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The Treatment of Complex Dual Disorders: Clinicians' and Service Users' Perspectives

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Abstract

Introduction: The present study examined how both clinicians and service users experience existing treatments for Dual Disorders (DDs), namely the co-occurrence of a Severe Mental Illness (SMI) and a Substance Use Disorder (SUD). The literature indicates that many individuals with DDs present with an even more complex clinical portrait, which often includes additional pathologies or stressors, such as cluster B personality disorders, Post-traumatic Stress Disorder (PTSD) or trauma history, and depression. Treatment for these individuals is complicated by these mitigating factors and it is not clear whether extant treatments for DDs are successful with this population, and how they could be improved.

Objective: This study aimed to explore the specific issues, successes and difficulties regarding the treatment of complex DDs, according to both clinicians' and service users' perspectives.

Methods: A qualitative design was used in this exploratory study in order to best grasp the complexity of this clinical issue. Thirty clinicians and program directors specialized in the treatment of DDs, and 31 individuals diagnosed with complex DDs participated respectively in three and four focus groups conducted in various settings. Collected data were coded using a mixed open and closed coding procedure.

Results: All participants expressed both positive and negative views on existing treatments. Clinicians and clinical directors expressed various issues, principally: powerlessness, dealing with personality disorders in people with DDs, seeking a common treatment vision, and services issues (notably housing). The main themes emerging in the service users' interviews pertained to exclusion from services, personalised treatment plans, medication, and therapy.

Conclusion: Although creative, personalised treatments were noted, it is clear to all clinicians, clinical directors and service users that existent services are not efficiently equipped for dealing with complex DDs. More integrated treatments, more comprehensive trainings and better access to adapted services would improve treatment outcomes for individuals diagnosed with complex DDs.

Keywords: Cluster B personality disorders; Complex dual disorders; Depression; Dual diagnosis; Focus group; Post-traumatic stress disorder; Psychosis; Severe mental illness; Substance use disorder; Treatment

Introduction

Individuals with a Dual Disorder (DD), namely a Severe Mental Illness (SMI) combined with substance misuse (or Substance Use Disorder (SUD) [1]), present several challenges to clinicians and service providers. For one, although most psychiatric services typically offer mental health and substance misuse treatments apart, close to 50% of individuals with SMI are reported as having a DD [2,3]. In order to offer better treatments to people with DDs, integrated DD services have been developed whereby people with SMI can receive substance misuse treatment and mental health services under the same roof [4]. Unfortunately, these specialized services are still scarce. Second, while mental disorders and alcohol or drug disorders are significantly interrelated, DDs are associated with increased severity and persistence of both disorders [5]. Among the negative consequences of having a DD, we find higher rates of treatment non-compliance (including medication non-adherence), higher relapse rates, more severe psychotic symptoms, important cognitive deficits, depression and suicidal ideation, social withdrawal and alienation, housing instability or even homelessness, poor money management, increased risk for violence or being victimized, highest costs of care, as well as several physical ailments such as higher risks for hepatitis, HIV, heart, liver and gastrointestinal diseases [6,7]. Furthermore, even when evidence-based treatments in psychiatric rehabilitation are offered, such as cognitive remediation treatments and supported employment services, people with DDs show lower success rates [8].

Why should treating individuals with DDs be such a challenge? Recent studies suggest that in fact people with DDs might have much more complex clinical presentations than initially thought. For instance, a recent meta-analysis mentions that close to 70% of people with SMI have also experienced severe childhood trauma [9]. Consistently, studies report higher rates of Post-traumatic Stress Disorder (PTSD) in individuals with substance abuse as well as in individuals with SMIs, compared to the general population [10,11].

