Learning the subtle dance: the experience of therapists who deliver mentalisation-based therapy for borderline personality disorder

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Key words*: Borderline personality disorder, mentalisation based therapy, therapist, MBT, phenomenology*

Abstract

Objectives: This study aimed to understand therapists' lived experiences of delivering mentalisation-based therapy (MBT), including their experiences of service user change.

Method: One-to-one semi-structured interviews or focus groups were conducted with 14 MBT therapists and analysed using interpretative phenomenological analysis (IPA).

Results: Four superordinate themes were identified: 1) experiencing the challenges and complexities of being with service users during MBT; 2) being on a journey of discovery and change; 3) being an MBT therapist: a new way of working and developing a new therapeutic identity; and 4) being a therapist in the group: seeing it all come together

Conclusion: Our findings highlight the complexity, challenges and individualised experience of working therapeutically with service users with a diagnosis of BPD. The study provides a perspective of service use change that is enriched by idiosyncrasies within the therapeutic encounter. We conclude with a consideration of implications for MBT research and clinical practice.

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Introduction

Treatment approaches for people experiencing borderline personality disorder (BPD) are limited but one effective evidenced-based treatment that is recommended by NICE (2009) in the UK and administered internationally is Mentalisation Based Therapy (MBT; Bateman & Fonagy, 2006). Mentalisation based therapy typically lasts 18 months as either a day hospital programme or intensive outpatient treatment and consists of initial psychoeducation followed by weekly individual and group therapy sessions (Bateman & Fonagy, 2006). The therapy has its roots in psychoanalytic theory, developmental psychopathology and attachment theory and works within the context of attachment relationships to promote mentalising (i.e., the individuals' ability to understand their own and others' mental states; Bateman & Fonagy, 2006, 2009). As individuals improve their capacity to mentalise, patterns of emotional arousal and behavior become more consistent with a secure rather than insecure attachment (Bateman & Fonagy, 2009), which can in turn improve emotion dysregulation, and reduce impulsive behaviours and interpersonal difficulties (Bateman & Fonagy, 2006).

The effectiveness of MBT for treating BPD is evidenced in multiple studies. A systematic review of 14 quantitative studies, including randomised clinical controlled trials (RCT), identified that MBT leads to the reduction of BPD symptom distress, anxiety and depression; fewer self-harm and suicide attempts; and improved quality of life, interpersonal functioning and social adjustment (Vogt & Norman, 2018). Another systematic review (Malda-Castillo, Browne & Perez-Algorta, 2019) has drawn similar conclusions.

Quantitative studies published since these systematic reviews have continued to demonstrate the effectiveness of MBT (Bateman et al., 2020; Einy, Narimani & Sadeghi, 2019; Smits et al., 2020), although for adolescents, MBT appears to be only as equally as

effective as treatment as usual (Beck et al., 2020; Griffiths et al., 2019). Some studies have focused more specifically on the mechanisms of therapeutic action, finding that improved mentalising is a mechanism of change associated with good treatment outcome in BPD (De Meulemeester et al., 2018). Yet, whilst studies supporting the central role of mentalising and the efficacy and/or impact of MBT for BPD are slowly accumulating, only a handful are qualitative, leaving gaps in our understanding regarding the broader experiential impact of the therapy on less quantifiable experiences, symptoms and behaviours.

Qualitative studies of MBT have enhanced our understanding of service users' experience and perceptions of the therapy, with common themes relating to the experience of having a BPD diagnosis, group therapy, trust, the need for validation from therapists, the structure of MBT, and change (Ditlefsen et al., 2020; Dyson & Brown, 2016; Gardner, Wright, Elliott, Graham, & Fonagy, 2019; Johnson, Mutti, Springham & Xenophontes, 2016; Morken, Binder, Arefjord, & Karterud, 2017; Morken, Binder, Arefjord & Karterud, 2019; Ó Lonargáin, Hodge & Line, 2017). At least three studies have focused specifically on advancing understanding of service users' experiences of change and/or perceived mechanisms of change (Gardner et al., 2019; Morken et al., 2017; Morken at al., 2019). As noted by Gardner and colleagues, qualitative insights into the lived experience are particularly important since they capture the individuals' construction of their experience of change and the ways in which they personally believe they have changed (Gardner et al., 2019). In Gardner and colleagues, service users reported improved mentalising and a range of cognitive, affective, interpersonal and behavioural changes consonant with the theoretical principals of MBT and some quantitative studies, but the findings mirrored Dyson and Brown (2016) who also found that service users reported a continued negative felt experience. Potential perceived catalysts for change included a strong therapeutic alliance, trust, and the group (Gardner et al., 2019), findings similar to those of Morken et al., (2019). These studies

