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MA Hons

EXPLORING MENTALIZATION-BASED PSYCHOEDUCATION GROUPS FOR PEOPLE WITH BORDERLINE PERSONALITY DISORDER

Section A: Mentalization-Based Therapy for borderline personality disorder: A review of the wider literature
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Acknowledgements

Summary of Major Research Project

Section A

Section A examines Mentalization-Based therapy interventions for adults with Borderline Personality Disorder. A systematic review of the available literature was completed, aiming to describe, synthesise and critique evidence from a wider range of settings and contexts than previously evaluated. Studies are chronologically summarised and critiqued to enable an appraisal of the current state of the evidence base. Results indicate positive outcomes for MBT, although inconsistency in its superiority to other treatments. Additionally, experiences of MBT are nuanced, and can be viewed as enabling positive outcomes but a challenging process. Further research and clinical implications are explored.

Section B

Section B explores lived experiences of a Mentalization-Based Psychoeducation group for adults with Borderline Personality Disorder in secondary-care services. An Interpretative Phenomenological Analysis approach explored eight individual experiences of this group. A general sense of a challenging but beneficial journey emerged, with three main themes relating attempts to navigate the group structure, process and impact in terms of increased awareness. Themes included '*managing complex group processes*', 'personalizing *knowledge*' and 'increased *understanding: the power and fear*'. Several impacts on core difficulties are noted, but some desire for more coping skills. Findings are discussed in relation to existing evidence and theories of Mentalization, Borderline Personality Disorder and psychoeducation. Research and clinical implications are outlined, with particular importance given to some individuals' desire for additional support or coping, and the view of benefits in context of further Mentalization-Based Therapy. The findings may support propositions that Mentalization-Based Psychoeducation groups provide a useful mechanism to promote mentalizing.

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Section A

Cerys Bradley-Scott MA (Hons)

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Abstract

Borderline personality disorder (BPD) is a complex, distressing disorder prevalent across healthcare settings. Although historical notions of BPD as untreatable have been dismissed, stigma and difficulties accessing mental health services remain. Mentalization-based therapy (MBT) is one of several psychotherapies demonstrating some effectiveness in treating this disorder. It conceptualises mentalizing deficits as central to BPD symptoms, and focuses on enhancing mentalizing skills in order to address core difficulties. Although MBT has the second best established evidence-base for BPD (Stoffers et al., 2012), previous systematic reviews have exclusively relied on two Randomized Control Trials. A recent descriptive review (Bateman & Fonagy, 2016) attempts to summarize the wider literature for MBT, but neglects critical synthesis of the evidence and possibility of researcher bias. This review attempts to bridge this gap, by systematically evaluating the wider literature for MBT for adults with BPD. A systematic search identified thirteen relevant studies; including two randomized control trials, two controlled trials, three uncontrolled trials, one naturalistic longitudinal study, three maintenance studies and two qualitative studies. Although there were some inconsistencies in findings, overall studies demonstrated positive outcomes for key variables associated with BPD. Qualitative studies support these outcomes, but highlight MBT can be experienced as challenging and unpredictable, and as beneficial but not sufficient for full recovery. Additionally, quantitative results do not consistently demonstrate MBT's superiority to other, less intensive interventions. Several strengths and limitations of the literature are summarized, and implications for both clinical and research areas considered. These include the need for more qualitative studies to explore experiences, individual differences, different modalities of MBT and the processes involved.

Keywords: Borderline Personality Disorder, Mentalization-based Therapy

Introduction

Borderline Personality Disorder (BPD)

BPD is a complex and distressing disorder that significantly impairs wellbeing, functioning and quality of life (Paris, 2009). Although highly heterogeneous, the diagnosis is characterised by pervasive patterns of instability in mood, relationships and self-image, alongside marked impulsivity, comorbidity, suicidal behaviours and self-harm (DSM-5; American Psychiatric Association, 2013). Consequently, BPD is associated with elevated health-care use (Bateman & Fonagy, 2009). BPD and other personality disorders are highly prevalent within UK secondary-care populations, with recent estimates of between 40 and 92% (Beckwith, Moran & Riley, 2014).

Historically, BPD was a diagnosis of exclusion due to misconceptions that it was unresponsive to psychological treatment (Zanarini, Frankenburg, Hennen & Silk, 2003). Access has improved since BPD's inclusion in mental health remits, yet this group continues to face stigma, prejudice and difficulties obtaining services (Department of Health, 2003). In addition, individuals with BPD have pronounced difficulties engaging therapeutically with services. Barriers include problems with regulating interpersonal experiences, attachment, impulsivity and anxiety, as well as committing to treatment (Clarkin & Kernberg, 2015). Clinical presentations are often characterised by recurrent patterns of crisis presentation and subsequent disengagement from services (Hörz, Zanarini, Frankenburg, Reich & Fitzmaurice, 2010).

Several psychotherapies demonstrate some efficacy for BPD, including Mentalization- Based Therapy, Dialectical Behaviour Therapy (DBT), Schema Therapy and Transference-focused psychotherapy, but all require further research (Stoffers et al., 2012). While intervention has shown some remission over time, continued experiences of

symptoms, impaired functioning and distress are common (Hoffman, 2002; Zanarini et al., 2003). Recent NICE guidelines (CG78, 2009) for BPD recommend access to a range of mental health services, including long-term psychological therapies for symptomology and pharmacology for comorbidities. Brief psychological interventions are not recommended, and there is an emphasis on developing trusting relationships and managing the emotive nature of transitions and endings. No specific therapeutic modality is prioritised, with the exception of DBT if self-harm is an immediate treatment priority. Providing information and choice about treatments, and a coherent, explicit theoretical approach are deemed essential.

Mentalization

'Mentalization' is the capacity to recognize internal mental states and psychological processes. It enables individuals to effectively manage their world through understanding and predicting their own and others' thoughts, feelings and behaviours (Fonagy & Target, 1997). This skill is necessary to distinguish between inner worlds and outer reality. It is vital for interpersonal relationships, and is suppressed with heightened emotions. Mentalization begins in the context of healthy early attachments, with parental attunement enabling the gradual development of a robust understanding of mental states of ourselves and others (Fonagy, 2004). For those genetically predisposed, insecure attachments or early trauma may hinder this ability to reason about mental states, due to inconsistency or threat from attachment figures. Subsequently, the capacity to form a coherent sense of self and others is impaired. Contemporary ideas of mentalizing also include 'epistemic mistrust'. This is a disturbance in reasoning with new social information, if previous experiences of social learning cues were damaging or misleading (Bateman & Fonagy, 2016).

Mentalization framework of BPD

Mentalizing is a multi-dimensional ability involving four poles of processing (automatic ←→ controlled; self ←→ other; internal ←→ external; cognitive ←→ affective). In BPD, hypersensitivity to attachment issues and associated emotional arousal can inhibit flexible mentalizing along these poles. At these times, mentalizing errors emerge which affect individual appraisals of subjectivity and mental states, and underpin the three core symptoms of BPD (Fonagy & Luyten, 2009). For example, emotional dysregulation involves the affective and automatic mentalizing poles, where the individual's understanding is dominated by stress reactions rather controlled reflection. This imbalance relates to the mentalizing error of psychic equivalence, where internal worlds are equated with external reality (e.g. flashbacks, concrete thought). Thus, emotions can feel overwhelming and alternative perspectives unreachable. Impulsivity also relates to the automatic pole, and an inability to self-reflect or connect to reality. It is characterised by the teleological mode, where internal states can only be understood through concrete external aspects (e.g. self-harm) and the pretend mode, where internal states are completely detached from external reality (e.g. intellectualising or dissociation). Social dysfunction is highly affected by attachment difficulties, and mentalizing limited to the external, other and automatic poles. Along with attachment hypervigilance, these imbalances disrupt social functioning in several ways, including an over-reliance on assumptions or external indicators of mental states (e.g. concrete expressions of care) and difficulties independently interpreting internal states (Bateman & Fonagy, 2016).

Mentalization-Based Therapy (MBT)

MBT incorporates ideas from attachment, psychoanalytic and cognitive theories (Bateman & Fonagy, 2004). It aims to enhance the ability to reason with mental states and, in doing so, affect underlying BPD difficulties. MBT interventions foster mentalizing within a secure therapeutic relationship, focusing on experiences in the moment, and process, rather than content, of thought. Permissive of a variety of therapeutic techniques, it requires a 'not knowing' clinician stance of active curiosity and empathic validation. There are different modalities of MBT, with the classic structure involving 18 months of therapy divided into an initial phase of engaging the client (which may include psychoeducation), followed by combined individual and group MBT, and final phase preparing for endings. Psychoeducation in MBT involves providing information about BPD, MBT and related topics alongside promoting mentalizing experientially in sessions and establishing a therapeutic relationship. Several manuals for implementing MBT across settings have developed in an attempt to provide structure and consistency (Bateman & Fonagy, 2012).

Research Challenges

NICE guidance (2009) recommends investigating the efficacy of BPD treatments through randomized-control trials (RCTs) of medium-term outcomes and cost-effectiveness, with specific attention to training and supervision. However, research with BPD populations faces a number of challenges. The clinical engagement difficulties outlined earlier contribute to high dropout, and those who participate in research may be less representative of the population (Paris, 2009). Rates of spontaneous remission demonstrated in BPD (Zanarini et al., 2003), along with overlaps of comorbidity of presentations (Ali & Findlay, 2016), are likely to pose challenges in differentiating effects. Given that rapidly changing symptoms

may obscure baselines and managing endings is a common difficulty in BPD, pre/post measurement of outcomes may also be problematic. MBT might face additional research challenges, because a therapeutic focus on process factors may be akin to contextual approaches rather than the component analysis of the medical model of illness (Messer & Wampold, 2002). Additionally, MBT holds the idea of mentalizing as common to all effective approaches (Allen & Fonagy, 2006) but has yet to establish this is the case.

Previous Reviews

MBT has an active and ongoing research presence. Recent systematic investigations of psychotherapy for BPD conclude that MBT has the second best established evidence base for BPD (Nelson et al., 2014; Stoffers et al., 2012). These studies indicate positive effects for MBT on suicide, parasuicidal behaviours, interpersonal problems and depression, as well as general psychopathology and overall functioning. Yet these reviews focus entirely on two RCTs (Bateman & Fonagy 1999; 2009). Recognising the need to synthesise findings from the growing clinically-oriented literature, a recent review by Bateman and Fonagy (2016) outlined 14 studies of MBT (10 initial studies with 4 follow-ups) across a variety of contexts and experimental designs. Although these show some inconsistency in significance of outcomes, they predominantly demonstrate positive impacts. While this review includes some acknowledgements of study limitations, it does not consistently do so. Crucially, as a descriptive review it does not provide a systematic framework or methodology for analysis of the studies, which is particularly important given the authors are, at times, reviewing their own work. The evidence base is not differentiated specifically for adults with BPD (by age or diagnosis), and fails to incorporate recent qualitative studies of experiences of MBT.

Review Aims and Scope

To the author's knowledge, previous systematic reviews analyse a maximum of two RCTs (e.g. Stoffers et al., 2012). A recent scoping review highlights positive outcomes from 14 studies (Bateman & Fonagy, 2016), but lacks a clear methodological framework and rigour. Taken together, these indicate the start of a promising evidence-base but a need for further, independent analysis of the MBT literature. Given MBT is a growing area of interest for clinicians, who often conduct quasi-experimental research (such as pilot or naturalistic studies), it is possible previous attempts to systematically synthesise MBT's evidence-base have neglected a wealth of information about its efficacy as a clinical tool. This review aims to build on the current evidence-base for MBT and address gaps in rigour or breadth by undertaking an independent systematic review of the literature, synthesising outcomes across contexts, experimental designs and methodologies (quantitative and qualitative). By exploring the wider literature available for MBT's efficacy and participant experiences, within a stringent framework, it is hoped this review will be helpful for scoping areas of further research and for synthesising clinically relevant findings.

Methods

Literature Search

Preliminary searches were undertaken to define main search terms. A systematic search of the literature published up to September 2016 was conducted to identify relevant studies. The databases PsychINFO, MEDLINE and Web of Science, along with the Cochrane databases, were examined using the search string '(Mentaliz* OR Mentlis* OR MBT) AND (BPD OR borderline OR EUPD OR PD)' within the body of text, and limited to adult populations. Truncation symbols (*) ensured studies using various conjugations of core terms were included. Due to the scarcity of empirical studies, no time limit was deemed necessary, except to account for the relatively recent (1999) establishment of MBT as an approach (Bateman & Fonagy, 2012). This search strategy produced 454 articles across all databases. These were initially screened by title to identify potentially relevant studies, with the selected studies further screened by full abstract. Reference lists of eligible papers were also searched, and yielded six further studies, which had not been identified through the main search. The PRISMA flowchart outlines the full search process (Figure 1; Liberati et al., 2009). Studies were included if they evaluated a Mentalization-based intervention specifically for adults with BPD. There was no restriction on co-morbidities, as BPD rarely presents in the absence of these (Ali & Findlay, 2016). Inclusion and exclusion criteria were evaluated using the PICOS framework (Table 1; O'Conner, Green & Higgins, 2008).
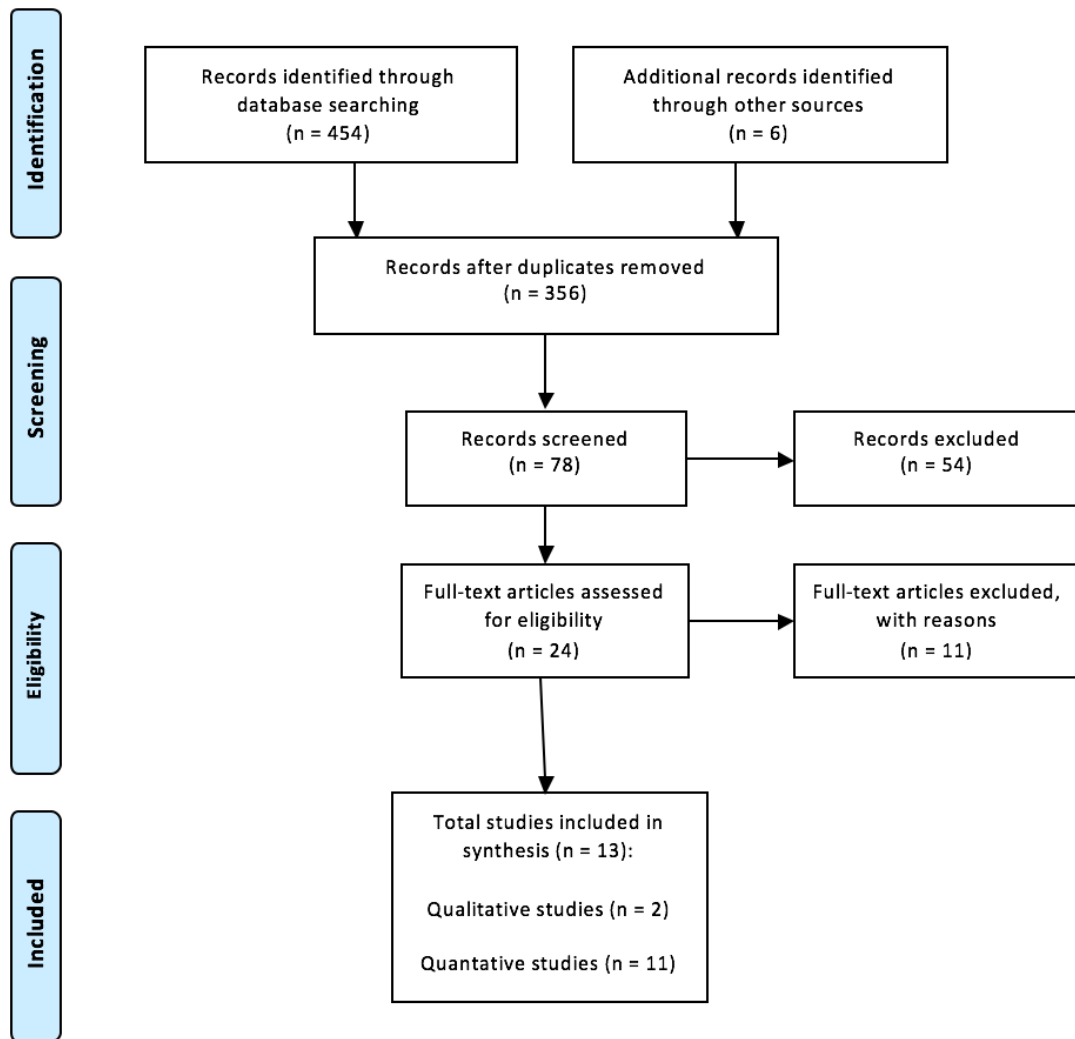
Figure 1. PRISMA Flowchart

Table 1. Inclusion and exclusion criteria using PICOS framework.