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Additionally, traumatic events are also frequently reported in individuals with Cluster B personality disorders - 60 to 83% of adults diagnosed with borderline personality disorder report childhood abuse [12]. According to Wickett et al. [13], 59% of the individuals in their study with schizophrenia or schizoaffective disorder presented with clinically significant Cluster B traits (histrionic, antisocial, borderline and narcissistic) and 24% endorsed items corresponding to a Cluster B personality disorder. Lysaker et al. [14] found that 40% of individuals with schizophrenia in their sample also likely had a borderline personality disorder, which is linked to having higher risk of abusing substances [15]. Furthermore, antisocial personality disorder is also quite prevalent in individuals with SMIs– averaging 22% [16], and is associated with substance abuse, housing instability, violence and trouble with the law [17]. Noteworthy, DDs with borderline and antisocial personality traits are linked to childhood trauma, the former with sexual abuse and the latter with physical abuse [14]. Lecomte et al. [18] also found that people with persistent psychotic symptoms and methamphetamine misuse had high rates of trauma (91%, n=259), with 49% (n=139) of the sample meeting criteria for PTSD, as well as high rates of antisocial personality disorder (68%, n=152).

Besides personality disorders and PTSD, depressive symptoms are also quite common in individuals with DDs. Kamali et al. [19] found that individuals with DDs who were hospitalized following a psychotic relapse reported significantly more suicidal ideation than past or non-substance users with psychosis. In a recent study by Lecomte et al. [20] of individuals with psychosis and methamphetamine abuse, 43% (n=96) of the sample presented with persistent and severe depressive symptoms, predicted in part by their substance misuse as well as by trauma history. This study also revealed that psychotic and depressive symptoms were quite interrelated in individuals with DD linked to methamphetamine misuse [20].

In this context, we define complex DDs as concomitant diagnoses of SMI (i. e. a psychotic disorder such as schizophrenia, schizo-affective disorder, etc.; or a mood disorder with psychotic features) and substance abuse, in addition to co-occuring personality disorders, as well as other comorbidities, such as depression, PTSD, anxiety, eating disorders, etc. Although the SMI and SUD must co-occur for the complex DD to be given, either the SMI or the SUD may have appeared first, and there is no time limit within which the second diagnosis must have appeared after the first one. Furthermore, we postulate that the observed shortcomings of DDs' treatments might be explained in part by the frequent presence of additional pathologies, which are typically not taken into consideration when developing or applying DDs treatments and case management protocols. These clusters of various psychopathologies reported in numerous studies suggest that, for individuals with complex DDs, current services focusing solely on psychotic symptoms and/or on substance misuse might only be partly helpful, as other co-occurring pathologies might make otherwise efficient therapeutic tools ineffective, as they are left untreated. Literature on the specific topic of complex DDs being scarce, little is known about what is actually happening in clinical settings dealing with these individuals. Investigating how people with such complex DDs, and clinicians working with them, both experience existing DDs treatments, from their respective perspectives, would foster insight into the development of more adaptive treatments. These experienced clinicians might have identified particular issues, dos and don'ts and other practical considerations, as well as perceptions of what is missing in currently applied treatment strategies and of what works best when treating service users diagnosed with complex DDs. Additionally, service users can from their perspective share which treatment experiences they felt made a difference, their perceived misses or unaddressed issues, how they feel treatments should be implemented in order to be more efficient, and so forth. Given the complexity regarding the treatment of service users with complex DDs, such information is needed prior to considering changing or offering novel services for this clientele. Given its potential to help clinicians develop novel services for people diagnosed with complex DDs, this study might bring on multiple clinical benefits such as improvement of psychotic symptoms management, treatment compliance, social inclusion, physical health, development of various protective factors, to name a few.

Objective

The purpose of the present study was to increase our understanding of: (a) specific issues, difficulties, and successes met by clinicians and program directors when dealing with individuals with complex DDs, and (b) specific issues, difficulties, and successes in treatment met by individuals with complex DDs. We wished to develop clinically useful data in order to foster the development of novel or modified interventions for this service user group. In order to do so, we oriented our exploration in two main directions: successes and difficulties in treatment. More specific themes, such as housing issues or difficulties within the treatment team, emerged naturally and were not initial targets of the investigator.

Methodology

This is a qualitative study using a mixed approach based on focus group interviews. A qualitative design was used to best capture the complexity of the phenomenon at study. Two sets of respectively three and four focus groups each were conducted: a first set with mental health professionals (i.e. clinicians and program directors) specialized in providing treatment and care to individuals diagnosed with DDs (set 1), and a second set with individuals diagnosed with complex DDs (set 2). This strategy allowed the exploration of subjective experiences, perceptions and understandings of the various stakeholders.