are a therefore valuable addition to RCT studies of service user change, capturing less quantifiable change mechanisms such as felt experience, the context in which these operate (e.g., the therapeutic relationship), and the meaning of these changes to service users. Indeed, the service user's frame of reference is crucial when understanding change and how individuals experience therapy (e.g., Duncan & Monyhan, 1994; Elliot, 2010; Elliot & James, 1989). According to Bohart (2000), the service user is the most crucial common factor in psychotherapy, and they are 'aided and abetted by the therapist' (p.130).

Whilst the service user experience is paramount, decades of psychotherapy research has also identified the therapist as a common factor in good treatment outcome in psychotherapy (Cuijpers, Reijnders & Huibers, 2019; Duncan, 2014; Hill & Castonguay, 2017), highlighting the importance of exploring and understanding the unique experience of the therapist. In MBT the therapist adopts a non-expert and inquisitive, open stance (Bateman & Fonagy, 2006) which is core to MBT as a means of enhancing mentalisation capacity of service users, a major goal of the therapy. Given the unique focus of MBT, qualitative research that focuses on understanding the therapists' internal world and how they experience and make sense of MBT as a therapeutic journey is important for understanding how MBT operates. For example, MBT therapists' must hold an understanding of the model of therapy in their mind, to guide the progression of the therapy, and qualitative research could offer a glimpse into therapists' experiences of holding to this model. Better understanding these experiences could also have implications for training, especially if it is possible to identify specific aspects of the model that are difficult to learn or employ (e.g., enhancing mentalising in service users). New therapists will need to be aware of any such challenges as they begin to align to the model.

In addition to understanding therapists' general experiences of the therapeutic journey, it is important to understand common and specific mechanisms of change in MBT

(e.g., the therapeutic alliance, enhanced mentalising, epistemic trust; Bateman & Fonagy, 2006; Fonagy & Bateman, 2006; Fonagy, & Allison, 2014; Folmo et al., 2021), as perceived by the therapist. Drawing on therapists' own experiences of how their service users have changed or transitioned/adapted over the course of MBT could triangulate and extend the understanding we have gained from existing quantitative (De Meulemeester et al., 2018) and qualitative service user studies (e.g., Gardner et al., 2019) of the mechanisms of action, and thus guide future research into how MBT works. Therapists may hold similar or different perspectives to service users (a meta-synthesis of 41 studies found that perceptions match in around 30-40% of cases: Timulak, 2010), and if points of difference do exist, these are important to understand since they can contribute to the therapeutic encounter and ultimately service user change. For example, misunderstandings or disagreements between therapist and service user about the tasks or goals of therapy (including goals related to change) can lead to alliance ruptures (Safran, Muran & Eubanks-Carter, 2011). Yet, both quantitative and qualitative studies thus far have focused on measurable or perceived levels of *service user* change, respectively; to the best of our knowledge, studies have yet to specifically explore therapists' experience of service user change as therapists attempt to support transition and adaptation during the therapy.

Some studies have explored the role of the therapist in MBT, though not all are qualitative, and the phenomenological experience of therapists has been overlooked. A thematic analysis of the group therapy sessions of two MBT therapists found that therapists struggled to establish authority and competently adopt the not-knowing stance (Inderhaug & Karterud, 2015). A similar analysis of the therapy sessions of six MBT therapists working with individuals with BPD and comorbid substance abuse disorder found that competency in practising the not-knowing stance is one of several therapist skills that predicts client continuation in therapy (Philips, Karlsson, Nygren, Rother-Schirren, & Werbart, 2017), and

Möller and colleagues' analysis of seven MBT therapists working with a similar client group found that therapists' who scored higher on competence and adherence to MBT principles increased service users' mentalising (Möller et al., 2017). A more recent Interpretative Phenomenological Analysis (IPA) study of the therapy sessions of four MBT therapists identified that a strong therapeutic alliance and strategic competence interact to produce a sense of epistemic trust (Folmo et al., 2019). Finally, an IPA study of nine nurses undergoing MBT skills training for use in generic health-care settings found that staff had few criticisms of the approach and described mentalising as a common-sense approach that is easy to understand, though this is a unique participant group and context (Warrender, 2015).