	Inclusion	Exclusion	Rationale
Participants	Adults with a diagnosis of Borderline Personality Disorder or Emotionally Unstable Personality Disorder (no limit on co-morbidities)	Young people under the age of 18, or adults without a core diagnosis of Borderline Personality Disorder or Emotionally Unstable Personality Disorder	Review focuses on the impact on adults with BPD, as presentation, diagnosis and intervention for adolescents differs. Comorbidity is common in this population.
Intervention	Mentalization-based therapeutic interventions in any setting	Any other type of therapeutic intervention	Review specifically examines the impact of Mentalization-based therapy for BPD
Comparison	All published studies of MBT - including pilot studies, uncontrolled studies and qualitative studies	Non-intervention based studies of MBT (e.g. purely conceptual or theoretical)	Review aims to synthesize the wide range of studies undertaken for MBT
Outcomes	Reported outcome measures pertaining to MBT, or reports of experiences of MBT	No reported outcome measures or experiences	Review examines impact of MBT on a range of outcomes, including symptoms, general functioning and experiences.
Study Design	Studies using pre/post measure format (quantitative) or analysis of lived-experience (qualitative) that outline original research findings	Purely conceptual reviews or reviews outlining previous research	Review examines the impact of MBT interventions.
Time Period	From 1999 seminal text, recognised as the first study of MBT	Prior to 1999 as would not be classed as MBT	From initial conception of MBT as a therapy
Language	English, or accessible in English	Not accessible in English	Reviewer unable to translate the literature

Structure of Review

The systematic review identified 13 relevant empirical studies of an MBT intervention for adults with BPD – ten of which were included in Bateman and Fonagy's (2016) summary (indicated by * symbol in text below) and three additional studies (one pilot

and two qualitative studies). This included two RCTs (Bateman & Fonagy, 1999*, 2009*); two controlled studies (Jørgensen, Freund, Bøye, Jordet, Andersen & Kjølbye, 2013*; Bales, Timman, Andrea, Busschbach, Verheul & Kamphuis, 2015*); three uncontrolled studies (Bales, Van Beek, Smits, Willemsen, Busschbach, Verheul & Andrea, 2012*; Brüne, Dimaggio & Edel, 2013; Jones, Juett & Hill*, 2013); one naturalistic longitudinal study (Kvarstein, Pedersen, Urnes, Hummelen, Wilberg & Karterud, 2015*); three follow-up studies to investigate maintenance effects (Bateman & Fonagy, 2001*; Bateman & Fonagy, 2008*; Jørgensen, Bøye, Anderson, Døssing, Freund, Jordet & Kjølbye, 2014*) and two qualitative studies to explore experiences (Dyson & Brown, 2016; Ó'Lonargáin, Hodge & Line, 2017). These studies are briefly outlined in a coherent chronology to provide a sense of the development of the evidence-base. They are then collectively critiqued and analysed to establish the current state of evidence.

Critiquing Tools

Quality assessment tools were used to ensure quality of evaluation of the selected studies and provide a coherent framework for critiquing and synthesising the literature - the Critical Appraisal Skills Programme (CASP, 2010) and Effective Public Health Practice Project (EPHPP, 2009). A checklist combining items from these quality assessment tools was constructed for experimental studies (Appendix A). The CASP tool for qualitative research was applied to evaluate qualitative studies individually. The CASP tools aim to evaluate the results of research studies, while the EPHPP provides an overall rating of the strength of studies based on methodological concerns and can be applied across domains of Public Health. These tools were used to aid the extraction of relevant data from the included studies, and synthesize key findings (Appendix B).

Results

Seminal studies – Day hospitalization

Study 1 (Bateman & Fonagy, 1999)

An initial RCT compared 18-months of MBT, partial hospitalization and standard care for people with severe BPD. Originally described as 'psycho-analytically orientated', the treatment is later summarized as 'mentalization' as the approach was demarcated (Bateman & Fonagy, 2008). All patients of a UK psychotherapy unit, with a diagnosis of severe BPD and aged 16 to 65, were included. The intervention group (n=19) consisted of partial-hospitalization treatment, with weekly individual psychoanalytic therapy, thrice-weekly group analytic psychotherapy, weekly expressive therapy and community meetings. The control condition (n=19) received standard psychiatric care for BPD, which varied greatly across participants. Outcome measures included self-harm, hospital admissions, BPD symptoms, depression, anxiety, social adjustment and interpersonal function. In comparison to the control group, MBT displayed significantly greater reductions in suicidal behaviour (from 6 months), self-harm, anxiety, depression and severity of general psychiatric symptoms, along with more stable interpersonal functioning and hospital use. The authors highlight that symptoms reduced in severity but remained stable in number. Medication usage reduced in both groups. Authors acknowledge limitations to the study's conclusions because of small participant numbers, an imbalance in treatment arms, inconsistency in the control treatment and a lack of attentional control. While this paper marks the beginning of MBT as an approach, it is unclear if the consistency of approach (demonstrated by monitoring and supervision) reflects a coherent MBT treatment or hybrid psychoanalytic approach.

Study 2 (Bateman & Fonagy, 2001)

An 18-month follow-up for the 1999 study compared maintenance effects for day hospitalization and control groups. Results indicate a preservation of initial gains for the treatment group, and some increased improvement relative to controls over this period on self-reported depression, general symptom severity and interpersonal problems. However, although classified as a follow-up study, the intervention group received a significant amount of group psychotherapy during this period (up to 180 hours), implying the study is in effect an investigation of a maintenance intervention. Authors argue the control group had higher professional contact during the follow-up period, demonstrated by high service-usage (e.g. inpatient admissions, generic partial hospitalisation). Limitations of low power and treatment integrity measures are acknowledged.

Study 3 (Bateman & Fonagy, 2008)

A second follow-up study examined maintenance effects of both groups five years after all interventions concluded. It is the first study to refer to the treatment group as 'mentalization-based', following the authors manualising the approach (Bateman & Fonagy, 2006). Using a more conservative approach, data from 41 participants from the initial study were included, including those who crossed treatment arms. While target outcomes parallel the prior studies, measures for general functioning and symptomology changed to measures demonstrating less general improvement in naturalistic BPD remission. Results demonstrated significantly greater reductions for the treatment group over the five-year follow-up period, including suicide attempts, crisis presentations, service use and BPD symptoms. Additionally, while general functioning remained problematic in both groups, the intervention group

showed greater improvement in impulsivity, interpersonal and occupational domains. The study also includes descriptions of two 'patient perspectives', akin to case summaries.

Replication – Outpatient

Study 4 (Bateman & Fonagy, 2009)

Building on these studies, a pragmatic randomised superiority trial of MBT in an outpatient setting was conducted. This study had significantly higher power, with 134 participants randomized to 18 months of MBT or an active control group of structured clinical management (SCM). The MBT intervention (n= 71) consisted of weekly combined individual and group psychotherapy aimed at enhancing mentalizing abilities, while SCM (n= 63) comprised of regular individual and group sessions based on counselling and problem-oriented approaches. Both groups were facilitated by professionals of equal experience and training. Outcomes were assessed at 6-month intervals by blind-raters. They demonstrated substantial improvements for both groups in severe parasuicidal behaviours (suicidality, self-harm, hospitalisation) and self-reported symptoms, social and interpersonal functioning. Both conditions showed improvement across outcomes, but effects for MBT were significantly greater than for SCM. However, it is notable that SCM had a swifter effect on self-harm at 6 months, potentially due to its focus on problem solving. This study's methodology addressed previous issues of minimization, attentional components, low power and issues of common comorbidity by using more specific exclusion criteria (e.g. opiate dependency rather than substance misuse). However, authors acknowledged that longer follow-up and independent replication were required.

Independent replication – manualised day hospital

Study 5 (Bales et al., 2012)

An uncontrolled prospective cohort study examined effects of outpatient day-hospital MBT when manualised and applied in an independent context. Adults with severe BPD and high comorbidity (n=45) completed up to 18 months of intensive MBT. Treatment focused on enhancing mentalizing through daily group psychotherapy, weekly individual psychotherapy, crisis planning, twice-weekly art therapy, mentalizing cognitive group therapy and writing therapy. Treatment quality was monitored through an adherence scale, ongoing supervision and observations by Professor Bateman. Therapists' clinical and MBT experience varied. Treatment-independent researchers completed outcome assessments, which indicated substantial improvements across clinical variables. Specifically, reduced self-harm, suicide attempts and hospital usage and improved quality of life, general psychiatric symptom distress, depression, interpersonal problems, social roles and BPD symptomology were noted. Results also demonstrated a large effect on the identity integration aspect of personality functioning, which reflects a coherent and stable sense of self and one's life (Verheul et al., 2008). Effect sizes ranged from moderate to large (d=.68-1.74) but with wide confidence intervals. This study adds some suggestive evidence to the research base by replicating reductions on clinical outcomes for severe BPD, at effect sizes beyond the rate of spontaneous remission. Due to the lack of control group, it is not possible to conclude results are due to MBT. Yet the specific impact on identity integration is noteworthy as it is theoretically consistent with an MBT model.

Exploring MBT as an adjunct– Inpatient

Study 6 (Brüne, Dimaggio & Edel, 2013)

An uncontrolled, feasibility study explored MBT elements as an adjunct to DBT treatment in an inpatient setting. This assessed MBT's acceptability and impact on a core component of mentalizing, 'reflective function', which had not been previously addressed. Sixteen participants with BPD entered a six-week inpatient treatment programme consisting of six weeks of DBT skills training, therapeutic groups and individual psychotherapy, in addition to occupational therapy input and physical exercise. Brief group MBT was incorporated in the final four weeks, with eight sessions split between psychoeducation (four sessions) and psychotherapy (four sessions). Dropout was low, with only one participant failing to complete the intervention, which authors conclude indicates the intervention's acceptability. While symptom severity reduced significantly over the period, mentalizing was unaffected. However, mentalizing was measured by a novel cartoon-sequencing task, lacking validity or reliability data. A non-significant trend for increased prosocial and decreased avoidant endings in this task was demonstrated. Due to a lack of control, small sample size and context of high support and staff input during inpatient admissions, it is not possible to draw any firm conclusions about MBT's efficacy from this study. However, it demonstrates clinical potential for elements of MBT to be included in other therapeutic approaches and acceptability of a brief intervention in the context of wider intensive support.

Independent comparison – Outpatient

Study 7 (Jørgensen et al., 2013)

A randomised clinical trial compared two years of combined MBT with supportive psychotherapy (SP) in an outpatient setting. One hundred and eleven participants met criteria

for BPD and were randomized to treatment (although four were re-diagnosed during the study). This sample was somewhat selective as those under 21 years and with lower functioning levels (<34 on the Global Assessment of Functioning - GAF) or severe substance misuse, Antisocial PD or Paranoid PD were excluded. Overall, 85 participants took part after randomization, with two thirds allocated to MBT (58) and one-third to SP (27). The MBT intervention consisted of six once-monthly sessions of psychoeducation, along with weekly individual and group psychotherapy, while the SP intervention involved fortnightly group therapy. Differences between groups at baseline included less social security use and higher comorbidity in the MBT group. Surprisingly, given the difference in treatment intensity, results showed significant improvement for both groups across outcome measures of symptomology (BPD, anxiety, depression), social adjustment, interpersonal functioning and general functioning. The majority of results showed medium to large effect sizes (confidence intervals were not reported) and no significant differences between groups – with the exception of general functioning, which showed an effect for improved therapist-rated general functioning compared to the SP group. Despite overall improvement, both groups continued to experience moderate levels of symptoms.

Study 8 (Jørgensen et al., 2014)

A naturalistic follow-up was completed 1.5 years post-treatment and demonstrated outcomes were largely sustained for both groups, with a non-significant trend for higher social and general functioning in the MBT group. Unlike previous studies, there was no further improvement during this period. However, both groups experienced reduced comorbidity (particularly depression and eating disorders) and self-harm behaviours, along with increased relational and employment status. There were significant differences between participants within groups, indicating different rates of improvement for individuals. It is

important to note booster sessions were offered over this time, and participants could access external treatment. There were no significant differences between groups in use of these resources.

Authors conclude the study shows no superiority for MBT above less intensive interventions like SP. They cite a number of possible explanations, including a lack of power and shared therapist variables (e.g. high experience, structured practice). In light of similarities in therapist and setting, they outline the study could be viewed as a component design study, where adding individual therapy made no difference to outcome. Yet, as there was a small, non-significant trend for greater recovery in the MBT group (in terms of BPD criteria met), authors acknowledge longer follow-up may shed more light on lasting impacts. Additionally, while there were few between-group effects, there was significant within-group variation on outcomes. This implies a need for further study of what works for whom and, potentially, post-hoc analyses and exploration of clinical change at an individual level.

Therapeutic community

Study 9 (Jones, Juett & Hill, 2013).

Preliminary outcomes of a pilot MBT-based therapeutic community were investigated. All patients were included if they met BPD criteria, and did not have substance misuse, psychosis or learning difficulties. Participants were also excluded if they were subjectively assessed as unable to make use of therapy, which may have inflated the 'wellness' of the cohort. The final sample (n=25) included two participants with borderline traits (rather than diagnosis) or a differing PD subtype. Intervention was a day therapeutic community informed by MBT principles - once-weekly individual MBT and twice-weekly group MBT in addition to the therapeutic community structure. Intensity of the intervention

varied from two to three days, based on the number of community meetings offered, access to additional drama or expressive therapies, and optional use of a service-user network (SUN) group facilitated by staff. Paired sample comparisons were used for the seven participants who had completed MBT therapy at 18 months. Results demonstrated variability with some measures of functioning, depression and symptom distress showing significant improvement (clinician ratings on GAF and Health of the Nation Outcome Scale - HONOS; self-ratings of Brief Symptom Inventory - BSI total distress and depression) and others remaining insignificant (self-rated social adjustment scale, interpersonal functioning and other depression measures). Anxiety measures showed no effect. Client satisfaction questionnaires were predominantly positive. The discrepancy in depression outcomes, despite correlations for measures, was accounted for by some measures being more sensitive to change in this population. A low sample size and lack of Bonferroni post-hoc analysis may have also impacted these results.

Comparison study – outpatient

Study 10 (Kvarstein et al., 2015)

A naturalistic, longitudinal study compared MBT (2008 – 2013) treatment effects with a Norwegian specialist centre's previous psychodynamic therapy (PT; 1993 – 2008). Over this period, data was available for 345 patients with BPD from the same clinic and geographical area (MBTn=64; PTn=281). The psychodynamic treatment programme comprised of an 18-week day-hospital programme, followed by weekly outpatient psychotherapy groups up to a maximum of 4 years. The MBT treatment involved 12 weeks of psychoeducation, followed by combined weekly group psychotherapy and weekly (reducing to once every three weeks in subsequent years) individual MBT for a maximum of 3 years.

Both treatments followed published manuals, and therapist adherence and competence was rated 'good'. Group differences at baseline were present, with younger participants with higher rates of paranoid Personality Disorder in the MBT group, and higher unemployment in the psychodynamic group, results that held when age was statistically controlled. Assessments were undertaken repeatedly for symptom distress, interpersonal problems and general functioning, while pre-post measures included occupational status, self-harm, suicidal acts, hospitalization and medication use. Following intervention, deliberate self-harm, suicide attempts and medication use decreased for both groups. MBT showed greater rates of improvement and large effect sizes for symptom distress, interpersonal difficulties, global and occupational functioning than the psychodynamic group, as well as significantly lower drop-out rates (2% vs 15%) and longer engagement. Despite a lack of randomization and temporal difference in control group, the authors conclude the study is suggestive of better clinical outcomes for robustly adhered-to MBT versus psychodynamic treatment.