Participants

All participants, both the clinicians and the individuals diagnosed with a complex DDs, were recruited from four outpatient or inpatient programs specializing in treating individuals with DDs in the East and Central regions of Montreal, Canada. These specialized programs are affiliated, or collaborating, with the Montreal University Hospital Network (i. e. CHUM) or the Montreal University Institute of Mental Health (IUSMM). Two of these programs are specialized in early and intensive care following a first psychotic episode and 56% of their users are reported as having a dual diagnosis. The two other programs are integrated DD programs for individuals with a dual diagnosis exclusively. Recruitment for clinicians and service users was conducted over a period of six months, using a convenient sampling strategy in both groups. Approvals by concerned hospital research ethics boards were obtained prior to recruitment, and all participants provided written informed consent to participate in the present study. Participants receiving services were provided a CAD$30 stipend for their participation, whereas mental health professionals were offered lunch during the focus group sessions, but no stipend.

Mental Health Professional Participants

Thirty clinicians and program directors specialized in the treatment and management of individuals with DDs participated in the first set of focus groups, which consisted of three focus groups (one per site) bringing together 11, six, and 13 professionals each. The clinician groups either included all the clinicians within a setting specialized in DDs or clinicians who had a high rate of individuals with DDs within their caseload. The program directors were contacted directly by the principal researcher (TL), who then mentioned the study within their clinical teams. As recommended by Morgan [21] and Kitzinger [22], the sampling did not consist of strangers but rather of colleagues working together, therefore one focus group per participating clinical setting was formed. An effort was made in order to gather everyone with experience with DDs in a given setting to participate. As a result, clinicians knew one another, and a hierarchy was likely present between some of them as they hold different roles within their team. Although the presence of a hierarchy might have somehow influenced the spontaneity of self-disclosure amongst some members of the focus groups, benefits from interviewing colleagues from a same team were estimated to be greater, as the inherent dynamic brought in by a team is expected to enrich narratives production greatly. Furthermore, the program director in each team was scarcely available for the entire focus group, enabling some clinicians to speak more freely during part of the group if they felt restrained by the director's presence. Across these three focus groups, the clinicians' sample included psychiatrists (n=8), psychologists (n=3), psychiatric nurses (n=5), occupational therapists (n=7), social workers (n=5), as well as one psycho-educator and one special-needs worker. All professions but the last two were represented in each focus group, except for psychologists who were only present in two focus groups. Participants' mean age was 40 years old (range: 25-63; median=39. 50; SD=10. 50) and 73% were women. On average, clinicians had worked with individuals with DDs for nine years (range: 1-30; median=7. 00; SD=8. 00). Professionals with less than six months of experience working with individuals with DDs were not eligible to participate.

Clinical participants with complex DDs

Fifty individuals diagnosed with a complex DD and receiving treatment in one of the aforementioned settings were referred by their psychiatrists. Psychiatrists were given flyers to hand out to participants who presented with a DD as well as one, or more, significant psychiatric problem, such as trauma history (or PTSD), personality disorder, depressive disorder, or anxiety disorder. Participants also needed to be verbal, i. e. able to express themselves in a small group of individuals. Only individuals who met our inclusion criteria (i.e. (1) being diagnosed by their psychiatrist as presenting with a complex DD, (2) being treated by a referring psychiatrist and a clinical team, (3) receiving treatment in one of the aforementioned settings, (4) being sufficiently verbal to participate in a small group discussion, and (5) being able to give informed consent), and who were interested in participating, were approached by our research co-ordinator over the phone (who explained the study in detail). Thirty-one service users accepted to participate in one of the seven focus groups (one or two per setting), consisting of two to six participants per group. Since we expected differences in the issues raised by participants, they were assigned to a specific group based on their age, gender, type of drug of abuse, and affiliation to the referring clinical programs. Although this sampling was not done randomly but purposively [23], we believed this strategy enhanced the quality of our qualitative data, by generating discussions and fostering self-disclosure amongst participants sharing sensitive material.