In summary, a qualitative phenomenological exploration of therapists' experience is needed and could advance our understanding of the importance of the therapist and in context, as MBT is taking place. The therapists' frame of reference also forms one of several important perspectives of the service user experience (Elliot & James, 1989). We concur with this view and argue that obtaining the perspective of the other individual within the therapeutic relationship (the MBT therapist) is important on theoretical, empirical and practical grounds, as described above. This study therefore aims to understand therapists' general experiences of MBT, and their experiences of service user change throughout therapy. The use of IPA as a philosophical framework (Smith, Flowers and Larkin, 2009) enabled us to view the data through a phenomenological lens, that is, to consider therapists' 'lived experience'.

Methods

Recruitment and Sample

Participants were recruited via a regional MBT therapist interest group in the North of England, and directly from one of four local NHS trusts that were associated with this group, using homogenous (purposeful) sampling (Palinkas et al., 2015). The therapists were all part

of specialist teams looking to deliver MBT specifically to groups of patients diagnosed with BPD. All had received introductory level MBT training and were receiving specific MBT supervision within their teams. We were interested in hearing the experiences of and therefore invited, all MBT therapists in these trusts to take part, irrespective of years of experience. Fourteen Participants (9 females, 5 males; *Mean* age=45.14; *SD*=10.41) were included who were trained in MBT and had worked in psychological or psychiatric care for between 7 and 30 years (*Median*=19.5), and as an MBT therapist for between 1 and 8 years (*Median*=3.75). Participants were clinical psychologists (n=7); medical psychotherapist (*n*=1), psychiatrist (*n*=1), psychotherapist (*n*=2), personality disorder case manager and/or nurse (*n*=2), psychological therapist (*n*=1). Additional demographic features are in Table 1.

Ethics

Approval was obtained from the University Ethics Committee of the first author, the NHS Research Ethics Committee and from the Research and Development departments of four NHS Trusts. All participants provided written consent for involvement. All data were held securely and confidentially in accordance with General Data Protection Regulation (GDPR).

Interviews/Focus Groups

Interviews were constructed, transcribed and analysed in line with established guidelines for IPA (Smith & Osborne, 2003). Both semi-structured focus groups and one-to-one interviews were offered (if unable to attend the focus group). In line with Smith and Osborne, one-to-one interviews were scheduled for 60 mins, though there was variation in length (interview 1 =29 mins; interview 2 =66 mins; *Mean* =47.5). Focus groups were scheduled for a maximum of 90 mins (group 1 =85 mins; group 2 =86 mins; group 3 =54 mins; *Mean* =75). Focus groups/interviews took place within NHS Trust premises and were conducted by one of the first three authors who had either extensive nursing experience of

working clinically with individuals with personality disorder and/or personality disorder research expertise from either nursing or psychology backgrounds. The second author was experienced in the use of IPA and trained the first and third author prior to the focus groups/interviews. The authors responsible for coding and analysis were not trained in MBT.

The focus groups/interviews were digitally recorded on an encrypted audio device. A topic guide with open-ended questions was used to promote a natural flow of conversation and to allow participants to: a) voice their general experiences of being an MBT therapist and b) explore how they experience and make sense of changes within their service users. Interviews were transcribed verbatim.

Analysis

We used interpretative phenomenological analysis (IPA) (Smith et al., 2009) as this approach places the individual participant, their subjective experience, attitudes, and beliefs, at the centre of the analysis (Shaw, 2001; Smith et al., 2009). We were interested in how therapists experienced MBT and made sense of the impact of MBT on service users. This was evident in the approach to questioning with participants in both the focus group and one-to-one interviews.

We followed the steps outlined by Smith and Osborne (2003), with the second most experienced IPA author leading the analysis. The transcripts were divided up amongst the first three authors and individually manually coded for recurrent themes, except for focus group three which was randomly selected for coding by all three authors. The three authors then met several times to discuss, debate and agree codes and emergent superordinate/subordinate themes, moving back and forth between the themes and transcripts to make sense of participants' accounts and the emergent themes. To ensure confirmability and credibility of these data the authors discussed potential bias and implemented recommended strategies to reduce bias, including a consideration of deviant cases, reflecting

back on quotations to discuss meaning and to ensure the codes stay true to participants' stories and data, and researcher and theoretical triangulation (Forero et al., 2018; Lincoln & Guba, 1985). The use of multiple analysts with different backgrounds led us to consider multiple explanations and helped us identify blind spots in our theoretical perspectives and interpretations (Lincoln & Guba, 1985). Once coded, all data were inputted into a secure excel document for authors to review and discuss the key themes. The final themes were translated into a narrative account and reviewed and commented on by all authors, some of which were experienced MBT practitioners.