Day-hospital

Study 11 (Bales et al., 2015)

A naturalistic, matched-control study compared MBT day-hospital treatment with other psychotherapeutic interventions (OPT) in the Netherlands. Overall, 29 participants in MBT were matched with 29 participants from a large sample pool for a separate trial (n=175) on a number of pre-treatment characteristics. The matching process accounted for baseline differences such as inpatient history and occupational status. However, the MBT group had equal or greater rates of personality dysfunction and the OPT group had higher exclusion criteria of comorbidities. The MBT intervention included a maximum of 18 months of manualised day-hospital, followed by up to 18 months of maintenance group therapy. OPT

involved a range of approaches and settings described as 'representative' for the population, but exact treatment approaches or lengths are unclear. Results showed improvement for both groups at 18 and 36-month assessment points. However, MBT demonstrated larger effects (moderate to large) on general psychiatric distress and personality functioning. Interestingly, only relational functioning showed no between-group differences. The authors acknowledge differential treatment dose, which was likely shorter for OPT, may account for this difference but felt estimates were conservative due to the higher severity of difficulties within the MBT group.

Exploration of Experiences

Study 12 (Dyson & Brown, 2016)

A qualitative study added to the breadth of literature by exploring service-user perspectives of MBT. Six females with BPD and a minimum 6 months' experience of MBT (unknown formats) were interviewed about their lived-experience using open-ended interviews. An interpretative phenomenological analysis (IPA) led to the emergence of a main theme of 'battle between BPD and me', with complex negotiations between participants' perceived self-identity and diagnostic identity, and more abstractly their attachment and identity formation. Subthemes included a sense that MBT helped but did not 'cure', willingness was important for change, and shared experiences were positive but obscured the individual. Descriptions of experiences of MBT were 'overwhelmingly positive', and outlined behavioural and emotional changes, suggesting this type of treatment was felt to be helpful. However, despite interpretation that it had been difficult for participants to criticise MBT, all participants described not feeling 'cured' and a sense of needing continued progression. The author interprets this as potentially reflecting that

participants had a cohesive sense of self, which felt rejected by society, thus requiring treatment. However, it may also relate to previous quantitative findings of substantial effects of treatment but ongoing experiences of symptoms and impaired general functioning. Some participants also discussed a desire for more direction and structure within sessions, which may relate in part to Jørgensen's (2013) proposition that well-structured, coherent therapeutic approaches appear to have equal efficacy when facilitated by clinicians with high expertise and competence.

Study 13 (*Ó'Lonargái*n, Hodge & Line, 2017)

A second IPA study interviewed seven participants (two male) receiving outpatient group MBT for BPD difficulties. It is unclear whether all participants had formal BPD diagnoses. Length of treatment ranged between three and 14 months. Therapy structures varied, although all had experienced a combination of group and individual MBT, with some psychoeducation. Participants described MBT as a challenging and unpredictable experience, but reported positive outcomes. These included an increase in perspective-taking and reduced tendency to assume others' mental states. For most, these were associated with an increase in interpersonal skills, improved relationships and reduced impulsivity, suicidal thoughts and self-harm. All participants attempted to make sense of the experience by reflecting on MBT's structure. A preference for individual sessions emerged, which was viewed as core to the process. Group MBT was seen as unpredictable and challenging, but beneficial in combination with individual therapy. Developing trust and cohesiveness were perceived as essential for good outcomes, but harder to achieve in group therapy. Those who had participated in MBT for 3 months reported minimal benefits for MBT, compared to those who had engaged for longer. For example, participants who had engaged for longer than 10 months identified some challenges as an opportunity for mentalizing. The author proposes

these results indicate that some structural elements of MBT contribute to disrupting mentalizing. Implications include an emphasis on preparing for unpredictability of MBT groups and seeing challenges as opportunities to mentalize and an emphasis on cohesion to begin with, as well as individual sessions close to group sessions to provide support. The study provides a clear description of methodology, validity considerations and application of IPA.

Critique

These studies have progressively attempted to address methodological challenges in earlier research (e.g. monitoring adherence, independent replication, and increased sample size). Yet, there remain a range of methodological and clinical issues to take into account when evaluating the evidence-base. The following critique is underpinned by the evaluation tools used to review the studies (Appendix B).

Methodological Considerations

The majority of studies demonstrate significant effects for MBT across outcomes, while active controls also show some improvement. This is despite some studies' small samples which, compounded by drop-out, lead to low power and corresponding reduced statistical sensitivity (Study 1, 11). Four studies demonstrate MBT's superiority over active controls, and several indicate moderate to large effect sizes for MBT. However, the quality of reporting varies and omission of confidence intervals prevents adequate scrutiny of effects (Study 7, 8, 10, 11). This is particularly important as large effect sizes with wide confidence intervals reduces accuracy. Levels of dropout (2% - 28%) may also impact integrity, particularly for smaller samples, by increasing the risk of additional variables affecting

outcomes (such as the likelihood of positive outcomes for completers versus non-completers). It is a strength of the literature that studies predominantly utilise intention-to-treat or longitudinal analyses less sensitive to this effect (Study 4, 5, 7, 10, 11). However, two studies with the smallest samples do not explicitly use this approach (Study 1, 6). Most studies recruit all referred patients to a service, and four studies found no difference between completers and non-completers (Study 1, 4, 5, 7).

Given BPD is a highly heterogeneous disorder, the inconsistent use of individual or post-hoc analysis across studies is a significant limitation. Participant complexity varied greatly through application of diverse exclusion criteria (e.g. levels of general functioning or comorbidities). While all studies report some positive outcomes, it is possible that nuanced individual-level effects are masked by group-level analysis or confound these outcomes. Despite its clinical importance in disentangling which participants MBT works for, individual-level analysis was not attempted for these studies (Jacobson & Truax, 1991). This is despite one study identifying significant within-group differences, but fewer between-group differences than other studies, indicating both treatments affected individuals in varying ways (Study 7). This is highly relevant not only for the evidence base but also the clinical implementation of these findings.

Similarly, analysis of potential moderators on treatment outcomes is sparse. Analysis of effects over time points (Study 1, 11) began to identify variable periods for outcomes, e.g. effects on risk behaviours from 6 months, which are extremely clinically important. Some additional exploration of severity found two variables (multiple comorbid Axis II diagnoses and symptom distress) impacted outcomes, but the study was underpowered to test moderating factors (Bateman & Fonagy, 2013). Higher powered studies may find subtler moderating effects. Some attempts have been made to control for age (Study 10) and

'common moderators' (Study 4) with no effect. Examination of admission variables also did not predict risk outcomes (Study 1).

Qualitative studies favour idiosyncratic understandings over generalizability of data, and both qualitative studies outlined have adequate samples for IPA analysis (Study 11, 12; Smith et al., 2009). Descriptions of analysis integrity are included in both, including use of IPA guidance, Yardley's criteria, and reflexivity. However, neither outline the topic guides used in data collection, which constitutes a barrier to the transparency of analysis.

Follow-up

Three studies reviewed include long-term follow-up, which is important as BPD has an element of symptom remission but is a chronic condition with functioning generally remaining impaired (Zanarini et al., 2003). Both 18-month follow-up studies (Study 1, 8) showed sustained gains, with the first demonstrating additional improvement for psychosocial functioning compared to controls. A long-term follow-up (Study 3) demonstrated improved gains for MBT in terms of crisis behaviours and BPD symptoms following the initial 18-month follow-up period. However, both initial follow-ups involved active MBT maintenance sessions (Study 1, 8), implying analysis is of a maintenance treatment effect. Although authors (Study 8) highlight their control group had more professional contact during this time, the availability of a (potentially containing) maintenance intervention is likely to have significant effects. This confounds the evidence base. While it suggests MBT's benefits are maintained across prolonged periods, it should be clearer that the evidence for this includes additional, active input from services.

Outcome Measures

Outcomes assessed across studies were relatively consistent, with most evaluating crisis behaviours (self-harm, suicide attempts, hospital use) and medication use, and all measuring psychiatric symptoms in some way. These variables parallel NICE recommendations for BPD (CG78, 2009), although only two studies assessed quality of life (Study 5, 13). Psychiatric symptoms were predominantly measured with variations of the Symptom Checklist 90 Revised - SCL-90-R (Prinz et al., 2013). However, this measure assesses generic psychiatric symptoms rather than specific BPD symptomology, and its susceptibility to natural improvement compared to measures like the Zanarini have been recognised (Study 3). Specific measures of BPD symptoms or distress were sparse and varied (Study 3, 5, 11). Given the remission rates in BPD, discussion of the suitability of measures used in terms of sensitivity to both BPD-specific difficulties and BPD natural remission would be helpful across studies. Measures of depression (Beck Depression Inventory - BDI - 6 studies), anxiety (Spielberger – 3 studies), general functioning (GAF – 6 studies), interpersonal functioning (Interpersonal Problems Circumflex - IIP-c - 9 studies) and social functioning (Social Adjustment Scale - SAS - 6 studies) were included with good validity and reliability. Consistent use of outcome measures with good psychometric properties across studies allows for easier comparisons, but a wider variety of measures would enable some analysis into the specific areas of improvement and may help to ensure that positive results in specific areas are not an artefact of a single measure.

Studies predominantly use self-reported outcome measures which theorists acknowledge fail to evaluate the complex processes integral to MBT, such as therapeutic relationship or reflective function (Jørgensen et al., 2013). Only one study attempted to measure changes in 'mentalizing', and found no movement on this concept (Study 6). However, psychometric properties of this novel cartoon measure are not established. An

uncontrolled examination of MBT treatment showed an impact on identity integration (Study 5). This improvement in a coherent sense of self is theoretically compatible with increased mentalizing, but requires further investigation to establish a specific correlation with MBT. This highlights the need for future inclusion of elements that are theoretically compatible with MBT, and reliable measures of these, to determine the active components of MBT (mentalizing vs therapist variables etc.). Only two qualitative studies have been undertaken, although these provide a way to add depth to understanding of the complex group processes of MBT. The qualitative studies included in this review lend additional weight to outcomes measures, with participants reporting positive experiences of MBT and changes in perspective-taking, behaviour (self-harm, impulsivity) and sense of identity. However, both highlight perceived challenges with the therapy process (Study 12, 13). These findings are crucial for contextualising quantitative MBT outcomes.

MBT coherence, theory and bias

Adherence and fidelity of therapists to MBT is crucial in assessing the quality of the evidence-base, and ensuring studies evaluate a common, coherent intervention. MBT's evolution is evident through the timeline of this review. While older studies do not explicitly define their 'MBT' approach (Study 1, 2, 3), the majority of new studies implement a manualized approach and measure therapist adherence (Study 5, 10, 11). This raises a question of the purism of MBT in the seminal RCT (Study 1), which constitutes half of MBT's evidence in previous systematic reviews (e.g. Stoffers et al., 2012).

Additionally, studies in this review demonstrate outcomes across a range of settings and contexts. While this enhances the breadth of the evidence base, designs are often less rigorous for more clinically-oriented pilot studies and require more systematic replication.

Analysis of the different components of classic MBT (group, individual, psychoeducational) is absent, and studies are inconsistent in their findings of the relevant importance of these. One study (Study 7) may be viewed as a component analysis where adding individual therapy made no difference to outcome. However, both qualitative studies reviewed highlight the importance of MBT structure for participants and emphasise the perceived importance of individual sessions for positive outcomes. This is a particularly important discrepancy, as intensive interventions are costly. However, MBT has demonstrated cost-efficacy, in terms of reduced service use following treatment (Bateman & Fonagy, 2003).

As mentioned previously, the role of mentalizing in outcomes is not adequately measured or addressed throughout the studies. In descriptions of experiences, participants discuss changes in perspective, the gradual development of trust and using individual therapy to help navigate and gain from group settings. It is possible this relates theoretically to concepts of mentalizing, group processes and attachment. Adding component or qualitative analysis to these studies would add to the depth of knowledge and ensure the evidence base for MBT accurately reflects the evolving clinical practice of MBT.

While there have been attempts to replicate findings for MBT independently of its main theorists (Bateman and Fonagy), several 'independent' studies included training or supervision by Professor Bateman (e.g. Study 5). This may be a strength in terms of consistency of approach but also remains a limitation. The importance of preventing bias in independent replications of results, is well documented and acknowledged by the authors themselves (Bateman & Fonagy, 2009; Lieb, Osten-Sacken, Stoffers-Winterling, Reiss & Barth, 2016). This may be resolved as MBT research moves beyond an emphasis on practice evaluations.

Acceptability

MBT is thought to demonstrate high engagement rates and in the studies reported, dropout was as low as 2% (Study 9). This rose to 26-28% in two studies where disengagement was higher for MBT than in comparison groups (Study 4, 7). Yet, even the highest dropout rates described are in line with average figures from a meta-analysis of psychotherapies for people with BPD (29% - Barnicot, Katsakou, Marougka & Preibe, 2011). Attendance is one possible indicator of the acceptability of a treatment for those who use it, and is an important aspect of efficacy. Two quantitative studies allude to positive participant views without adequately reporting these (Study 3, 6). Qualitative studies develop this idea, describing positive but challenging experiences of MBT. These experiences are described in complex inter-relational and attachment terms (Study 12, 13). This may relate to dropout as, when activated, these experiences may feel overwhelming for people with BPD who have interpersonal difficulties and high emotional distress in this context (Bateman, Fonagy & Allen, 2009). In light of these complex experiences, more attention to the acceptability and lived experience of MBT is required. This is particularly important for assessing the holistic efficacy of MBT and ability to apply it clinically, as well as providing an arena for in-depth explorations of therapeutic processes that are difficult to quantify, as seen from the service-user perspective. As some studies included in the review demonstrated no significant differences on a limited number of variables (e.g. severity of BP, demographics) in statistical comparison between those patients who do and do not finish treatment (Study 7), further qualitative exploration of lived experiences of MBT is required.

Summary

Overall, studies showed positive experiences or effects of MBT over a variety of contexts and intervention formats. Yet, they do not consistently demonstrate superiority to less intensive psychotherapies and were experienced by participants as somewhat challenging. Ongoing limitations in the research include insubstantial measurement of BPD-specific symptoms, a difficulty establishing independent research and neglecting to investigate the complexity of individual differences, moderating factors or theoretical constructs such as mentalizing. These limitations do not necessarily jeopardise the research as, overall, studies reviewed in this paper showed relatively consistent positive effects of MBT on several areas that significantly impact individuals' wellbeing and quality of life. All eleven quantitative studies demonstrated statistically significant changes following MBT for areas of risk behaviours, hospital use and some symptom severity (including psychiatric symptoms, anxiety and depression). Some studies also demonstrated improvements for interpersonal problems, and social and occupational functioning. Effects on general functioning were less robust, with an inconsistent tendency for improvements at a greater rate for MBT than active controls (Study 7, 10). This is significant as this construct often remains problematic for people with BPD (Zanarini et al., 2003). Two qualitative studies highlight positive but challenging experiences of MBT, and complexities with navigating the interpersonal and group elements. Accounts of lived experience acknowledge a change in behaviour or perspective following the group. This relates to the aims of MBT and, although it cannot be generalised, lends some support to quantitative outcomes. Active maintenance studies demonstrated gains, which were either held or improved at follow-up, indicating effects of MBT can be preserved across a prolonged period with ongoing input from services. Demonstrations of MBT's superiority, or degree of superiority, to other well-structured active psychotherapeutic comparison groups, were less consistent. It is not possible to attribute

changes specifically to mentalizing, as this construct was not measured robustly, if at all (Study 6), although lived experiences outline examples of increased mentalizing. Positive results, and an absence of negative effects, are particularly important as the possibility of harmful effects of psychotherapy with this client group have been raised (Bateman, Fonagy & Allen, 2009).

Clinical implications

The current evidence base for MBT has nuanced clinical implications. Firstly, studies reviewed demonstrate generally consistent effects on some psychiatric symptoms and risk behaviours. Given the high rates of suicidal behaviours in clients, short-term impacts on risk are particularly important when considering a treatment approach. Results that included temporal analysis indicate MBT may be best used for long-term gains rather than immediate risk, although some change is evident after 6 months. Improved functioning is also difficult to achieve for people with BPD, and some findings indicate MBT improved social and general functioning for some participants. Lived experiences of MBT highlight that participants perceived changes in their perspective-taking, behaviour (including impulsivity, social engagement and self-harm) and sense of self following MBT. These are all theoretically consistent with MBT and clinically important, providing additional weight and depth to quantitative findings. However, MBT was also experienced as challenging and there was a sense of needing further treatment in the qualitative accounts. This sits alongside findings of improvement but continued symptoms in quantitative studies.

Clinicians should be mindful when considering the research outcomes, that the MBT process may be experienced as difficult as well as beneficial for patients. Despite this, relatively low dropout rates regardless of severity of BPD, has an impact for allocation of

resources for this client group. While there was some evidence of individual differences in who benefits from MBT or less intensive psychotherapies, the specifics of this are not yet known. While further research may have more specific implications for whom MBT works best for, at present there appears to be some impact with some individuals experiencing severe impairment.