Clinical participants' ages ranged from 19 to 59 years old (mean age: 33 years; S. D.= 10.8) and 84% were males (n=26). They were all fluent in French. Ninety-four percent (n=29) reported being Canadian citizens, and half were Caucasians. Ninety percent (n=28) reported being single, divorced or separated. Forty percent (n=12) of participants had not completed their secondary education, 43% (n=13) had finished it but had not attended University, 13% (n=4) had completed some University and 3% (n=1) had graduated (one did not answer). Sixteen percent (n=5) were currently employed, 19% (n=6) were students, and 84% (n=26) reported receiving some financial support from the government.

Clinical participants were all diagnosed with (a) a psychotic disorder, (b) SUD – current (58%) (n=18), or in early or sustained remission (42%) (n=13), and (c) current PTSD (or a history of severe childhood trauma), and/or a cluster B personality disorder, and/or depressive or anxiety disorder. These diagnoses were established by their treating psychiatrists. All clinical participants were being prescribed psychotropic medications: 100% were prescribed antipsychotics and 42% (n=13) a mood stabilizer and/or an antidepressant as well. Drugs of abuse were identified by self-reports and information provided by psychiatrists. Cannabis, alcohol, amphetamines, and cocaine were respectively used by 90% (n=28), 68% (n=21), 48% (n=15), and 32% (n=10) of clinical participants. None were addicted to opioids, and 3% (n=1) reported having used LSD and mescaline. Forty-seven percent (n=14) of the sample was using three or more illegal drugs.

Procedure

Standard focus group principles were adhered to ensure the collection of valid and reliable data [24-26]. The same moderator (TL) conducted all focus groups, accompanied by an assistant moderator present to take notes. The moderator used a topic guide to ensure consistency in covered themes, and she systematically addressed the issue of confidentiality right at the beginning of each focus group. Groups lasted two hours each and were digitally audio-recorded and later transcribed verbatim into written texts using the moderator's assistant's notes in order to attribute each statement to the correct participant. One participant refused to be recorded and the assistant's notes were transcribed instead.

Analysis

The data analysis process was similar across all focus groups. After several in-depth readings of the transcripts in addition to listening to the audio records and checking the transcripts' quality, an open coding procedure was applied. Segments were coded within each focus group sets' data, allowing for participants' personal experiences to come into view in an exploratory manner. Next, emerging themes were organized, grouped together for analysis, and combined with concepts from the literature to develop (respectively by PT, and by PT and AL) a coding tree for each set of focus groups. These coding trees guided further analyses of the data emerging from participants' experience, and were conducted by the first author (PT). Combined, these open and closed procedures participated to best capture the expression of the experience of treatment of both individuals with a complex DD and clinicians. A similar method was used in a study by Thérien, Tranulis, Lecomte and Bérubé [27]with a related population but using individual interviews. The qualitative data analysis software QDA Miner 4.0.11. was used for computer assistance throughout this process. Set 1's codings were compared for agreements. Twenty percent of this material was randomly selected and independently scored by a trained rater (AL), with an agreement rate of 81%. Consensual agreements were achieved on the remaining discordant scores. Set 2's transcripts were coded by two trained raters who reached consensual agreement on all codes before the results' interpretation.

Results

Clinicians' perspective on treating people with complex DDs

Various themes emerged with clinicians and clinical directors, mostly pertaining to powerlessness, dealing with personality disorders in people with DD, seeking a common treatment vision, and services issues.