Findings

This paper reports on four superordinate themes (Table 2). Example direct quotations illustrate each theme (linked to interviewees by pseudonym). The themes reflect the phenomenological concept of 'being' (Heidegger, 1962) i.e., the therapists' lived experience of 'being' a therapist in MBT.

Experiencing the challenges and complexities of being with service users during MBT

This theme captures therapists' experiences of working with service users in MBT and some of complexities and challenges they faced. Several therapists reflected on the time that service users had spent in mental health services, and in how this had impacted them individually: '*my expectation setting with any of my service users in whatever model always feels a bit fudged…they've…been round the system for years.'* (Pat). They also attempted to make sense of the complex histories, clinical complexity, repeated cycles of '*interpersonal crisis*', and relational difficulties that service users presented with. Pat went on to describe the use of specific therapeutic techniques in terms suggestive of a struggle: '*I'm constantly pulling her back. Sometimes I've almost felt like it's felt invalidating…*'.

A small number of therapists recounted their service users' positive or negative experiences of receiving a diagnosis, for example, '*a relief*' (Chris). Negative connotations

included the suggestion that BPD was sometimes used by service users to attribute their difficulties to. Hopes and expectations were also highlighted as therapists recognised the utility in diagnostic criteria in providing understanding and direction for treatment for some service users.

Alongside the common and expected traits of BPD, some therapists mentioned the '*massive impact*' that illicit substances (a contraindication to therapy) can have on service users' mentalising, and how as therapists they dealt with this: '*I try and put an emphasis on them…to reduce and potentially stop using substances actually so that it becomes part of their therapy. But not to expect that as a realistic.'* (Jamie). Jamie's narrative captures a contradiction in practice and expectations as a therapist.

The therapeutic relationship was one that also presented a challenge. Therapists described how their service users expressed feeling '*broken'* with a general sense of mistrust in other people and expressed a desire to stop MBT because they felt it was not working. Despite this, the narratives suggest that the therapist commitment in MBT to sticking with service users through the therapy was clear. This was a common experience and a realisation of the need to balance different therapeutic skills such as directly addressing feelings about each other to ensure a strong therapeutic relationship/ alliance:

> '*…she comes in, she says this isn't good, it's not working, not bothered, I want to stop, what I haven't done is stop. I've said look I still want to work with you...I think it's sometimes we can be too passive in MBT and I think you should be active, you should be managing intensity but still keeping curiosity. So it is quite a subtle dance to learn.'* (Sam).

Being on a journey of discovery and change

This theme represents therapists' experiences of helping others change, as well as the therapists' experiences of their service users' journey and change through MBT. Pat seemed uncertain about what helps service users change and what to expect from MBT, and this seemed to be tied into the experience (or lack thereof) of delivering MBT and the subsequent impact on expectation setting for the service user: '*…what I found difficult about setting expectations…was because I hadn't seen somebody through a course of MBT before I didn't know what was realistic…*'.

Almost all therapists explored in some detail how their service users had improved in terms of better mentalising (a potential mechanism of change) and subsequent symptom reduction. Therapists' narratives included descriptions of either specific or fairly global personality changes, as well as behavioural (e.g., reduced self-harm/suicidal behaviour and impulsive behaviours such as substance abuse), cognitive (e.g., improved awareness, focus and self-questioning), affective (e.g., less depressed/angry/aggressive/impulsive, calmer, better able to tolerate emotion, and slower to react), interpersonal (e.g., improved interpersonal relationships and dynamics) and practical changes (e.g., better self-care). Jesse described observing these changes as '*so lovely when you see people able to handle situations differently*.' Yet, there was an acceptance by some that not everyone can be helped by MBT nor make *'amazing changes'* (Billy). Moreover, Sam's description suggests a sense of responsibility: '*we did not achieve good outcome'*, and Billy experienced change as an ongoing battle: '*…it's a case of… you stop the leak in one place and… then it squirts out of somewhere else'*.