The adaptation of MBT across a range of clinical settings is also important for services, although the efficacy of components is not yet established. Consistency of findings across MBT structure and format is unclear due to variations in study designs and rigour. The choice to use an MBT approach over others needs to remain clinically informed as its superiority to alternative psychotherapeutic treatments is not yet firmly established. One study proposes that due to shared therapist variables, their comparison of MBT was in effect a component design with individual therapy making no difference (Jørgensen et al., 2013). Although this may have implications for the allocation of clinical resources to group or individual formats, the individual aspect was most important for participants in qualitative studies. The cost effectiveness of long-term MBT through reduced healthcare usage has been established (Bateman & Fonagy, 2009). While there is inconsistency in MBT's superiority to less intensive interventions, it is possible the difference in effects is most evident with long-term follow up. An awareness of this is particularly important for commissioners and clinical services, who may experience a 'revolving door' phenomenon for this client group.

Future Research Directions

MBT theorists continue to marry theoretical and research findings with clinical practice (e.g. New, 2015). The evidence-base presented in this review favours quantitative studies of outcome measures above studies of experiences or process. Given MBT's focus on

promoting the process of mentalizing and its psychodynamic roots (Bateman & Fonagy, 2016), this oversight is a particular gap in evaluating it as a therapeutic approach. While the evidence-base's reliance on symptomatic outcome measures provides some evidence for theoretically compatible aspects such as identity integration, there is a need to include more theoretical mechanisms in future research (e.g. mentalizing, therapeutic alliance). The sole study attempting to assess mentalizing in this review demonstrated non-significant trends towards change (Study 6). Qualitative explorations, however, highlighted indications of developments in mentalizing through personal experiences of a change in perspective, behaviour and a negotiation in their sense of self. Reflections on a change in behaviour included reduced self-harm and impulsivity and an increase in social engagement. Impulsivity and social functioning are two areas where quantitative outcomes have difficulty in consistently demonstrating improvement. The quantitative studies reviewed also often prioritised generic psychiatric symptomatic outcomes over BPD specific outcomes. Therefore, further qualitative studies are needed to both complement findings from outcome measures, and add depth to our understanding of these. They should explore the complexity of the MBT process, and the acceptability of this for participants.

As outlined in this review, the evidence-base highlights relatively consistent effects for MBT, but difficulty in establishing superiority to less intensive psychotherapies. One study indicated a difference between individual outcomes for both MBT and an active control condition, but failed to explore this in depth. This is an important area for further research, and particularly important given the prevalence, severity and heterogeneous presentation of BPD in secondary care settings (Beckwith et al., 2014). Quantitatively this could be achieved through stratification sampling or individual analysis of broad clinical factors that may impact outcomes or rates of clinically meaningful change. Qualitative studies would also serve a unique purpose in this, gaining insights into individual differences and similarities in

experiences of MBT. This is particularly important given qualitative data reflecting a challenging experience of the MBT process and a sense that it was helpful but insufficient for recovery.

While MBT interventions are now more explicitly defined and adherence is routinely monitored, there is a need to preserve this when adapting MBT to clinical contexts. The research reviewed shows effects across treatment modalities, structure and intensities. However, theorists acknowledge that relatively little is known about the individual components of MBT, and which aspects work best for whom (Bateman & Fonagy, 2016). Additionally, conflict exists between quantitative data of a quasi-component study that postulates individual components made no difference to outcomes (Study 7), and lived experiences of the importance of individual MBT to benefit from group MBT. Future research should evaluate both the efficacy and lived experience of different modules of MBT, including the individual, group and psychoeducation elements.

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SECTION B

Cerys Bradley-Scott MA (Hons)

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SALOMONS

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Abstract

Borderline Personality Disorder (BPD) is a distressing difficulty prevalent within UK secondary-care settings. Previous qualitative studies have examined individual experiences of long term Mentalization-Based Therapy (MBT) groups for people with BPD. However, the psychoeducational component of MBT has not yet been researched coherently. The current study explored lived experiences of manualised MBT-psychoeducation groups for people with BPD within NHS secondary care settings. Eight participants took part in interviews about their recent participation in these groups. Interpretative phenomenological analysis was used to interpret individual meaning-making of these experiences. While some accounts were characterised by contradictions, MBT-psychoeducation was generally viewed as a challenging but predominantly beneficial experience. Three main themes emerged, comprising eight sub-themes. These highlighted individuals' attempts to manage complex group processes, strategies for personalising knowledge, and the power and fear of increased self-reflection. Participants felt the group had impacted their sense of self, their understanding of others and their impulsivity, particularly within interpersonal relationships. Research and clinical implications of these findings are discussed. Particular importance is given to the implications of some individuals' perceived need for additional support or coping, the desire for further MBT group therapy and the possibility that these findings support propositions that the groups provide a useful mechanism to stimulate mentalizing.

Keywords: Mentalization-based therapy, psychoeducation, borderline personality disorder

INTRODUCTION

Mentalization and BPD

Borderline Personality Disorder (BPD) encompasses intense distress and impaired functioning. It is a prevalent difficulty in patients within UK secondary-care settings, with estimates of PD between 40 – 92% (Beckwith, Moran & Riley, 2014). Challenges for services treating this population include managing high-risk behaviours, difficulties accessing services, poor engagement and presentations characterized by recurrent crisis presentations and high dropout rates (Crawford et al., 2009). Mentalizing is suggested to be a core deficit in BPD (Bateman & Fonagy, 2012). Mentalization is the awareness of mental states in the self and others (Fonagy, 2004). It develops in the context of healthy attachment and is necessary for an integrated self-concept, emotion-regulation and interpersonal relationships (Fonagy, Gergely, Jurist & Target, 2002).

Balanced mentalizing requires flexible transitions between four competencies, with opposing poles, necessary for processing information about mental states (automatic vs controlled, self vs other, interior vs exterior and cognitive vs affective). Polarization on any of these dimensions leads to various mentalizing errors characteristic of BPD (Fonagy, Luyten & Bateman, 2015). The automatic/controlled pole requires transitioning between non-conscious, automatic mentalizing and more reflective, conscious, controlled mentalizing when needed. An over-reliance on automatic mentalizing, characteristic of BPD, hinders flexible consideration of the complexity of inner worlds, and thus impairs social understanding. The external/internal pole involves inferring mental states through considering both internal and external aspects. In BPD, interpretations of mental states often focus on external cues (e.g. behaviours) as a source of knowledge, at the neglect of internal ones (e.g. thoughts, beliefs). The affective/cognitive pole requires reasoning with both cognitive and emotional knowledge. A tendency to prioritize emotional logic can lead to both

concreteness of thought and a tendency to attribute one's own mental states to others. The self/other pole includes the ability to separate the external world from the internal mind, with difficulties leading to restricted perspective-taking, an expectation that others will hold identical view points and emotional responses to the minds of others. Recently the role of 'epistemic trust', or the ability to engage with social knowledge, has also been recognized in the mentalizing process (Bateman & Fonagy, 2016).

MBT

Although enhancing mentalization may underlie all effective psychotherapy, Mentalization-based therapy (MBT) specifically focuses interventions on developing this ability (Fonagy, 2004). MBT has a growing evidence base and is one of several recommended psychotherapies for BPD (Stoffers et al., 2012; NICE, 2009). Many of these include psychoeducational components, such as Dialectical Behaviour Therapy (DBT; Linehan, 1993) and Systems Training for Emotional Predictability and Problem-Solving (STEPPS; Blum, Barttels, St John & Pfohl, 2002). MBT's traditional structure, of an introductory psychoeducational group followed by combination of individual and group therapy, aims to promote mentalizing development. Theorists acknowledge that little is known about the efficacy of individual components of MBT (e.g. psychoeducation, group, individual therapy). However, experimental studies exploring MBT in varying combinations and intensities have demonstrated medium to large impacts on a range of clinical outcomes including risk behaviours, reduced hospital usage and symptom severity, along with less consistent impacts on general functioning (see Bateman & Fonagy, 2016). Noticing a dearth of qualitative research in MBT's evidence-base, three recent studies explored lived experiences of traditional MBT groups with nuanced results.

The first of these studies found MBT was experienced in terms of attachment and identity formation through a sense of a 'battle' between participants' sense of self and BPD (Dyson & Brown, 2016). Within this were themes of feeling helped but not 'cured', the role of individual willingness and a sense that shared experiences were positive but lost the individual. A second study highlighted that participants found MBT challenging and unpredictable (Ó'Lonargáin, Hodge & Line, 2017). As such, trust was key to benefitting, but took time to achieve in groups. All participants described a more positive view of the world due to MBT, with those who had participated for longer identifying most benefit. While participants valued the structure of MBT, they prioritized individual therapy as most important and perceived the primary value of the group as an experience to reflect on in these sessions. As part of the experience of structure, participants outline introductory sessions as preparatory for future sessions. The sole participant who engaged in a 12-week psychoeducational course felt this had been too long without individual support, and felt overwhelmed by the amount of information provided. The final study outlines three service-user perspectives of the journey beyond an intensive MBT group (Johnson, Mutti, Springham & Xenophontes, 2016). This study viewed MBT as enabling increased social inclusion, resources and support, and a view of the world as less threatening. There was a need for deliberate mentalizing after MBT, facilitated by social support. A vulnerability accompanied increased self-awareness, as well as hope and enjoyment of social contact.

MBT-Psychoeducation

Psycho-education has a wide evidence base across a variety of clinical populations and settings, and is recommended in the NICE guidelines for PD (Lukens & McFarlane, 2004; NICE, 2009). MBT-psychoeducational groups are viewed as an opportunity for clients to actively learn and practice the skill of holding mental states in mind through explicit

discussion and attention to mentalization. They aim to build an awareness of the process and focus of future therapy, and to promote the mentalizing process (Haslam-Hopwood et al., 2006). These sessions have been seen as a preliminary, adjunctive or stand-alone intervention based on the level of complexity of difficulties (Bateman & Fonagy, 2012). While they are designed to prepare and motivate participants for the full MBT therapy course, they also include a screening aspect of confirming diagnosis (Bateman & Fonagy, 2016). Additionally, while low drop-out rates are reported in empirical studies of MBT (e.g. Kvarstein et al. 2015), high disengagement is common in secondary care settings. Therefore, not all individuals who undertake MBT-psychoeducation participate in future groups. Finally, people with BPD continue to face challenges in accessing appropriate mental health treatment (Kealy & Ogrodniczuk, 2010), which, along with a high prevalence rate in services, have led to calls to make BPD treatments more accessible through briefer interventions and a stepped care approach (Paris, 2015). It is possible that brief MBT-psychoeducation groups, while not developed for this purpose, may be advantageous in increasing access to, and quality of engagement with, psychological interventions in a population often neglected within psychotherapy.

A brief psychoeducational group may have the potential for detrimental effects for people with BPD, like other interventions which activate dysfunctional attachment systems associated with personality disorder (Bateman, Fonagy & Allen, 2009). However, Banerjee and colleagues (Banerjee, Duggan, Huband & Watson, 2006) demonstrated no impairment in therapeutic relationships and positive outcomes within generic psychoeducation groups for BPD. These groups also demonstrate increased motivation within this client group (Long, Fulton & Dolley, 2013). With regards to MBT-psychoeducation, clinicians report informal positive participant feedback and describe low dropout rates compared to other therapies, indicating a higher level of acceptability to service-users (Groat & Allen, 2011). These

groups are thought to aid mentalizing ability by increasing agency and knowledge, building the therapeutic alliance and providing an opportunity to practice and consolidate explicit mentalizing skills (Groat & Allen, 2011). It is clear from the use of MBT-psychoeducation in practice that therapists believe them to be beneficial. However, it is important to bear in mind that service-users have experienced MBT as a challenging process (Dyson & Brown, 2016; Ó'Lonargáin et al., 2017). Benefits of all interventions, but particularly brief interventions, rely not only on cost-efficiency and outcomes but also the acceptability of the intervention (Bower & Gilbody, 2005).

Rationale for research

While research has begun to explore experiences of full MBT programmes, which include psychoeducation, no literature exists for the independent impact or lived experience of the psychoeducational aspect of MBT. This study aims to address this gap in the literature by exploring the impact of MBT-psychoeducational groups from the perspective of service-users, adding to the knowledge base for both an MBT perspective and time-limited interventions for people with BPD. Exploration of short-term interventions for BPD is important, given the need to increase engagement and access to services for prevalent and complex PD presentations within secondary care settings, e.g. through stepped-care approaches (Paris, 2015). This is particularly important given the possibility that MBT-psychoeducation may be an independent intervention for more stable clinical presentations, the challenging experiences of MBT previously documented, and a theoretical query about the detrimental effect of brief interventions for BPD. This research is clinically relevant, connecting to NHS values of ensuring high quality care for everyone.

Research questions

1. What are people's experiences of MBT-psychoeducation groups in secondary care settings?

2. In what ways does the group impact how participants think about themselves and cope in everyday life?

3. In what ways does the group influence how participants think about others and experience interpersonal relationships, both inside and outside the group?

METHODOLOGY

Design

Interpretative Phenomenological Analysis (IPA) was used to explore how individuals' make personal sense of MBT-psychoeducation. IPA views lived experiences as interpretative, and recognizes the dual nature of participant and researcher meaning making in understanding these accounts (Smith, Flowers, & Larkin, 2009). This approach was chosen over other methodologies as it is particularly relevant to exploring perceptions of participants with intra and interpersonal difficulties. Providing a psychological focus to this understanding seeks to enable an opportunity for more meaningful findings.

MBT-psychoeducation

MBT-psychoeducation groups studied were MBTi manualised groups (Bateman & Fonagy, 2016; Appendix C) to ensure consistency across interventions. The group focuses on experiential mentalizing while increasing knowledge about mentalizing, PD and associated topics (including the significance of emotions, attachment, depression and anxiety in mentalizing). The group also aims to prepare individuals for long-term treatment, increase motivation to engage, and develop therapeutic alliances. Sessions ran weekly for between 10 and 12 weeks, and lasted for 90 minutes. The groups were specifically for people with BPD within the community teams. They were run by two facilitators, either Counselling or Clinical Psychologists, with at least one trained in MBT.

Recruitment

Recruitment took place across two secondary-care services in the South-East of England. All members of the MBTi psychoeducation groups between June 2016 and January 2017 were invited to participate. Exclusion criteria were a level of distress such that participation may impact the individual's wellbeing, those who missed more than a third of group sessions and those without a formal diagnosis of BPD (or Emotionally Unstable Personality Disorder). Based on service-user consultation with ResearchNET, the project was introduced in the third group session by the researcher and, whenever possible, a service-user expert. Formal recruitment occurred in the penultimate session, allowing ample time to consider participation (Appendix D-H). At interview, the research was explained individually. Confidentiality and its limits were discussed, with space provided for questions. The potential impact of participating and the right to stop at any point were also emphasised. Interviews included both warm-up and debrief periods. Participants were later contacted via telephone to request consent for transcription services if required.

Participants

IPA favours a small sample size to enable a depth of understanding (Smith, Flowers & Larkin, 2009). Although eighteen group members agreed to be contacted, cancellation rates were high. Those who were not invited to interview were individually contacted to explain, and reminded of other avenues to provide feedback to their service. In total, eight participants took part in the research, recruited from four different MBT-psychoeducation groups. This was a theoretically homogenous sample, with all participants diagnosed with BPD or EUPD, and having recently completed the MBTi group (Table 1). For anonymity, pseudonyms are applied throughout and any identifiable information has been altered.

Table 1. Participant Demographics

	Pseudonym	Gender	Age Range	Comorbidities	Ethnicity
1	Sian	Female	31 - 45	3	White
2	Mark	Male	31 - 45	0	White
3	Emma	Female	20 - 30	4	White
4	John	Male	31 – 45	2	White
5	Chris	Male	31 – 45	0	White
6	Amy	Female	31 – 45	0	White
7	Gabriella	Female	20 – 30	0	White
8	Siobhan	Female	31 - 45	1	White

Ethical Issues

Ethical approval was obtained from Canterbury Christ Church University, the Health Research Authority and both NHS Trusts' Research and Development departments (Appendix I). BPS code of Human Research Ethics (2010) and local NHS policies were adhered to throughout. The impact of taking part was considered carefully, risk was monitored during interviews and individuals were signposted to their clinical team for further support. Local NHS policies, supervision and access to the individual's care team were in place to manage any risks that arose. Reports were written for participants, services and ethics committees involved (Appendix J-L).