Powerlessness

Clinicians described how powerless they often felt when working with this clientele, and believed that this feeling could be perceived by their clients. Clinicians explained that hard-won progress on symptoms was easily lost. One clinician suggested that they could accomplish work with clients between the 15th and the end of the month, but once the 1st of the month rolled around (and the clients received their benefits checks), all the work they had done went out the window and clients would abuse substances again. Some reported imposing rules and even money management regarding concrete things (e. g. lodging, food) in order for the clients to develop some insight into their behavior: "It pissed me off, but at the same time, it's nice having something to eat at the end of the month". Sometimes tolerating the client reaching the bottom of the barrel and using legal tools were considered to be essential by some clinicians, despite the initial negative consequences on the therapeutic alliance. Clinicians felt that being the tenth or eleventh person to work with a person, they were most likely repeating interventions that had already failed in the past (and clients were quick to point this out). Many clients in their caseloads had such complex problems that they sought help, while boycotting the treatment at the same time, creating feelings of incompetency and of powerlessness in their clinicians. Some clinicians mentioned that reminding themselves of their desire to help, and ideally getting more relevant training, could help them. One clinician suggested that it was difficult for clients to accept their empathy, commenting that since clinicians had always had a roof over their heads and enough to eat, they could not truly understand their experience. She suggested that peer helpers might be helpful to deal with this issue.

Dealing with individuals with personality disorders and DD

Many clinicians mentioned difficulties in treating people with a personality disorder as well as a DD, in part because of contradictory treatment recommendations. For instance, they felt the treatment of choice for personality disorders is enabling individuals to suffer the consequences of their actions but for people with psychosis, they believed they needed to protect them from the consequences of their actions, given their lack of insight. Sticking to a treatment plan with a proper balance between responsibility and structure, at all costs, was perceived to be the best way to deal with this clientele. As such, the proposed treatment evolved over time to best meet the needs of the client at any given moment of their recovery. Manipulation was a common complaint: clinicians described how some individuals would "use" their comorbid condition to avoid taking responsibility for their actions and investing in treatment. For example, a client would say "I have a psychiatric disorder, it's not my fault" in order to get out of taking responsibility for his decisions. Taking a step back and laughing about it was proposed by clinicians as the best medicine in order to not take clients sabotaging their treatments too personally.

Others mentioned needing to find a 'spark' in order to motivate these difficult clients. Giving the client the space necessary in order to develop this 'spark' was considered difficult due to the negative consequences of some of their actions, but was deemed essential seeing as some clients had been consuming substances and in psychosis for so long that their only point of reference was obsolete. One clinician mentioned asking what a client had liked to do before he started using street drugs: "I used to play with a ball in the park with my friends". Otherwise, clients didn't see the interest in working on clinicians' priorities: "A client who was constantly in toxic psychosis because he was using cocaine, but he didn't want to work on his substance abuse, he wanted to get a job."

Common vision

During the interviews, it was clear that clinicians held different visions regarding the treatment of individuals with complex DDs. Some favoured the slow emergence of insight, whereas others had more directive and structured approaches to treatment. Similarly, clinicians could not agree on which diagnosis to prioritise or which treatment approach to favour. Not having a consensus within the team regarding the best treatment for a given client created feelings of isolation, with the clinicians not feeling they could rely on the other team members for support. Teams, particularly integrated DD teams, with flexible guidelines applicable to most of their clients felt more confident. Examples of good teamwork, with a common vision, were given with positive results, even in complex cases.

Services

Clinicians mentioned living a constant struggle with external services, particularly housing services. Although DD services exist, no DD housing services per se are available. Clients are either accepted if they no longer use or if they no longer present with psychotic symptoms, and in both cases can lose their housing resource if they relapse. Individuals with personality disorders as well as DD are notorious for 'burning bridges' making their housing options even more difficult.

Getting resources to accept clients with their complexities is a challenge. For example, one resource wanted to kick out a resident because he wasn't "interacting with others" and was always listening to music on his iPod, as described by his clinician: "He's on his iPod because he's hallucinating. You don't understand, he's been on the street and coked up for 15 years, so just the fact that he's in an apartment and sober is a huge step. If he loses his apartment…"

Most clinicians agreed that dealing with housing resources was extremely energy consuming for them, and that as much as they wished to offer stability and structure to their clients, the current housing system ships them from one place to the next. As one clinician mentioned, the challenges in working directly with individuals with complex DDs are present but expected; whereas the housing system should offer support, not hurdles, making the situation even more frustrating.

Individuals with complex DDs' perspective on treatment

Participants had various views on their experience of treatment. Although many took the opportunity to voice their dissatisfaction regarding certain aspects of their treatment, both positive and negative aspects were discussed. The main themes that emerged pertained to exclusion from services, personalised treatment plans, medication, and therapy.