Therapists' experiences of the point at which service users changed were varied. In some cases, therapists reported that change was as a discrete event occurring at a specific moment during MBT, from '*quite a large change happened fairly quickly, early on'* (Ellis) to *'the standard halfway point…'* (Ali). Some therapists acknowledged the variation in service

user experience and how there is no uniform pattern to the point at which service users change: '*…my experience has been that it varies massively…you could be 10 or 11 months in before you see a change, but others you might see a change even within the intro group'* (Jesse).

Change was explored in both qualitative and quantitative terms. Harley described their feelings about how their subjective (qualitative) impression of change didn't always map onto the quantitative measures used by their service to capture change*: '…sometimes I think oh you look different, you seem different, you're more this way, but it's not reflected in the scores…but…I'm not a big fan of questionnaires.'* On the other hand, some therapists reflected on service user change in quantifiable terms. For example, '*we talked about these big epiphany moments of realising it, but I think it is probably those small incremental changes that are probably most helpful.'* (Charlie). Ultimately, therapists' experiences of service user change were varied: they described how change occurred at different points throughout the course of MBT and the magnitude of change was perceived to be highly varied. If the service user's journey through MBT could be conceptualised as a mode of transport, then '*the vehicle is different for each*' (Jordan). Jordan's own personal description here eloquently reflects the collective experience of the other therapists in this study.

Finally, Alex placed value on the group as a '*live'* catalyst for service user change, a view that was implicitly or explicitly shared by others. Yet, work outside of MBT was also deemed critical '*to make therapy work'.*

Being an MBT therapist: a new way of working and developing a new therapeutic identity

This theme encapsulates what it feels like to deliver MBT. MBT was described by some therapists as challenging to follow. Key elements described focussed on emotional arousals and the linking of mentalising to attachment. MBT was reported amongst some

therapists to create a new self-insight into their own interpersonal stances, as well as the potential for iatrogenic harm through interactions. For Charlie, the transition to MBT and reflections on this new way of working was a profound experience:

> *'…acknowledging that part of why BPD has looked like a lifelong condition is because actually it's not but effectively professionals have been egging people on to stay borderline [laughing] and that was quite a crushing blow to us, I'd been part of that and it took quite a moment to sort of recover from my god what have I been doing.'*

For Harley, there was a sense that MBT '*creates a very strong therapeutic alliance',* more so than other therapies. This was attributed in part to '*a more human level, less therapist patient'*. In relation to the adoption of the non-expert stance, Sam felt that MBT approaches provide a unique and different approach: '...*they have to find answers for themselves…that's really quite powerful*.'.

There were, however, less positive nuances identified in these data, with post MBT training experience and time practising being described as underpinning therapists' MBT knowledge, skill, confidence, and perceived competence. A minority reported the complexity of understanding the intervention and how it is hard to understand and set up model of treatment, that left one therapist talking about floundering and questioning the intervention and their ability to deliver it:

> *'I have sometimes felt like I am foundering a bit in the model that I have kind of wanted to go back to what I suppose I feel more comfortable with which is…to talk about what happened when you were five' (*Pat).

For Pat then, the development of MBT skills appeared to conflict with other therapeutic approaches they had previously trained in. MBT was experienced differently by Sam who as well as describing how others have idealised MBT went on to say: '*I love it because you*

think about things differently and it's about changing the service user's perspective…'. Similarly, the model specific techniques that characterise MBT were experienced by Alex as *'…therapy in action… rather than just reflecting you, commenting upon things that are happening live'*. Ultimately, these varied experiences capture a dichotomy of expectations of MBT for both themselves as therapists, and their service users.

This perception was echoed by Sam who described also how they felt that MBT had been idealised by therapists as *'a fantasy of the new therapy…people love to go on training, inspirational trainers…you then start it and…actually the key isn't necessarily setting it up, it's sustaining it…Because actually none of the therapies are a cure …'*. Therapists' acceptance that no therapy is a cure contrasts with their descriptions of how their service users desire '*advice*' (Ali) and '*answers*' (Sam), a common experience for the therapists.