Interviews

Interviews followed a semi-structured schedule with questions moving from descriptive to interpretative levels (Appendix M) to allow a deepening of the data. A draft was constructed through searching the literature and consulting supervisors. This was brought

to consultation with a service-user research group and feedback was incorporated into the final version. The interview schedule was piloted with a service-user representative and a Trainee Clinical Psychologist. The schedule served as a guide, with active listening and accounting for the interpersonal nature of the interview prioritised. Interviews lasting approximately an hour took place in a quiet room in a local NHS setting, were audio-recorded and later transcribed. Each began with a warm up and concluded with a debrief and signposting to the individual's clinical team for additional support if needed. All participants reported the interview had been manageable, with five stating it was a positive experience. Several participants emphasised wanting to take part because they felt there were not enough services for people with BPD, and they wanted to increase the awareness, as well as quality, of these. Notes were taken about the context after each interview, along with entries to the research diary.

Analysis

To immerse in the data, repeated listening to the interviews, reading transcripts and analysing context notes was undertaken prior to line-by-line coding. Observations or reflections were noted during this process. As recommended, a flexible and iterative process of coding was used, moving between descriptive, linguistic and conceptual levels (Smith, Flowers & Larkin, 2009). Emerging themes were gathered on a mind-map for each individual, with the most salient highlighted and similar ideas clustered together to develop subthemes. This was repeated for each individual, before relationships between these individual maps and subthemes were explored. Subthemes were then grouped together and analysed to produce superordinate themes. These were checked back against the raw coded data to ensure they remained a true reflection and represented the essence of experiences (see Appendix N - O for example coded transcript and mind map).

Quality Assurance

Quality assurance guidelines (Yardley, 2008) were applied throughout to ensure integrity of the data. An article outlining common pitfalls of IPA also provided guidance (Hefferon & Gil-Rodriquez, 2011). Regular, reflective supervision (both clinical and academic) was utilized and supervisors checked sample recordings, transcripts, mind maps and data audit trails to check quality and coherence throughout the project. Prior to conducting interviews, supervisors provided feedback on a preliminary sample interview to ensure quality of the questioning style and use of the interview schedule. After the interviewing stage, all transcripts were double-checked against their audio recordings to maintain accuracy of the raw data. Supervisors checked a sample of two of these audio recordings and their accompanying transcripts. Codes from these two samples were reviewed, to provide an independent view of the analysis. Mind maps for each participant visually charted the analysis process. To monitor coherency of this analysis, both supervisors viewed all eight mind maps of initial codes for each participant, against mind maps of the superordinate themes developed from these. A reflective research diary was also kept (see Appendix P). These methods promoted an awareness of personal sensitivities, biases and preconceptions in an attempt to remain open to giving voice to experience rather than imposing the researcher's understanding of phenomena.

RESULTS

Participants gave rich, varied accounts of their experiences of MBT-psychoeducation. There was an overarching sense of a challenging but (predominantly) beneficial journey towards changes in understanding of the group, self and others. Three superordinate themes (with 8 subthemes) emerged from the data, highlighting participants' meaning making through the structure, process and impact of these experiences. Illustrative examples are provided (Table 2) along with a model of the connections between them (Figure 1). These concepts are interrelated, with each theme influencing the others.
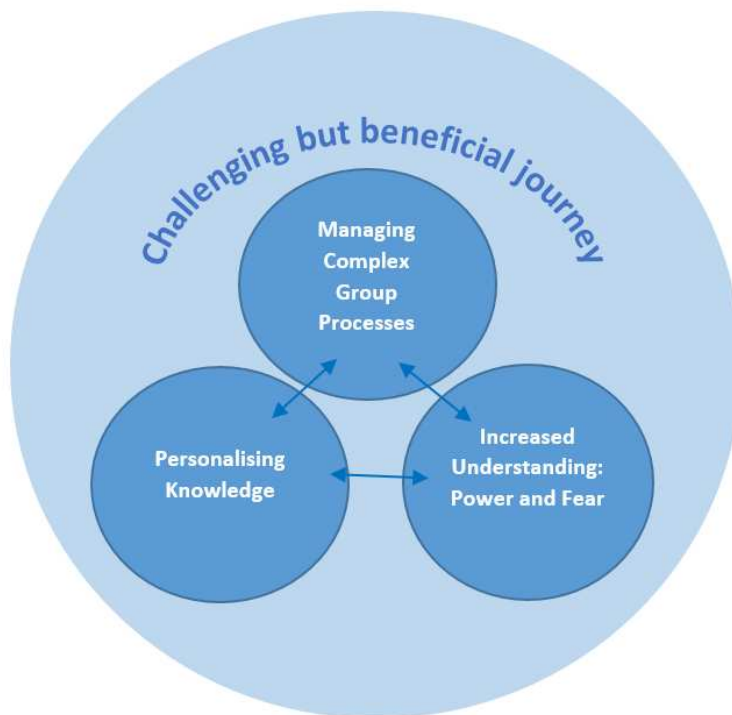
Figure 1. Superordinate themes and connections

Accounts frequently embodied contradictions, which may relate to difficulties in cohesively integrating information about the self (Fonagy, 2004). This was held in mind when interpreting the intentionality of accounts and attempting to establish an overall sense of individual narratives. This ambivalence may be particularly apparent in the interpersonal context of an interview and sense of '*limbo*' (Mark) in the period between the psychoeducation and subsequent MBT group. Potentially reflecting the mentalizing nature of the interview, one participant commented 'my opinion and my views and my thoughts, my personality will constantly change and it does…' (Siobhan), while another observed '*... what I'm doing here is not dissimilar to what I'm trying to do for myself*' (Chris).

Table 2. Example Quotations

Superordinate	Subtheme	Example Quotation
	Group purpose	"And you're able to get some help there. Not only from those instructing … but also those around you who've had the same experiences and were feeling the same feelings …" – Mark
	Desire for emotional containment	'…It was orderly but it was chaotic at the same time'– John
		"…I mean it was sort of like "ok, I'm sort of turning up for the group and then going away for the week being completely left with it"" – Chris
Personalising knowledge	Directly relating to information	' … the science behind it all, and that really made me feel understood' – Siobhan
		"It's not in layman's terms. It's not relative enough" – Sian
	Self in relation to others	"So you know, everybody had a completely different character, personality. We had very quiet people, we had very loud people, depressed or impulsive, the quiet borderline, the louder one. And then we had older." – Amy
		"…it was also interesting seeing people on different spectrums of where they were and how they dealt with it … it was reassuring" – Chris
	Self within others	"… to finally know that there are other people … I'm not a freak, that it actually has a name … gave me a relief that there was help out there."– Gabriella
		'…everything that was off topic in the real world was absolutely normalised in a room where everyone could discuss these things." – John
	Understanding as empowering	'So being able to just take that moment to think … just knowing you've got that control over yourself is so liberating, I can't even explain it, it's such a feeling of relief that you can, this is your life and you can control it …' – Gabriella
		"It teaches you about understanding yourself … the more you understand yourself, the better you are able to understand and help yourself and understand why you're having these {difficulties} and control them and improve your situation" – Mark
Increased understanding: the power and fear	Understanding as insufficient	"… I have benefitted to a certain extent, but I haven't got any additional tools now than I had before if something really does go wrong, I don't feel any better equipped … but I'm more aware of possibly why I'm doing things." – Chris
		"I think there's not enough to help, it's a lot of knowledge but not enough ways to help." – Sian
	Sense of agency and perceived resources	"I knew it was a big giant first step to take" – Mark
		"…I've come a long way anyway, I've got a lot of support … I just thought this was a brilliant opportunity … I deserve to do it for myself … I owe it to myself and my family." – Emma

Theme 1. Managing Complex Group Processes

This superordinate theme captures attempts to manage the dynamic nature of MBT-psychoeducation. Participants varied in their perception of the group's purpose, but predominantly viewed it as understanding their diagnosis and reducing their difficulties. Processes involved in achieving these aims were less clear, leading to uncertainty. This, along with the groups' emotional impact, needed containment to enable helpful engagement. The theme relates to the idea that groups are particularly challenging for people with BPD, but allow opportunities to mentalize and successfully tolerate intense emotional experiences (Bateman & Fonagy, 2006).

"… *I'm not too sure if it was because it's a group therapy, or the things what we learnt as the subject of the therapy. You know, mentalization, I don't know which*" (Amy)

Group purpose: Participants used their perceptions of the group's purpose to situate experiences and navigate the process. Two distinct but overlapping learning modes appeared to characterize this; '*evolutionary educational'* (Mark) involved direct engagement with theoretical information, while 'shared interpersonal experiences' prioritized listening and being heard. The significance of these educational and interpersonal aspects varied but, generally, their interplay was important. Most participants felt the MBT-psychoeducation group positively prepared them for the next MBT therapy group although, related to the theme of agency, some felt it was akin to '*hoop jumping'* (Chris).

Managing the group purpose was achieved either by facilitator guidance or the group itself. Some participants reported the development of a shared understanding of the groups' purpose and supportive stance 'by the end of therapy everybody was more focused on the reasons and the right attitude towards the symptoms ..." (Amy). However, there was marked

variation in the groups' ability to develop this '*unified environment*', with five participants feeling this was achieved (Mark, John, Amy, Siobhan, Emma - "we were all in it together") and other accounts providing a sense of this as lacking or inconsistent (Sian, Gabriella, Chris - '*I wouldn't say supportive, but...*"). When successful, it was achieved through openness, vulnerability and trust ("*being open was the therapy*" - John).

Personal disclosures were often seen as crucial to the group, but could also constrain progress. At times navigating this balance led to frustration at having to moderate one's own interaction with the group, or at other group members failing to do so. '… *you couldn't necessarily talk about people's individual issues that come up or people would almost take over with their individual issues*' - (Chris).

Desire for emotional containment: This theme outlines participants' desire for containment during the group and some surprise at the emotional impact of the experience. *"... I was so amazed how I broke down and what I broke down about in front of strangers…"* – (Siobhan). In line with the idea that mentalizing is suppressed with intense emotions (Bateman, Fonagy & Allen, 2009), anxiety and levels of wellbeing impacted ability to engage with the group. "*If I'm really depressed, that's going to go over my head*" – (Sian).

Accounts highlighted the first three sessions as particularly difficult, but all participants felt the safety of the group improved as the 'boundaries became more firmly established" – (Chris). Boundaries were described as important for managing strong emotions, with some valuing a flexible approach and others desiring more structure. Facilitators' support to manage interpersonal challenges within the room was valued "... was *moderated in a way ...where miscommunication was always* quickly resolved *...it wa*s needed" – (John). However, one participant reflected that "because of the nature of the group

certain things just weren't challenged, that I felt should have been ..." (Chris) including self-harm behaviours. This indicates a desire for more concrete displays of care or clearer boundaries. It may relate to teleological modes of mentalizing, where observable behaviour is needed to reflect on the mental state of another (Bateman & Fonagy, 2006).

The impact of absences and lateness were described as particularly disruptive to the group process and evoked concern or resentment of others, and a want for more input from facilitators in managing this. '… *when you're kind of getting in to the flow of it and you don't trust people easily… I don't think they thought* it was a big deal, but I know that it distressed *me"* – (Gabriella).

Several participants described actively reaching out to others during the course of the group '… *other members of my family … colleagues at work*, I would say I was attending this course, a*nd I felt less ashamed about having mental health problems'* – (Mark). Some accounts highlighted an improved relationship with services, which was predominantly in comparison to past negative experiences or long waits for access. This included an increased ability to talk to professionals, or feeling "*on the right path"* with them (Amy). However, four accounts described a desire or perceived need for more consistent support outside the group. *"I struggled …* my anxiety levels increased, increased, increased. A*nd it wasn't made particularly clear to me that I could also access the team outside of the group situation"* – (Chris).

Theme 2. Personalizing Knowledge

In this theme, relating to information from the group in a personal way was key to bringing about change in understanding of self, others and difficulties. This self-reflection occurred through directly applying information, learning from others or an awareness of the

experiential process. It appeared this was mediated by individuals' perceived agency, attachment to the group or ability to relate to the information in a containing way.

Directly relating to information: Although at times information was perceived as "too *basic"* or "*not relative enough"*, most people identified directly with some topics covered, and found these normalizing or validating. Others felt guided in applying theoretical concepts through facilitator input, the use of experiential or concrete activities and literature. These may demonstrate a need for more concrete, external experiences to begin making sense of internal experiences. "*... some of it was quite difficult to grasp. But then (facilitator) would break it down for us and we'd do like activities, writing lists or drawing*" – (Emma).

Participants spoke about internalizing theoretical information and interpreting it in their own way. All participants felt they knew what 'mentalizing' was and provided examples of attempts to use it, acknowledgment of mentalizing failures and challenges to mentalizing in the 'heat of the moment'. '*… I didn't feel like we did a lot of learning about how to deal with it … But now I've had some time to think about it I think just learning about it has enabled me to personally figure out how to deal with it ... Like when I was explaining mentalization, t*hat's just my interpretation' *– (Gabriella).

Self in relation to others: Participants' accounts suggested they defined themselves through seeing themselves through the eyes of others, or negotiating differences, within the group. Through this, most people noted increased perspective-taking in relationships and thinking of themselves as separate but connected to others *"...* I've always thought that it was me, everything was to do with me. And now I've started to look outside a bit more. Instead of *inside"* – (Sian).

Despite difficulties bearing witness to other people's distress, positive comparisons to other group members appeared to instil hope in their ability to manage BPD. A variety of '*types of BPD*' (Amy) were identified. While some individual characteristics were seen as isolating (e.g. maleness, quietness), participants also attempted to understand themselves and others by identifying underlying reasons for perceived differences. 'But, my understanding of the louder people, it absolutely changed by the end of the therapy. And I understood that the frustration sometimes is more verbal in their cases than in mine.' – (Amy).

There were unanimous descriptions of personal challenges in managing connections, and facilitators positively supporting individual interactions within the group in some way. Experiences of managing boundaries were often applied beyond the group. Three participants felt that through managing different communication styles and being heard in the group, they were more aware of their own needs and confident in their ability to be assertive "*I think I've learned it's okay to say when … I felt that my voice wasn't being heard… I've learnt having boundaries is important.*" (John). Some examples of beginning to tolerate potential conflict in resolving miscommunications, both in the group and outside, provided a chance for increased understanding and validation from relationships. "And she went *'I completely understand' ….* I never thought she did because she thought I was ignoring her but actual*y she'd never* said, that was in my mind. So I realize now, that people do understand." (Sian).

Attachment was consistently described as crucial knowledge for attempting to understand experiences. Several people commented on ambivalent group attachments and the emotional impact of this. John identified discussing these processes rather than acting them out, as crucial for gaining an awareness "*… but in there everyone was discussing these attachment issues rather than acting them out … breaking them down and* learning about them. So, everyone was an individual but at the same time, very connected to each other in a real way and not in an unhealthy way." There were attempts to use this knowledge to change

personal ways of relating inside or outside the group with family, friends and colleagues. While directly discussing attachment with family members had positive impacts for some, others experienced barriers to this, such as a fear of blame "*... we stripped it down and* started again and I think for all these year*s we've both been just painting over it. And it was kind of nice to see her [mother] feel sorry, even though that wasn't what I wanted out of her"* – (Siobhan).

Varying views existed about the benefit of contact with group members outside, with feelings that it had the potential to be both supportive and destructive. There was tension between the perceived support it could offer and concerns about the privacy and stability of those connections. "And I felt we should have supported- been able to support each other, *but we were told we shouldn't contact each other outside the group... I'm not* 100 percent sure *... two people with the diagnosis might not be a good thing"* – (Sian).

Self within others: This theme relates to identifying with others and navigating similarities. There was a sense of belonging and relief through the shared understanding of 'BPD' difficulties. "*it's sort of a sense of relief that "God, it's not just me. It's not just me* that feels this way about things, or has problems"' (Chris).

This enabled a different kind of discussion and deeper analysis of problems than would be possible in the outside world. Through this, Siobhan reflected she was able to identify and challenge some of her own perspectives through discussing these '*mad'* shared experiences '*because you can't see them things yourself but if someone tries to tell someone like us that, we just won't have it*! ….. *and so you have to think 'oh my god I'm a bit of an idiot!' ... It definitely gave me some sort of acceptance'*.

