This suggests that this may be a systemic problem that is reflective of healthcare more generally and is not a specific barrier to those suffering from serious mental illness or personality disorders. However, there does appear to be greater overall satisfaction in the general population in relation to their physical healthcare whereas this feeling has not been echoed in individuals with personality disorders [17].

Perhaps the most surprising difference between the findings of this meta synthesis and the findings of previous research was the absence of facilitators identified the access of physical healthcare. Research has shown that having a disability card has elicited sympathy around patients' mental illnesses and this has subsequently facilitated their physical healthcare access. There is also evidence that family support helps those with serious mental illness to gain better access to physical healthcare. However, there was little mention of the role of families or carers within the studies included in this meta-synthesis.

Strengths and limitations of the included papers

A key strength of the meta-synthesis was the quality of the studies included within it. These factors helped in enhancing the validity and utility of the findings. Each of the three studies was of medium to high quality. Two out of three studies addressed issues of reflexivity and the potential roles the authors may have had in the analysis of their findings and each study outlined a rigorous description of their analysis process.

One limitation of the included studies was the overwhelming gender skew towards female participants. This may be because two of the three included studies only involved participants with borderline personality disorder and this type is predominantly diagnosed within women. Future research would benefit from investigating if there are experiences of accessing physical healthcare that are specific to different types of personality disorder, as well as exploring the experiences of men with personality disorders in order to determine if there are potential gender differences in the experiences of accessing physical healthcare in people with personality disorders.

Another limitation of the included studies was that all three studies were conducted in high-income Western countries with relatively homogenous socio-cultural environments. This makes it difficult to generalise the findings of this study to other cultural contexts and infer the experiences of those with personality disorder in lower income and non-western countries. More research is therefore needed to assess if the experiences illustrated in this meta-synthesis arise across a range of cultural and social contexts.

Strengths and limitations of this review

This qualitative meta-synthesis expanded on current research by integrating available primary data to answer a novel research question about the experiences individuals with personality disorders face when accessing physical healthcare. Robust methodology was used to develop this study and inform a search strategy. The pre-registration of this study on PROSPERO allowed for transparency of the research [18].

One limitation of this review was the lack of studies included within the meta-synthesis. As only three studies were included in the meta-synthesis this review may not reflect the true depth or range of the experiences individuals with personality disorders face when accessing physical healthcare. The limited qualitative research relating to the experiences of accessing physical healthcare in individuals with personality disorders highlights that this is an important area for future research.

Another limitation of this review was the lack of Public and Patient Involvement (PPI). A lack of responses from relevant organisations combined with time restraints made such involvement less viable. The interpretation of the study findings and clinical implications would have benefited from a lived experience perspective of individuals with personality disorders. This perspective could have enhanced the research process through prioritising the discussion of the most important findings. This would have helped to improve the clinical utility of this review by ensuring the findings are relevant to the service

users, families and healthcare professionals that would benefit most.

Clinical and policy implications

This study presents important implications for clinicians, researchers, healthcare providers and policymakers and most importantly individuals with personality disorders and their families and careers. To address the stigma and discrimination perpetuated by healthcare professionals, specialist training on personality disorders should be provided. GP's have also reported a lack of confidence in dealing with the psychiatric symptoms those with personality disorders display. Strategies such as ensuring frequent communication between GP's and patients with personality disorders, as well as discussing short-term and long-term goals for their physical health may be useful in facilitating the physical healthcare of people with personality disorders.

Personality disorders symptoms such as self-sabotaging or self-defeating behaviours and impulsivity may also create difficulties in the manner in which those with personality disorders comply with health treatment. This can lead to actions such as forgetting to take medication, not following instructions from doctors and not regularly attending check-ups. Due to the stigmatisation around those with personality disorders on the behalf of healthcare practitioners, these behaviours are often perceived as being intentional and can therefore magnify the negative expectations that healthcare professionals have of this population. This can lead to barriers in the access of necessary healthcare for these individuals through pathways such as under-assessment and a lack of quality treatment in relation to their physical health and the problems that accompany it. It is therefore important that healthcare professionals understand the symptoms that may cause treatment incompliance for those with personality disorders.

Social support groups whereby people with personality disorders are provided peer support by other individuals with similar lived experiences may be beneficial. As support groups were not mentioned within the data of this meta-synthesis, however, the results suggest a need for greater promotion of existing groups and easier access to such groups across a range of social spaces, including online forums. Physical healthcare interventions which incorporate person centered care, continuity of care with the same healthcare professionals and coordination with community resources appear to be promising for those with serious mental illness but data specifically for those with personality disorders is currently limited [19].

Future research

Future research should conduct more qualitative interview studies that investigate the experiences those with personality disorders face when accessing physical healthcare, as there is a significant lack of research pertaining to this research area. More research is needed in countries of low-and middle income to assess if different cultural contexts and healthcare settings with less resources impact this population in ways that differ to the impact faced by those in the studies included in this review. As existing research relates predominantly to individuals with borderline personality, further investigation of the experiences those with other types of personality disorder encounter when accessing physical healthcare, is required. Research is also required in male populations in order to explore if there are any gender differences in the experiences described and this relates further to investigating different types of personality disorder as it has been reported that men present higher rates of antisocial personality disorder, compared to types such as borderline. Marginalized groups should also be considered, especially as these groups experience greater levels of stigma, both in society and within healthcare settings.

The absence of facilitators in accessing physical healthcare within the existing research suggests that future research should attempt to explore the potential of factors that might enhance the access of physical healthcare in this population. This would enable healthcare providers to create strategies that focus on the positives of the experiences faced by those with personality disorders, as this might be more effective in improving their access to physical healthcare in comparison to strategies which focus on removing existing barriers. These findings should also inform the practices of social support services for those with personality disorders. These services have been shown to improve the self-identity and social wellbeing of this population which is relevant to the findings in this review and may provide significant help in times of physical health crises [20].

CONCLUSION

These findings demonstrate the significant distress and difficulties people with personality disorders have relation to accessing healthcare for their physical health conditions. Stigma surrounding personality disorders and the reported instances of diagnostic overshadowing presented significant barriers to the access of physical healthcare in those with personality disorders. There was a great emphasis upon the overall disregard and ignorance healthcare professionals displayed towards this population and this presented the greatest barrier to quality and necessary physical care. These results highlight a need for healthcare policies that prevent those with personality disorders from facing discrimination when accessing health care for their physical health conditions. Future research should determine if there are potential facilitators for accessing physical health care in this population.

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