Some frustration was reported with the speed to see therapeutic benefits of MBT. A self-reported '*fairly novice*' therapist explained that '*it is theoretically so dense as a model… I guess I feel I could have provided her with a richer experience or perhaps moved things more quickly'* (Pat). Interestingly, the complexity shared by a minority was contradicted by many whom described the intervention as a *'straightforward framework'* (Riley) and one that was non-expert. One therapist went on to explore the impact that learning MBT had on them, both personally and professionally, describing it as '*a revelation in my career seeing how powerful it is… it just feels like really learning about how you are in relationships, and your relationship with yourself'* (Jesse). Additionally, it was recognised and shared with conviction that this approach was different to others, in that it is a more neutral '*very adult*' (Jesse) approach that allowed for dynamics in the natural push and pull of human interactions. The adoption of a 'not knowing' stance and the opportunity this allowed for more open and collaborative interactions with service users was valued and clear in some narratives. Benefits of group interactions, the inclusion of co-therapists and the opportunity

to work as a '*multi-modal'* therapist delivering both individual and group MBT were also reported strengths of this approach: '*it feels really supportive, but it also feels like you're learning and you get sharper… I feel more competent*!' (Robin). The need for good supervisory practices, strong leadership and guidance in setting up MBT therapies was also clear. Indeed, supervision was felt to be critical to MBT: '"*maintaining the mentalising with this person has been a real challenge… I feel like we are going around in circles… without more supervision, I think especially as a new practitioner, made it really hard.'* (Pat). As Jordan exclaimed, '*… we're gonna struggle being contained if we're not ourselves'*. One-to-one rather than group supervision was also valued by some as a place where therapists could express their vulnerable side and thoughts such as: *'I feel really unskilled and I think I am wasting my client's time.'* (Pat).

Being a therapist in the group: seeing it all come together

This overarching theme represents the experience of being in and delivering group therapy, including the difficulties associated with this process and the possible impact on service users.

Two thirds of therapists felt that one of the most critical aspects of the group for them, was service users finding others who have similar experiences to themselves: '*It's actually quite a powerful experience*' (Charlie). This was described as a normalising process which allowed a strong group dynamic and sense of belonging for all parties: '*there's that sense of being in it together'* (Jesse) and '*feeling connectedness with other people and sense of belonging … it is very, very powerful'* (Sam). In making sense of this normalising process, the powerfulness of shared purpose and group cohesion was recognised. Chris described the paradox of how '*it can go haywire much faster but…be a great ground for them thinking'*. Thus, concluding that the work from MBT really comes together in a group setting eliciting great satisfaction. As one therapist phrased it, *'it comes alive in a group doesn't it?'* (Alex).

Powerful emotions were positively experienced in the room, from pain to humour: *'there's really strong emotions but there's also a lot of laughter, it can be really good fun at times.'* (Jesse). Humour was recognised by Harley as a '*shared kind of humour…that creeps in'* between therapists and service users, and helpful especially when therapists got it '*wrong'*.

Most therapists felt that mutual trust was a more prominent aspect of being in the group and service users' learning to trust one another in '*potentially one of the first safe spaces they've ever had'* (Jamie). Trust could be easily disrupted, and this impacted them as therapists:

> *'I came in and took over, and you know the change of facilitator I think it was a little bit of a nail in the coffin for that group in terms of their cohesion and their willingness to sort of trust the group process …So it was quite a bitty experience…it was for me I guess learning how to be an MBT therapist, it taught me a lot about…what it is like when you do not have a well formed group to provide that type of mentalising experience.'* (Pat).

Ultimately it seemed that whilst building trust was difficult, therapists felt it remained one of the most important aspects as it was a '*steppingstone to…trust other people outside'* (Harley). For Jesse, trust was central to their own positive experience of MBT: '*one of the things I really love about MBT is seeing people start to feel a bit, a bit more trust in others.'*

The role of men in the group was both explicitly and implicitly referred to by two therapists. For example, Harley talked about how their '*service user was the only male in the group'* and empathised with how uncomfortable this may be. For Jesse, this evoked strong emotions: *'it feels really sad you've got very gendered erm diagnoses and treatments.'*

Discussion

This study provides new insights into the lived experiences of those delivering therapy for people experiencing borderline personality disorder. Here, the therapists have delivered intensive outpatient MBT. The core themes of 'experiencing the challenges and complexities of being with service users during MBT', 'being on a journey of discovery and change' and being a therapist in the group: seeing it all come together' mirror closely the themes reported by service users in Gardner et al. (2019), but they are enriched by the idiosyncrasies, experiences and perspective of the other person in the therapeutic encounter: the therapist. We also identified a novel theme of 'being an MBT therapist: a new way of working and developing a new therapeutic identity'. In contrast to previous studies of MBT therapists which typically analyse MBT therapy sessions (e.g., Inderhaug & Karterud, 2015), we interviewed therapists and used IPA as a philosophical framework, thus extending the field with experiential accounts of this under-researched group.