There was a sense that people could also learn from each other in the group in terms of their experiences and ways of coping. "*... if it works for them then there's a reasonable chance it may work for you. It gives you those options. I mean, it's always nice to hear by experience rather than just a text book*" – (Mark).

For some, developing empathy with others, along with facilitator containment, allowed the expansion of meaningful connections and beginning to think about others' perspectives in the room. '*I was able to open up and, sort of, listen to people more deeply. I was able to empathize more ... and it's not all about me, it became more of a 'team' effort. I think that's what ultimately helped so, putting myself in their shoes.*' – (John).

However, similarities also had the potential to be experienced as intense or overwhelming. People situated their own and others' experience of the group in terms of a fluctuating level of wellbeing of their past self, or in terms of their age and missed opportunities. Participants commented on the difficulty of tolerating the '*dropout*' of the group. Although they disliked the disruption this caused, they also identified with these members and acknowledged that in the past they may have acted in a similar manner. "…the dropout thing. The people that possibly needed it the most and who are in the most chaotic *and the most disturbed state at the moment …. that would have been me*" – (Chris).

Theme 3. Increased Understanding: The Power and Fear

This theme encapsulates a desire for, but fear of, increased personal awareness, knowledge and self-reflection. The group promoted participants' understanding of their own and others' mental states, through an emotionally evocative process. While all acknowledged some impact of this on their behaviour, the perceived depth and benefit varied. It appeared to be influenced by individuals' sense of personal agency or resource. "*... at the beginning, you*

think that '...I understand myself, I know that I've got problems'. But, at that time I didn't

understand how ... deeper you can understand yourself." – (Amy).

Understanding as empowering: Most participants viewed their increased

understanding of themselves and others as a positive tool for coping and future development.

It engendered a sense of relief, increased control and choice over their reactions and hope for

managing symptoms. This change had a positive impact on some people's experience of their

self, feeling an increased self-acceptance, trust, self-worth and confidence. *"...I didn't really*

like myself b*efore. I didn't understand why I would hurt people I care about ... it's had a*

tremendous impact on my confidence, my self-respect." – (Gabriella).

Six participants believed personalized understandings of mentalizing had guided their

ability to 'step back', get space and think about things differently. They described an

acceptance that while this was not always possible, when used, it impacted their perspective,

behaviour and relationships across settings. Some participants felt it also broke cycles of

rumination and reduced their stress levels. "…*So that's what I understand menta*lization to

be, just sort of taking a few moments longer than you normally would to think about what

someone else is thinking or what you're thinking, why you're thinking the way you are" –

(Gabriella).

Some participants felt that by knowing themselves better, they could understand

others more. "I didn't really understand my behaviour in the past. Now I can put my

behaviour into perspective. And therefore I can put other people's behaviour in perspective."

– (Amy).

An increased understanding of mental states, reasons for mentalizing failures and the

experience of belonging in the group influenced their relationships with others. For Mark,

knowledge of the BPD diagnosis built his confidence to communicate his difficulties to others and reach out for support when needed. John felt he had learnt to perspective-take, which led to more meaningful connections and a positive view of himself. "By knowing things, it gave me the tools and the con*fidence… sometimes you're not open with people because you don't really know what to say, whereas I just found that I was actually able to* talk about things and I was able to sort of hear the sound of my own voice." – (Mark).

There was a widespread desire to communicate new understanding to others. This may demonstrate wanting to reach out and establish more helpful attachments. However, some perceived a need to continue managing their boundaries with others until they better understood their own needs and identity. "*...* because I'm learning who I am. …. And I used to get into friendships and relationships in the past, without the knowledge of my needs … and therefore it never really worked out for me *… So right now it's a transition, I have to* realize, I have *to discover who I am."* – (Amy).

Understanding as insufficient: While all participants acknowledged that understanding impacted their behaviour, some felt there was an unhelpful aspect to having an increased self-awareness without additional coping tools. Understanding was seen as an insufficient tool for crisis points, or even a detrimental process of raising awareness of negative parts of the self. Within this theme was a sense of a possibility for a critical or hypermentalizing experience, and it is possible these interpretations of knowledge relate to prementalizing modes. There was an ambivalence between '*blissful ignorance'* of difficulties versus the anxiety of being aware of these difficulties, and a marked desire for more concrete coping strategies. "I just think there should have been more methods to help. The <u>whole</u> course was based on 'this is the reason you have that' but not 'right this is what we can do to help' or 'this is what you can do to help*'.*" – (Sian).

There was also a sense of the possibility of misinterpreting information or self-criticism. "*... because it was quite broad brushstrokes you could take the wrong interpretation from certain things ... maybe I didn't take enough out of it*" – (Chris).

Additionally, although the shared experience of intense emotions, impulsivity and behavioural reactions were normalized through the group experience, there continued to be a sense of these difficulties as '*negative aspects*' of the self (Mark). It is understandable then, that some experiences were characterized by a feeling that the group had highlighted intolerable parts of their identity "*...basically drew a highlighter through some really bad points*" – (Chris).

Sense of agency and perceived resources: Participants differed in their views of their personal agency, which in turn influenced interpretations of the groups' benefit. For some there was a sufficient sense of agency to experiment with new ways of being, both during and after the group, but for others this did not feel enough. Perceived access to internal and external resources also influenced individuals' agency. There was a sense that without the next stage of the MBT group, they would not have access to enough support or resources to develop their progress and cope independently. Several people noted a need to feel in control to manage intense emotions, but increased control or ability to cope fluctuated across individuals.

There was an acknowledgment of a tension between using new understanding for personal development and the potential for self-criticism. Positive views of this related to a perceived need to change and dedication to this. "*...being aware that there is a problem ... maybe there's a danger of going a bit far and being a bit overly critical, but I think at this*

stage I do need to t*ake stock of where I'm going wrong so that I can try and improve it."* – (Gabriella).

Education and understanding were viewed as potentially more 'long-*term'* (Mark) than other therapies. Several participants viewed their experience of the group as a 'giant first *step'* in feeling better or a foundation to build on "…. *you're kind of going back to basics and you're sort of getting a handle on what you're dealing with*." – (Gabriella).

Some participants reported feeling they could progress with mentalizing over time and with effort. This indicates an internal agency over their own development, which appeared to relate to more empowering views of the group. "*It's [mentalizing]* like any skill: *if it's repeated and practiced, one will get better at it and one will reap the benefits. But it's putting that work in. So, it's a very positive tool to have in your toolbox*" – (John).

However, three participants expressed a desire for more support outside the group. Perceived levels of support from external sources influenced people's perception of the group as either positive or inadequate, respectively. '*...* those weeks when I couldn't meet up with care coordinator, I felt a little bit lonely and confused, frustrated, stuff like that. But, generally speaking the group therapy, it was good actually.*"* – (Amy).

"to have to dig yourself out of a hole *... it feels you're offered a little bit of a lifeline ...* then *it's almost like 'we'll sort of pull you a little bit of the way out, but that's it' ...."* – (Sian).

A sense of personal resource impacted how people tolerated the '*limbo'* (Mark) period between these two stages, overlapping with the desire for containment. Some experienced it as "very anxiety producing" (Chris), while others felt it was an opportunity to apply the skills they had learnt "*... you can always use the lessons you've learnt ...* to actually help yourself in the meantime, to try and practice them at home" (Mark). Most viewed the next stage as vital for their development and there was a sense of it being "…a privilege to be offered a

place" (Mark). Some felt that their MBT-psychoeducation experience would only be useful if they could continue to the full MBT therapy group "*... you've kind of just scraped the top off and then you're kind of left* with – *if you don't pursue it ..."* (Gabriella), although she also recognised '*for some people they might just find it interesting and feel like they've learnt something and that's enough ...*".

DISCUSSION

Psychoeducation is an important, but under-researched, component of MBT. This study explored experiences of MBT-psychoeducation groups for people with BPD. Findings captured a sense of these groups as a challenging but predominantly very beneficial process. Three superordinate themes emerged, reflecting both difficulties and development in affective, interpersonal and identity instabilities characteristic of BPD (American Psychiatric Association, 2013). Descriptions of managing emotions and complex group processes allude to experiences of affect regulation; 'personalising knowledge' through reflecting on self and others navigates identity and relationship instabilities; while tensions between benefits and risks of increased self-awareness involve identity and distress tolerance. All accounts highlighted a perceived impact of the group on individuals' understanding of the reasons why difficulties associated with BPD may occur. For some people, this impacted their sense of self and understanding of others, leading to positive changes in impulsivity, identity or relationships. These are noteworthy, given the importance of these areas in mentalizing and quality of life. However, some participants highlighted a perceived need for additional coping strategies or external support during the group.

The current findings compliment previous reports of MBT, but add an understanding of specific processes of personalizing knowledge and perceived impact of increased awareness within MBT-psychoeducation. They highlight that participants predominantly viewed MBT-psychoeducation as the start of a process of change. Experiences of these groups as beneficial but not all-encompassing pull together previous findings of MBT groups as challenging and unpredictable, and a feeling of change but no 'cure' (Ó'Lonargáin et al., 2017; Dyson & Brown, 2016), generating potential explanations of an ambivalence of self-awareness and agency.

Along with inherent interpersonal challenges, group psychotherapy can activate attachment anxieties for people with BPD (Bateman, Fonagy & Allen, 2009). In long-term MBT, Ó'Lonargáin and colleagues (2017) found individual therapy provided a secure base from which to experience the unpredictable group aspect. However, current findings demonstrate that while perceived group unity varied, shared experiences and containment were unanimously important. Descriptions of shared group purpose and structure to manage this anxiety, and enable engagement, provide a sense of the group acting as a secure base. Furthermore, in contrast to explanations of long-term MBT groups obscuring individuality (Dyson & Brown, 2016), the current data indicates group attachments enabled a better understanding of the individual self as connected and distinct to others. This had an impact on people's sense of identity in connection to others and curiosity about differences. Results also suggest emotions needed to be stimulated at a tolerable level to enable engagement. It is possible secure group attachments allowed experiences of the neurological emotion regulation necessary for mentalizing, given its reliance on frontal-lobe functioning inhibited by stress (Fonagy & Luyten, 2009). Yet the desire for additional individual support indicates the psychoeducational group environment, while important, may not be sufficiently containing for everyone.

Within 'personalising knowle*dge',* secure group attachments promoted abstract information processing (e.g. viewing self in other). Although directly applying information was experienced as normalizing and validating, more abstract forms of relating to knowledge embodied self-reflection and increased curiosity. Unlike previous descriptions of a 'parroting' of mentalization terminology (Dyson & Brown, 2016), several participants described internalizing personalized ideas of 'mentalization'. Theoretically, active curiosity about mental states is critical to a mentalizing mind, but may be inhibited in BPD (Bateman & Fonagy, 2016), although enabled within contained group dynamics (Yalom & Leszcz, 2005). Moreover, experiences of identifying with others or a trust in the group's purpose relate to epistemic trust (Bateman & Fonagy, 2016). When knowledge was perceived as personally relevant, participants attempted to apply it outside the group context e.g. attachment, mentalizing. This impacted relationships through active attempts to relate to others in more helpful ways e.g. assertive communication, meaningful connections, perspective-taking. Conversely, participants who experienced information as unrelatable also described less supportive group experiences and fewer benefits.

A sense of ambivalence emerged about the impact of '*increased understanding'* and awareness. This was often viewed as an empowering tool for development, and a method of coping in its own right. All participants believed self-reflection had impacted their sense of self, relationships, impulsive behaviours or ability to cope with intense emotions in some way. Multiple accounts outlined how explicit mentalizing provided the 'space' to prevent impulsivity, enable perspective-taking and increase control. This subsequently reduced relational conflict, stress and a negative view of self in relation to this (e.g. guilt). This links to the proposition that mentalizing difficulties bidirectionally impact core deficits of BPD (Bateman & Fonagy, 2016). These effects lend weight to previous quantitative and qualitative reports of positive impacts of MBT, particularly improvement in interpersonal

and impulsivity domains. Understanding reasons for behaviour and emotions also had a normalizing effect, leading to an increased confidence, self-acceptance and self-worth. This also appeared to influence individuals' sense of agency in terms of their ability to use this understanding as a resource.

However, some participants experienced understanding as insufficient, increasing self-criticism or awareness of difficulties without additional coping strategies. This connects to experiences of an inherent vulnerability in increased self-awareness following long-term MBT (Johnson et al., 2016). Additionally, it is possible this discomfort with understanding reflects a teleological mode of prementalizing, where externally valid coping strategies may be prioritised over internal experiences of understanding. This relates to the proposition that psychotherapy for people with BPD can be detrimental if attachment is activated without mediating non-mentalizing modes (Bateman, Fonagy & Allen, 2009).

Unlike interpretations of participants navigating group MBT with a coherent sense of self (Dyson & Brown, 2016), current narratives of MBT-psychoeducation often contained marked inconsistency, suggestive of difficulties holding multiple perspectives in mind or establishing a coherent self-image (Fonagy, 2004). The groups' content and process were experienced as impacting individuals' views of self, suggesting reactivation of the developmental stage of identity formation (Erikson, 1968). Thus, accounts of agency may be understood in the struggle between dependence and independence characteristic of this phase. Agency includes elements of mentalizing about our mental states and intentions, and increases flexibility and perceived choice (Groat & Allen, 2011). Sense of agency and resource played a role in interpretations of self-awareness, enabling a confidence in participants' ability to use understanding as a tool and acceptance of challenges in doing so. These findings may build on the notion of 'willingness' for change in intensive MBT

(Dyson & Brown, 2016), demonstrating this influence on outcomes may be mediated by both personalised knowledge and perceptions of the utility of awareness.

Several participants believed access to the full MBT group was necessary to maintain gains from the MBT-psychoeducation group. This was characterised by hope and desperation for further development, but also relates to perceived group purpose, which may play a role in this evaluation. Some participants expressed concern about their ability to cope independently in the transitionary period and uncertainty about the possible impact of the group. Perceived need for continued access to services, and difficulties tolerating the transition period, echo current NICE guidelines (2009) proscribing brief interventions for BPD and emphasising managing transitions and endings. However, the hope for future therapy reflects positive relationships to services, and could indicate an activation of care-seeking attachments that may promote engagement.

Finally, opportunities to mentalize in challenging interpersonal situations are key to group MBT. Findings of MBT-psychoeducation as challenging yet beneficial echo previous reports of MBT as unpredictable but with positive impacts (Ó'Lonargáin et al., 2017). Interestingly, while this exploration of MBT showed that trust and views of challenge as an opportunity to mentalize took several months to build, the current participants outlined successes in these processes within the brief psychoeducational stage. Additionally, some participants commented on their increased awareness of attachments and ability to reach out to others for support, which are both likely to positively impact the therapeutic alliance. This may support the idea that these groups, with a clearer structure and explicit focus on mentalizing, rapidly promote the mentalizing process and therapeutic alliance (Bateman & Fonagy, 2012).

Strengths and limitations

A number of strengths and possible biases exist within this study. The sample was representative in terms of diagnosis and gender, but unrepresentative of ethnic diversity. Due to inclusive recruitment, both those who participated and those who declined are likely to be representative of secondary-care populations. Consistency was ensured by interviewing participants who had experienced manualised MBT-psychoeducation. However, interviews preceded the transition to the MBT group, which is likely to have impacted anxiety levels and therefore ability to reflect on experiences. Separation from the clinical team was emphasised, but it remains possible the researcher's professional identity (trainee clinical psychologist) may have affected participants' descriptions, particularly in light of a desire to access the MBT group. Additionally, by its nature, the interview involved mentalizing in practice and one participant commented on its 'intimate' nature, which may indicate stimulated attachment. Finally, participants provided rich, detailed accounts, but inconsistent narratives necessitated researcher interpretation of ambiguity. Validity was increased by engaging in reflexivity, use of audit trails to ensure transparency, research diaries and supervision. While these results are not generalizable, given the strengths of internal validity outlined above, they may have transferability (Lincoln & Guba, 1985).

Clinical implications

Participants described their experience of MBT-psychoeducation groups as the start of a process of change. Gains were explicitly viewed by some in the context of continuing MBT therapy, with a turbulent 'limbo' period after MBT-psychoeducation and a desire for additional therapeutic input. While this implies acceptability of the model and group, MBT-psychoeducation was not viewed as an independent intervention by participants in secondary-

care. This may be impacted by expectations of the purpose of the group. However, it is noteworthy, as pressure exists for services to develop ways of increasing access to BPD interventions.