Exclusion

Participants mentioned different occasions where they had been excluded from services because they didn't meet treatment criteria, usually due to substance abuse. Most commonly mentioned were being kicked out of supervised apartments for consuming drugs or being refused at the emergency room because they were intoxicated. Others mentioned being excluded due to their multiple diagnoses. These exclusions led participants to prematurely terminate treatment and contributed to a "swinging door" use of services, as described by one participant:

". . . I've always been someone who tried to deal with things and be independent on my own. So accepting, maybe it's misplaced pride, but accepting that you need help, and going to get it, it's not necessarily the easiest thing. And there's also the fact that you tell yourself: 'Ok, fine, I need help, it's fine, I accept it, but where do you start?'So you tell yourself: 'Ok, I'll go knock on that door'; 'Nope, we can't do anything for you, you have to go there', but then they tell you 'No, you were misinformed; you're not supposed to come here'. So, after a while, you tell yourself: 'It's fine, I'll just go back to doing what I've always done and I'll figure it out on my own'".

Personalised treatment plans

Personalised treatment plans were greatly appreciated by those who received them, and were perceived as innovative in their flexibility and acceptance of their specific problems. One participant gave the example that his budget included expenses linked to street drug purchases. The fact that his clinician, while encouraging him to reduce consumption, accepted that he would use drugs during his recovery, increased his optimism given that his treatment plan felt realistic to him. Individualised treatment plans were also perceived as beneficial when addressing other problems or emotional issues.

On the other hand, non-personalized treatments, such as hospitalisations (often due to an increase in psychotic symptoms, very often substance-misuse related), were experienced as prison sentences where their individuality was not respected. Many described planning on abusing drugs as soon as they would leave the hospital, with some even managing to obtain street drugs while hospitalised.

Participants mentioned being aware of a lack of specialised services for people with a plethora of difficulties and diagnoses. Some participants found that the treatment of only one of their problems at a time was inefficient because of the mutual influence between their problems. For example, one participant mentioned "They help me with my psychosis […], they help me with my substance abuse […], but no one has ever helped me with my anorexia, and keeping thin is what got me using drugs in the first place!" Other participants found that the various interventions they received from different services were disconnected and often redundant.

Medication and psychotherapy

Medication and psychotherapy were 'hot' topics with strong dichotomous opinions being voiced either for or against medication, and similarly for or against psychotherapy. Although most 'pro-medication' participants were against psychotherapy, and vice-versa, group effects could be found with opinions changing during the interview. Of importance, even those in favour of a specific treatment, either medication or psychotherapy, felt that improvements could be made in improving the efficacy of that same treatment.

Discussion and Conclusion

The current study aimed at expanding our knowledge regarding the treatment experience of people with complex DDs from both the perspective of the service users and of their clinicians. Just as reported in the recent qualitative study by Thérien et al. [27] pertaining to the treatment perceptions of people with concurrent borderline personality and psychotic disorders, participants and clinicians in the present study also reported positive as well as negative accounts of their treatment experiences. The most salient negative aspect of treatment mentioned by both clinicians and individuals receiving services was the one linked with housing services problems. In fact, although many treatment settings either adopt or aim at adopting an integrated DD service model, housing services often still exclude individuals for presenting with either psychiatric symptoms or substance misuse. Housing is a basic need, as well as an important aspect of recovery, enabling someone to integrate the community [28]. In fact, Health Canada recently funded a large multi-site randomized controlled trial called 'Housing First' to determine the efficacy and the cost-effectiveness of a specialized supported housing service for homeless people with SMI (and often also with substance misuse problems) [29]. Although the results are not yet published, this initiative underlines the importance of offering specialized housing services to people with complex DDs in order to avoid homelessness, victimization and help people in their path to recovery.