Descriptions of MBT-psychoeducation as challenging but predominantly beneficial, reinforce the importance of clinicians managing group processes and hypermentalizing at the psychoeducational stage. They highlight the impact of dropout, anxiety and structure on individuals' engagement, as well as strategies for personalising learning. Although some found an increased understanding of the reasons for their difficulties validating, others regarded it as insufficient and outlined potential for self-criticism. There was a pervasive desire for additional external support during the MBT-psychoeducation, to promote meaningful engagement and tolerate the emotional impact. This sits alongside accounts of the importance of shared experiences, an ambivalent desire for additional peer contact and concrete coping skills. Therefore, services may consider offering additional support through individual or service-user led groups with a focus on coping and self-compassion.

Clinically relevant changes were described over this brief intervention period, including increased understanding of the reasons for difficulties and some attempts to explicitly mentalize. This impacted people's sense of self, relationships and impulsivity. Some descriptions of improved perspective-taking, understanding of attachment, acceptance of the challenges to mentalizing and confidence in communicating difficulties (including with services) may indicate the start of more positive care-seeking relationships. Taken together, these may aid future engagement with services and personal recognition of early warning signs of difficulties. Incorporating this knowledge collaboratively into care plans may influence recovery and future use of services.

A sense of agency and resource were crucial to individual differences in personally relating to information, or perceptions of the utility of increased understanding. An awareness

of these differences may aid clinicians in tailoring support for participants to relate meaningfully to the group, and could be explored prior to the group. Additionally, explanations at assessment of the group purpose and understanding as an independent outcome may shape experiences of MBT-psychoeducation.

Future Research

Given a sense of challenging but positive experiences for those who completed MBT-psychoeducation, investigation of experiences of those who dropped out, and reasons for doing so, would significantly enhance the literature and aid tailoring interventions to maintain engagement. As participants viewed MBT-psychoeducation groups as the start of a process of change, more research is necessary before offering MBT-psychoeducation as an independent intervention for BPD. Studies could investigate the role of agency and support in perceived acceptability and outcomes key to interventions (Sekhon, Cartwright & Francis, 2017). Given a desire for additional input following MBT-psychoeducation, it would be helpful to explore experiences of those who do not proceed to further MBT therapy and investigate differences for those who attend MBT-psychoeducation alongside group MBT. Future research into MBT-psychoeducation would benefit from occurring during a period of stability rather than transition.

Participants' descriptions of positive perceived effects on impulsivity, identity and interpersonal relationships provide nuanced support to previous research concluding MBT impacts symptoms of BPD. Further research could investigate whether these perceived changes hold across time, and whether there is an ongoing impact of increased understanding long-term. Personalising information and perceptions of the value of increased self-awareness were pivotal to perceived benefits of the group, but varied across individual experiences.

Further research should explore factors contributing to this variance, including investigation of the connection of personalising knowledge with the recent concept of epistemic trust.

CONCLUSION

The study added to the small evidence-base for experiences of MBT-psychoeducation, using an IPA methodology. Groups were understood as challenging yet predominantly beneficial, demonstrating an overall positive view of MBT-psychoeducation. Perceived benefits related to a contained, unified group environment, the ability to personally apply knowledge, and a view of understanding as empowering. Participants reported attempts to use mentalizing in practice and positive impacts on impulsivity, perspective-taking and understanding of the self and others, relating to core BPD deficits. Some desired additional support or concrete coping strategies was reported, and difficulty tolerating increased self-awareness and the period following MBT-psychoeducation. These findings broadly concur with perceived impacts and challenges of previous studies of MBT and NICE recommendations for BPD (2009). However, they also highlight increased awareness of explicit mentalizing, internalisation of this concept and attempts to navigate interpersonal challenges and attachments within a brief period. This indicates support for MBT-psychoeducation's potential as a useful mechanism to stimulate mentalizing and therapeutic alliances. Implications for practice include providing access to additional, coping-focused support and tailoring strategies to enhance engagement. Most participants viewed gains and development from the group in the context of continuing to the full MBT group. Further research is therefore needed before offering MBT-psychoeducation as an independent brief intervention for BPD.

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Appendix A

Checklist (EHPP for methods & CASP for results)

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Appendix B - Study Grid

	Authors	Area	Drop-out	Sample	Study type	Treatment Intensity/Length	Outcome Measures	Results	Quality control
1	Bateman & Fonagy (1999)	UK	12%	44 Ps 38Ps MBT=19 TAU=19	RCT Partial hospitalization	Up to 18 months MBT vs Treatment as usual	DSH, SA, hospital use, medication Symptoms - SCL-90-R Depression – BDI Anxiety - State-Trait Anxiety Inventory Functioning - Social Adjustment Scale (SAS) Inventory interpersonal problems (IIP)	-For both - reduced medication. -For MBT – reduced DSH, SA, days in hospital, anxiety and depressive symptoms, and severity of general psychiatric symptoms. Improved psychosocial functioning.	Supervision and monitoring of adherence Query of fidelity of MBT as it's a seminal study
2	Bateman & Fonagy (2001)	UK	5% MBT <25% TAU	44 Ps (incl. +6 excl. from previous)	Follow-up Maintenance MBT vs Treatment as Usual	18 month ongoing maintenance (twice weekly MBT) TAU (control group) but higher professional contact.	Same as above	-For MBT group, maintained effects and depression, symptom severity and interpersonal problems continued to improve. -No effect on trait anxiety.	NA
3	Bateman & Fonagy (2008)	UK		41 Ps	Follow-up	8 year follow-up 5 years after treatment completion	Same as above, exception of change from: SAS and IIP to GAF SCL-R-90 to Zanarini	-Maintenance of effects 5 years after discharge for suicidality, diagnostic status, service use, medication, impulsivity, global functioning and vocational status, but general social functioning remained impaired.	NA
4	Bateman & Fonagy (2009)	UK	26.7% MBT 25.4% SCM	134 Ps MBT=71 SCM=63	RCT Outpatient Vs structured clinical management	18 months MBT –weekly individual & group SCM – individual & group (support/problem solving)	DSH, SA, hospital admission Symptoms - SCL-R-90 Functioning – GAF & IIP-c Depression - BDI	-Reduction for both on all outcomes, but steeper decline for MBT -(SA, DSH, hospitalization, social and interpersonal functioning, symptoms).	Both treatments manualized, but no assessment of adherence
5	Bales, Van Beek, Smits, Willemsen, Busschbach, Verheul & Andrea (2012)	Europe	15.5%	45 Ps (severe BPD)	Prospective cohort study Pilot, uncontrolled Day hospital	18 month MBT & 18 month maintenance 4.5 hours, 5 days a week	DSH, SA, hospital use Symptoms - GSI of SCL-90, BPDSI Depression - BDI Quality of Life - EQ-5D Functioning - OQ-5, IIP-c SIPP118	-Improvement in quality of life, symptom distress, social and interpersonal functioning and general functioning. -Reduced suicide attempts and self-harm from 6 months. -Reduced care consumption	Manualized – supervision etc Varying experience of facilitators

	Authors	Area	Drop-out	Sample	Study type	Treatment Intensity/Length	Outcome Measures	Results	Quality control
6	Brüne, Dimaggio & Edel (2013)	Europe	1/16	15 Ps	Uncontrolled feasibility study Inpatient - MBT as adjunct to DBT	6 week programme: 2 weeks of twice-weekly DBT 4 weeks of twice weekly DBT & MBT. Plus individual review, OT and physical health input.	Symptoms - BSL-23 borderline symptom list Mentalizing - Cartoon mentalizing task (unpublished)	- Significant reduction in symptom severity. - No change in mentalizing - Non-significant trend towards more prosocial endings and less avoidant endings.	None reported
7	Jørgensen, Freund, Bøye, Jordet, Andersen & Kjølbye (2013)	Europe	43% 28% MBT 22% SP	85 Ps MBT=58 SP=27 (GAF >35)	Randomised outcome study Outpatient	2 years outpatient intervention: MBT-weekly group, individual + PE Active control -fortnightly Supportive Psychotherapy group + PE	Symptoms – SCL, SCID Depression - BDI Anxiety - STAI/BAI Social adjustment - SAS Interpersonal functioning - IIP General functioning - GAF (interview, team decision)	- Significant changes for both groups on general functioning, depression, social functioning and symptoms. - Only GAF significantly higher in MBT group. - Both had significant improvement on most measures, large or very large effect sizes (but no Confidence Intervals). - GAF-S better for MBT, and GAF-T significant only for MBT (*skewed dis). - Differences between patients in groups. - Non-significant trend for higher recovery from BPD and less criteria for MBT.	Supervision but no systematic monitoring
8	Jørgensen, Bøye, Anderson, Dossing, Anne, Freund, Jordet & Kjølbye (2014)	Europe		58 Ps MBT=40 SP=18	Naturalistic follow-up	18 month follow-up, some booster sessions	Same as above at .5 and 1.5 years after treatment	- Effects maintained from end of treatment, but no further progress. - Non-significant trend for MBT to be better for functional remission (48% vs 19%) but social functioning higher in SP.	Some booster sessions, quality not monitored
9	Jones, Juett & Hill (2013)	UK	N/A	25 Ps 23 BPD 1 BPD 1 traits 1 PD-other (7 Ps completed)	Controlled pilot study Therapeutic community with MBT principles	MBT 6 – 30 months (differences in intensity) SUN (service-user network group) end of treatment, 18 months n = 7	Clinician-rated: Functioning - GAF HONOS Self-reported: Symptoms - Brief Symptom Inventory, Distress – CORE-OM Depression - BDI, PHQ, Anxiety - Spielberger state, GAD7 Social adjustment – SAS Interpersonal functioning - IIP, Self-esteem - Rosenberg self-esteem scale Quality of life - EuroQol Client satisfaction – CSQ-8	- Inconsistencies in findings. - Improved social, psychological and occupational functioning (GAF and HONOS). but social adjustment and interpersonal functioning scores non-significant - Improved symptom distress (brief symptom inventory, P-rated).. but quality of life (QOL) non-sig. - Improved depression BSI depression, but not other dep measures (although correlated) - Satisfaction, majority of responses positive (CSQ-8)	Once weekly supervision for 'adherence to therapy', unsure if strictly MBT

	Authors	Area	Drop-out	Sample	Study type	Treatment Intensity/Length	Outcome Measures	-Results	Quality control
10	Kvarstein, Elfrida, Pedersen, Urnes, Hummelen, Wilberg & Karterud (2015)	Europe	2% MBT	345 Ps MBT=64 PD=281 Comparative baseline severity	Naturalistic, longitudinal Combined day & outpatient	Max 3 years MBT – 12 weeks of PE, weekly group MBT and weekly (reducing to 1 in 3 week) individual sessions PD – (previous) day hospital for 18 weeks, followed by weekly group support	Diagnosis - MINI & SCID-II Symptom intensity - BSI Interpersonal problems - CIP General functioning - GAF	-Both significant for lower SA/DSH, hospital admissions and medication -MBT better for drop-out, engagement, symptom distress, interpersonal functioning, global functioning, occupational status. -Lower symptom distress (large effect at 3yrs), interpersonal problems. Higher GAF and occupation increase.	Treatment adherence scale - ACS
11	Bales, Timman, Andrea, Busschbach, Verheul & Kamphuis (2015)	Europe	Not reported	29 Ps MBT=29 OPT= 29/175	Matched control non-randomized. Day hospital setting,	MBT – 18 months day hospital & 18 months maintenance OPT – variety of psychotherapeutic approaches and settings	Psychiatric symptoms - BSI Personality functioning - SIIP-18.	-Improvement at 18 and more at 36 months on both outcomes. -Large effect on reduced symptoms and improved personality functioning. -MBT larger effect size. (moderate – to large d). -OPT – small to medium effect size -Psychiatric distress –large reduction for MBT, moderate for OP -No diff in group for relational functioning -	Varied experience, but supervision and adherence scale – 'good to excellent'
12	Dyson & Brown (2016)	UK	N/A	6 Ps Age 20–44 Self-identified BPD (internet)	Qualitative study – IPA Varied MBT	Minimum 6 months MBT (self-identified)	Semi-structured interview schedule	Overarching theme: Battle between BPD & me (sense of self/identity) Subthemes: -helped but not cured (self-harm and social engagement) -willingness and personal choice -shared experience/connection, but individual lost. (Recognition of change in behaviour)	Self-identified, so no consistency in intervention or diagnosis. Analysis – inclusion of Yardley's criteria & reflection, but not of supervision.
13	Ó'Lonargáin, Hodge & Line (2016)	UK	N/A	7 Ps Age 26–52 (groups for BPD)	Qualitative- IPA Intensive MBT outpatient group	3-14 months MBT Recruited from groups	Semi-structured interview schedule	4 themes: -unpredictable and challenging -building trust -putting the pieces together (structure) -seeing the world differently: a positive shift. (recognition in change of perception)	-Yardley criteria, Supervision, reflective diary, paper trail, Interview schedule included in appendix but not in body of text.

Appendix C - MBTi group outline

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Appendix D- Participant Information Sheet

Canterbury Christ Church University

V3, 18.02.2016

Participant Information Sheet

'Exploring experiences of a MBT psychoeducation group'

My name is Cerys Bradley-Scott and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important you understand why the research is being done and what it would involve for you. You can use this sheet to think about the study, and to discuss with your family, friends or key worker if that would be helpful.

What is the purpose of the study?

This study aims to develop a better understanding of how people experience a specific type of psychology group, called Mentalization-based psychoeducation (MBTi). This group is a form of Mentalization-based therapy, which aims to help people with a wide range of mental health difficulties including personality disorders. It is important for health care professionals and service-users to know what these groups are like for the people who attend them, in order to know whether they are a useful intervention to offer.

Why have I been invited?

You have been invited to participate in this study because you are currently in, or have recently taken part in, a MBT psycho-education group. For this project, a maximum of 11 other people will be invited to share their experience of this specific group.

Do I have to take part?

No, it is entirely up to you whether you decide to take part in the study. If you agree to take part, I will ask you to sign a consent form before we start. You are free to stop taking part in the study at any time, without giving a reason. This would not affect your current or future care in any way.

What will happen to me if I take part?

If you take part you will be invited to meet with me at your most convenient (SERVICE NAME) location to discuss and share your experience of attending the MBTi group. This interview will take about an hour and will be audio-recorded on a Dictaphone. There will be space at the start of the interview to discuss any concerns or questions you may have about taking part in this project. I will also ask you for some basic information about yourself e.g. your gender, and for consent to access some questionnaires that you will have filled out in the MBTi group e.g. the CORE.

After the interview, I will transcribe the audio recording, listening to what you spoke about and identifying the key things that you told me about the group. These will be combined with the other participant's key points, and I will try to identify overall themes from the data. I will then invite you to give me some feedback on these themes in a second meeting a few months later, if you wish to do this.

V3, 18.02.2016

All information and data you provide for the study will be kept anonymous and confidential. However, if a researcher is concerned about your wellbeing, it may be necessary for them to share some of this information with your care team or key worker.

The audio-file of your interview will be anonymised and stored using encrypted, password protected devices. It will be deleted from these immediately after it has been transcribed. In line with research guidance, the anonymized transcription will be stored on a secure disk at Canterbury Christ Church University for 10 years, after which time it will be securely destroyed.

Expenses
You will be reimbursed for your travel expenses to attend the initial interview, up to a maximum of £10. Please keep receipts for public transport or parking costs. If you drive, please provide the mileage for your trip.

What will I have to do? You will need to attend one meeting to discuss your experience with me, which we will arrange at your convenience. You will be invited to a second, briefer meeting to provide feedback on themes at a later date.

What are the possible benefits and disadvantages of taking part?
Participating in this study is an opportunity to have your voice heard, and may be a useful chance for you to reflect on the group. We cannot promise that this study will help you, but the information we get from this study may help to develop the treatment for other people with personality disorder.
It is unlikely that there will be any negative effects of taking part in this project. However, you may find discussing your experience uncomfortable or distressing. If this happens, you will be supported in the interview, and can also discuss this with your therapy team following the interview.

What if there is a problem?
Any complaints about the study or the way you have been treated during the study will be addressed. Full information about this is available in Part 2.

Will my taking part in the study be kept confidential?
Yes. The study will follow ethical and legal practice at all times and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Canterbury Christ Church University

V3, 18.02.2016

Part 2

What will happen if I don't want to carry on with the study?
If you decide to withdraw from the study, you can request for your data to not be used. In this case, the data you have already provided can be destroyed and will not be included in the final project.

What if there is a problem?
If you have a concern about any aspect of this study, you should contact me on 0333 011 7070 and I will do my best to answer your questions. Please leave a message stating it is for the attention of Cerys Bradley-Scott and provide a contact number so I can get back to you. If you remain unhappy and wish to complain formally, you can do this by contacting the Research Director at Salomon's Centre, Professor Paul Camic on 0333 011 7114.

Will my taking part in this study be kept confidential?
Yes, all information collected about you during the course of the research will be kept confidential. However, if researchers become concerned for your wellbeing during the course of the study, this information may be shared with your care team or key worker. Your information will be stored securely at all times and anonymised with your name and other personal details removed so that you cannot be recognised. Research supervisors will only have access to view anonymised data. In line with research guidance, your data will be stored securely for 10 years following the completion of this study, and will be disposed of securely after this time.

What will happen to the results of the research study?
The results of this study will be written up in the form of a Doctoral thesis which will be submitted to Canterbury Christ Church University and are intended to be published in a scientific journal. These publications will include anonymized quotes from your interview. You will not be identified in any report or publication unless you have given your explicit consent.

Who is organising and funding the research?
This research is primarily organised by me, Cerys Bradley-Scott, as a PhD student of Canterbury Christ Church University and is funded by this institution. The project is supervised by Dr Tony Lavender of Canterbury Christ Church University and Dr Ann Fitzgerald of ████ NHS Trust.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved by Salomon's Research Ethics Committee and (SERVICE NAME) R&D department.

You will be given a copy of this Information sheet and a signed consent form to keep.

Further information and contact details
If you would like to speak to me to find out more about the study or have any questions about it, you can leave a message for me on a 24-hour voicemail phone line at 0333 011 7070. Please say that the message is for me (Cerys Bradley-Scott) and leave a contact number so that I can get back to you.

Appendix E – Consent to Contact Form

Canterbury Christ Church University

Salomons Centre for Applied Psychology

Please fill out this form if you feel you may be interested in participating in the study 'exploring experiences of MBT psychoeducation groups'.

(This **does not mean you have to participate** but allows the researcher, Cerys Bradley-Scott, to contact you once by phone to invite you to participate.)

Name: ………………………………………………………………………………………………….

Telephone number: ………………………………………………………………………………..

Signature: …………………………………………………………………………………………….

Date: …………………………………………………

Appendix F – Consent Form

Canterbury
Christ Church
University

TRUST LOGO

Salomons Centre for Applied Psychology

Centre Number:
Study Number:
Participant Identification Number:

CONSENT FORM

Title of Project: Exploring experiences of a MBT psychoeducation group

Name of Researcher: Cerys Bradley-Scott

Please initial box:

1. I confirm that I have read and understand the information sheet dated 18.02.16 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by the lead researcher (Cerys Bradley-Scott) or supervisors (Dr Ann Fitzgerald and Prof Tony Lavender). I give permission for these individuals to have access to my data.

4. I understand that my participation in this research will involve me being interviewed by the researcher (Cerys Bradley-Scott) and consent to this interview being audio-recorded for the purpose of transcription.

5. I agree that anonymous quotes from my interview may be used in published reports of the study findings.

6. I agree to take part in the above study.

Name of Participant_____   Date_____

Signature _____

Name of Person taking consent _____   Date_____

Signature _____

Appendix G – Demographic Questionnaire

Demographics V1

Canterbury
Christi Church
University

Salomons Centre for Applied Psychology

Please outline your:

Age: _____ years

Gender: Female ☐   Male ☐   Other ☐ (please specify):_____

Ethnicity:

White

☐ 1. English/ Welsh/ Scottish/ Northern Irish/ British
☐ 2. Irish
☐ 3. Gypsy or Irish Traveller
☐ 4. Any other White background, please describe _____

Mixed / Multiple ethnic groups

☐ 5. White and Black Caribbean
☐ 6. White and Black African
☐ 7. White and Asian
☐ 8. Any other Mixed / Multiple ethnic background, please describe _____

Asian / Asian British

☐ 9. Indian
☐ 10. Pakistani
☐ 11. Bangladeshi
☐ 12. Chinese
☐ 13. Any other Asian background, please describe _____

Black / African / Caribbean / Black British

☐ 14. African
☐ 15. Caribbean
☐ 16. Any other Black/African/Caribbean background, please describe _____

Other ethnic group

☐ 17. Arab
☐ 18. Any other ethnic group, please describe _____

Demographics V1

Canterbury
Christ Church
University

Salomons Centre for Applied Psychology

Mental Health Diagnoses: _____

_____

Highest level of education:

GSCE (or equivalent) ☐

A levels (or equivalent) ☐

College, diploma or NVQ ☐

Undergraduate degree ☐

Post-graduate degree ☐

Current employment status:

Employed ☐

Unemployed ☐

Student ☐

Relationship status:

Single ☐

In a relationship ☐

Married/Civil Partnership ☐

Have you ever had therapy before? Yes ☐   No ☐

If yes,   How many previous periods of therapy have you had? _____

How long (roughly) did these sessions last (e.g. 6 sessions, 1 year)? _____

Was this group or individual therapy? _____

Appendix H – Transcription Agreement

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Appendix I - NHS ethical approval

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Appendix J – NHS Ethics Report

Research Summary Report

Project: 'Exploring experiences of MBT-psychoeducation groups for people with Borderline Personality Disorder in secondary care settings'

Background: Mentalization-based therapy (MBT) has demonstrated some efficacy with treating Borderline Personality Disorder (BPD), a prevalent difficulty in secondary-care settings. Experiences of MBT-psychoeducation groups have not yet been explicitly studied. This is important because, as a brief intervention, they have potential to positively increase therapy access but also interact with attachment difficulties inherent in BPD.

Study Aims: To explore lived experiences of people with BPD who attended MBT-psychoeducation groups in secondary care settings. The study's research questions were:

1) What are people's experiences of these groups?
2) Has the group impacted the way participants think about themselves and cope in everyday life?
3) Has the group influenced the way participants think about others and experience interpersonal relationships?

Method: Eight participants with a diagnosis of BPD were interviewed about their experience of MBTi groups. Interpretative Phenomenological Analysis was used to explore and interpret these accounts.

Findings: Rich, varied descriptions provided a sense of MBT-psychoeducation as a challenging but beneficial process. Three superordinate themes and 8 subthemes emerged:

1) Managing complex group dynamics – attempts to manage the dynamic group nature.
   a. Group purpose – perceived purpose of group and methods to achieve this.
   b. Desire for emotional containment – managing emotions evoked to enable engagement. Facilitator input, group attachment and structure were important.
2) Personalizing knowledge – ways of personally applying information and experiences.
   a. Directly relating to information (from topics or others)
   b. Self in relation to others (managing differences, boundaries)
   c. Self in others (managing similarities, empathy)
3) Increased understanding: the power and the fear
   a. Understanding as empowering (as a coping skill or foundation to build on)

   b. Understanding as insufficient (increased awareness without strategies to manage)

   c. Sense of agency and perceived resources (affected perceptions of impact)

Themes highlight nuanced experiences, outlining effects on awareness of self and other. These varyingly impacted participant's identity, impulsivity, perspective-taking and ways of relating interpersonally. The group was seen as the start of a process, with participants predominantly viewing gains in the context of further MBT group therapy.

Implications: Variance in the themes presented can inform tailoring interventions and supporting engagement. Awareness of some perceived importance of accessing further MBT group therapy for benefits of MBT-psychoeducation is crucial to offering this intervention. Participant's desire for additional support and coping could be addressed with access to service-user groups focused on coping or crisis management.

Further research should explore variance in personalising information and perceptions of understanding. While experiences of the group indicate acceptability of the intervention, this was often in terms of further access to MBT groups. More research is necessary before offering MBT-psychoeducation independently. Experiences of those who disengaged, or are not offered further access to MBT, would be informative of the acceptability of MBT-psychoeducation.

Conclusions: MBT-psychoeducation groups were seen as challenging but beneficial. Impacts of awareness of the group, self and other was predominantly viewed as positive tools. Yet for some this was viewed as insufficient for coping. Gains were often viewed in terms of access to further MBT therapy. Further research is needed before offering these groups as an independent intervention. Impacts on mentalizing, group purpose and managing relationships over a brief period may suggest support for its role in promoting mentalizing and therapeutic relationships.

Dissemination:

   - Feedback to participants and services in the form of a summary report, and independent feedback sessions. (These will be updated following any information from Viva and examination.)
   - Future submission of empirical paper for consideration in Journal of Mental Health.

Appendix K – Participant Report

Participant Summary Report

Dear (Participant Name),

Thank you very much for your time and generosity in taking part in this study and sharing your experience with me. The study has now ended, and I am writing to give you a short summary of the main research findings. These findings are an overall sense of what all participants told me.

Study findings:

Peoples' descriptions of their experiences were very rich and quite different. Sometimes there were differences within peoples' own explanations which I think shows how complicated the experience was. Overall, it seemed most people found taking part in the MBT-psychoeducation group was a challenging but positive experience. Three main themes came out of peoples' descriptions of the group.

Theme 1: Managing complex group dynamics – people spoke about the different parts of the group, managing the way it all worked together and emotions from it. They did this by thinking about what they thought the groups were for, and things that made the group feel more comfortable (like facilitator and peer support and a flexible structure) or uncomfortable (like other people not attending consistently). While there were lots of positive descriptions for this, at times people felt they needed more structure or support during the group.

Theme 2: Personalizing knowledge – this was how people talked about relating the information from the group to them personally. Most people felt they learned not only from the topics that were covered but also through the (sometimes very positive and sometimes very challenging!) experience of being with other people. Feeling similar and different to other people led to empathy or better understanding about why this might be, and impacted peoples' ideas of themselves and other people. This was an extremely important part of the group.

Theme 3: Increased understanding: the power and the fear - Everybody described the group as having an impact on how they understand or think about themselves and other people. This was mostly described in terms of understanding reasons why difficulties, intense emotions or miscommunications might happen. Being able to use mentalizing to get some 'space' or 'step back' from thoughts or before deciding to act helped to reduce peoples' stress or conflict in relationships. Understanding symptoms of BPD, the science of emotions, and attachment sometimes helped people feel better about themselves and more confident – especially when talking to people about BPD or reaching out to

other people for support. Most people felt that increased understanding of themselves and 'mentalizing' helped them to cope with difficulties, or was a foundation to build on but other people wanted more specific coping strategies. It could also sometimes feel like MBT highlighted difficult things for people and made people feel critical of themselves. There was a sense that how people felt about themselves, their own ability to try mentalizing on their own and their ability to get support from family, friends or services influenced how they felt about the group.

Most people spoke about a 'limbo' feeling of being in-between the MBT-psychoeducation group and finding out about the next MBT group. Some people found this exciting, some people didn't mind it and some people found it very worrying. People explained that they thought future participation in the MBT group would help improve their progress or might even be necessary to feel MBT-psychoeducation was worth attending or to cope with the thoughts and emotions that it had raised.

Next steps:

I am hoping to publish the research in an academic journal in the near future, so that findings from your input and the other participants can be used to improve and better understand the experience of these MBT-psychoeducation groups. If the article is published and you would like to read it, I would be happy to send you a copy.

If you have any further questions about the study, please contact me on my research line. If the study or this feedback letter has been difficult in anyway, please be aware that you can contact your care coordinator or clinical team to discuss this further.

Finally, I would like to say a sincere thank you for taking the time to participate in this study. I am hopeful the study will help develop future MBT-psychoeducation groups and improve peoples' care. It was a privilege to hear your experiences, stories and thoughtful perspectives on the group and your personal journey. I wish you the very best in future.

Yours sincerely,

Cerys Bradley-Scott

Trainee Clinical Psychologist

Appendix L – Service Report
R&D Summary Report

Project: 'Exploring experiences of MBT-psychoeducation groups for people with Borderline Personality Disorder in secondary care settings'

Study Aims: This study sought to explore lived experiences of people with BPD who attended MBT-psychoeducation groups in secondary care settings. The study's research questions were:

1) What are people's experiences of these groups?

2) Has the group impacted the way participants think about themselves and cope in everyday life?

3) Has the group influenced the way participants think about others and experience interpersonal relationships?

Method: Eight participants with a formal diagnosis of BPD were interviewed about their experience of MBTi groups. This included four participants from two MBTi groups run within your Trust. Interpretative Phenomenological Analysis was used to explore and interpret these accounts.

Findings: Rich, varied descriptions provided a sense of MBT-psychoeducation as a challenging but beneficial process. Three superordinate themes and 8 subthemes emerged:

4) Managing complex group dynamics – attempts to manage the dynamic group nature.
   a. Group purpose – perceived purpose of group and how to achieve this.
   b. Desire for emotional containment – managing emotions evoked to enable engagement. Facilitator input, group attachment and structure were important.

5) Personalizing knowledge – ways of personally applying information and experiences.
   a. Directly relating to information (from topics or others)
   b. Self in relation to others (managing differences, boundaries)
   c. Self in others (managing similarities, empathy)

6) Increased understanding: the power and the fear
   a. Understanding as empowering (as a coping skill or foundation to build on)
   b. Understanding as insufficient (increased awareness without strategies to manage)
   c. Sense of agency and perceived resources (affected perceptions of impact).

Themes show nuanced experiences, outlining effects on awareness of self and other. These varyingly impacted participants' identity, impulsivity, perspective-taking and ways of relating interpersonally.

The group was seen as the start of a process, with participants predominantly viewing gains in the context of further MBT group therapy.

Clinical implications:

- An awareness that these groups can be experienced as both challenging and positive is clinically important.
- Themes from this data can be used to tailor interventions and support engagement. For example:
    - Access to additional support during the groups, potentially support groups focused on coping/crisis management, incorporation of new understanding into crisis planning
    - Supporting moves from concrete to abstract strategies to engage with information (in the context of secure group connections)
    - Preparation for the idea of understanding as an independent outcome
    - Encouragement of self-compassion to prevent self-criticism, and alertness to hypermentalizing
- While experiences of the group indicate acceptability of the intervention, benefits were often viewed in terms of further access to MBT groups. More research is necessary before offering MBT-psychoeducation independently.
- Impacts on mentalizing, group purpose and managing relationships over a brief period may suggest some support for the groups' role in promoting mentalizing and therapeutic relationships.

Conclusions: MBT-psychoeducation groups were seen as challenging but beneficial. Impacts of awareness of the group, self and other was predominantly viewed as positive tools and impact core components of BPD. Yet, for some, increased understanding was viewed as insufficient for coping. Gains were often viewed in terms of access to further MBT therapy. Further research is needed before offering these groups as an independent intervention.

Dissemination of findings: I have included a copy of the participant summary form for your information. I will also be conducting feedback sessions for both participants and specific clinical services. I am submitting this study in partial fulfilment of an academic qualification, and am aiming to submit the empirical paper for consideration in Journal of Mental Health.

Research contact details:

(excluded from copy)

Appendix M – Interview Schedule

Draft Interview Schedule (Version 3, 07.10.2016)

Intro – descriptive/narrative questions

1. Can you tell me how you heard about the (MBT psychoeducation) group?
2. Can you tell me what made you decide to take part in the group?

   Prompts: What were your expectations, goals, difficulties at the time

3. In general, what was your experience of the group like?

   Prompts: What happened? How did you feel? What did it make you think?

Process

4. Have you learnt anything from the group?
5. What does the term 'mentalizing' mean to you?

   (If already covered, prompt 'Can you tell me a bit more about what Mentalizing means to you?')

6. Did you feel the group changed as time went on? If so, how?
7. As the group went on, did the way you think about the other people and facilitators in the group change? If so, how?

Impact

8. Were there any aspects of the group or specific moments which were most important for you or had the most impact? Which one(s)? Why?
9. Was there anything about your experience of the group that made a difference to you as a person?

   Prompts: The way you think about yourself, how you cope with everyday life.

10. Has your experience in the group changed the way you think about your relationships with family or friends outside the group? If so, how?
11. Has your experience of the group influenced your relationship with mental health professionals or services in general? In what ways?

Ending Q (to move back to general rather than personal) – In your opinion, what do you think would be the most important thing for people to know about the mentalization group?

General prompts: Why? How? Can you tell me more about that? Tell me what you were thinking? How did that make you feel? Can you explain that further?

Appendix N – Example (anonymised) Coded Transcript

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Appendix O – Example mind map showing theme development for one participant

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Theme Prevalence

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Appendix P – Extract of Research Diary

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Appendix Q – Journal Author Guideline

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