Among the positive aspects of treatment received, participants spoke highly of personalized treatment plans that held realistic goals. Personalized treatment plans are central to the recovery of people with DD in that they are based on an agreement between the service user and the clinician regarding the goals to achieve and the best means to reach them. In this study, it became evident that only some of the participants, namely those receiving services in an integrated DD clinic or in a specialized first episode program, had such treatment plans. The same participants also appeared to have a more integrated view of treatment, perceiving the advantages of both medical and psychological treatment, whereas those who did not have such a personalized plan had more dichotomous views (i. e. all good or all bad) of those treatment modalities. Furthermore, a well-conceived personalized treatment plan could consider emotional issues and complexities, as well as substance misuse and psychiatric symptoms – the absence of such a comprehensive treatment plan was a complaint voiced by many participants who felt that only psychosis or substance misuse were being targeted.

Looking at the clinicians' responses, the paucity of more comprehensive personalized treatment plans could be linked to feelings of powerlessness, of incompetence and the many difficulties voiced, especially when working with service users presenting personality problems (such as Cluster B disorders). Although some clinicians clearly had extensive knowledge and effective tools pertaining to working with complex DDs, others mentioned lacking appropriate training and expressed more self-doubt, and feeling powerless when they could not perceive progress in their clients. Clients' self-defeating behaviors, boycotting treatment, and manipulative tendencies were mentioned as most difficult to deal with for many clinicians. In fact, such Cluster B behaviors often create resentment and rejection from clinicians, instead of compassion and understanding. Sakheim et al. [30] even describe a 'compassion deficit disorder' found in clinicians working with people with borderline personality disorders, and strongly encourage clinicians to keep in mind the important traumas their clients have experienced and the often inadequate coping strategies that they have developed to survive. Given the high rate of trauma exposure in people with DDs [31,18], integrated DD treatments that include third wave strategies such as compassion, acceptance, and mindfulness should be considered. In fact, their efficacy has been demonstrated in improving emotion regulation in people with various mental health problems, including psychosis [32] and personality disorders [33].

This study has some limitations. For one, the use of focus groups limited inclusion to people who were able to speak in a group and also could create group effects, as was seen regarding the discussion on medication and psychotherapy. It is possible that the results would have differed with participants met individually. Second, the material was also influenced by the setting, such that participants currently hospitalized were more likely to complain about hospitalization than those receiving outpatient services. As for clinicians, the presence of the clinic directors might have slightly hampered the discussions for those concerned about their superior's evaluation of them. However, given that we reached a certain level of saturation in both sets, i. e. no new information was emerging from the interviews [23], we are fairly confident that the information presented here portrays the experience of treatment of people with complex DDs and of their clinicians. What is more, triangulation is an important component in determining the quality of a qualitative design [34]. In the present study, we triangulated information from clinicians, individuals with complex DDs and the literature with concordant results. To our knowledge, this is one of the few studies addressing treatment experiences from both the service users with DDs and their clinicians.

Although creative, personalised and successful treatments were noted, and although collaborations between services can be effective at times, it is clear to all clinicians, clinical directors and service users that extant services are not efficiently equipped for dealing with complex DDs and that important challenges remain present. More integrated treatments, more comprehensive trainings, and better access to adapted services would improve treatment outcomes for individuals with complex DDs. Given the complexity of the clinical presentation of these individuals, a multi-modal, interdisciplinary, integrated treatment that evaluates and takes into account the personalised and changing needs of these individuals is recommended. Noteworthy, peer helpers may improve the face-value of these treatments to service users. In this context, it would be pertinent to develop novel collaborative treatment approaches that take into account the perspectives of both expert service users [35] and experienced clinicians. Furthermore, collaborative trainings between specialised services would allow the integration of various and complementary expertise, stemming from diverse and relevant contexts. For example, presentations, supervision and consultation between a DDs treatment settings and personality disorder clinics could offer great benefits. More formal training of clinicians was mentioned by clinicians and could improve consistency and cohesion in treatment teams, which in turn may protect clinicians from burnout risks, and clinical teams from high turnover rate. Finally, funding for specialised housing services catering to service users with DDs that would avoid excluding residents when they have a relapse would help reduce the traumatic impact of forced transitions [27] and therefore, among other things, contribute to protect the therapeutic alliance between service users and service providers.

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