The theme of 'experiencing the challenges and complexities of being with service users during MBT' largely captured therapists' reflections on some of the challenges of working with service users with BPD and socialising them to a therapeutic process. The experiences were likened to a struggle by some, due in part to the fact that they are working with complex presentations and individuals who in many cases have been in the mental health system for some time. Some therapists described the potential for substance abuse to interfere with service users' ability to use and respond to the therapy, and/or their experiences of hearing client's reactions to receiving a diagnosis of BPD. Assessment and formal diagnosis of BPD is preparatory work in the initial phase of MBT which aims to engage the service user in the mentalising focus of treatment (Bateman & Fonagy, 2006). Therapists described polarised perceptions (i.e., positive vs negative) of the impact of diagnosis with effects that could continue for the duration of therapy, similar to service users' descriptions

(Gardner et al., 2019). Though not a main focus of treatment, diagnosis was an object of concern for therapists.

Also subsumed within this theme was therapists' commitment to MBT and the need to provide a strong therapeutic alliance. The alliance is a well-evidenced common factor in psychotherapy (Wampold, 2015) and a potential mechanism of change in MBT (e.g., Folmo et al., 2021). Some therapists in our study talked about relational work with service users in the form of explicit discussion in the here and now about the therapeutic alliance (or mentalising relationship). Hill and Knox (2009) identify these direct statements as a mechanism of change in psychotherapy, though Bateman and Fonagy (2004) note that if they are made too early on in therapy they can negatively impact service users; yet, the latter was not one that therapists in this study recounted. The importance of directly challenging service users with the aim of creating a strong alliance has been evidenced in a recent qualitative analysis of therapists' MBT sessions (Folmo et al., 2019).

In our theme of 'being on a journey of discovery and change' therapists described aspects of their own journey and feelings about supporting transition and focused on making sense of service user change. For some therapists, MBT was a new therapy and journey and this created a sense of uncertainty about what helps service users change. For other therapists, experiences of the nature of service user change were varied, with therapists describing how service users changed almost immediately, or more drastically towards the end of MBT. This finding corroborates service users' very varied experiences of their journey through MBT (Gardner et al., 2019) and suggest that change should be clinically and empirically measured early on in MBT. In Gardner et al. (2019), service users were included only if they had completed at least 6 months therapy, a timeframe deemed to be the minimum that service users would be able to discuss aspects that may have changed during the process of MBT. Yet, therapists' observations of very early change, along with service users' own experiences

(Gardner et al., 2019) highlights the need for both qualitative studies and RCTs to capture more immediate changes (in RCTs the first timepoint at which service users are assessed for change is often 3 months post-baseline e.g., Bateman & Peter Fonagy, 1999; Rossouw & Fonagy, 2012).

Therapists' descriptions of how their service users have changed during MBT were wider ranging and extend beyond the typical outcomes measured in RCTs (see Vogt & Norman, 2018, for review). The changes described also parallel the service users' own reports of change (e.g., improved mentalising, reduced impulsivity, improved positive affect; Gardner et al., 2019). There was an acceptance by therapists that change through MBT is not a universal given, mirroring service users' accounts of continued negative felt experience (Dyson & Brown, 2016; Gardner et al., 2019). Catalysts for change included the group, applying what is learned during MBT to the real world, and trust as part of the therapeutic relationship and between members of the group, some of which feature in other themes and in studies of service users (e.g. Gardner et al., 2019; Morken et al., 2019). Thus, when considered alongside previously published qualitative studies of the service user experience, our findings suggest a shared understanding of therapeutic mechanisms and outcomes between therapist and service user.

Ingredients specific to MBT were experienced by some therapists as *powerful* and the narratives highlight how therapists' perceptions of success experience also linked with the theoretical claims made for the mechanism of therapeutic action. Moreover, therapists' explicit and implicit idealisation of MBT was due in part to the adoption of the non-expert or not-knowing stance captured in our theme of 'being an MBT therapist: a new way of working'. Competency in adopting a not-knowing stance improves the likelihood of a service user continuing in therapy (Philips et al., 2017) and bears resemblance to the concepts of 'humility' and 'openness' that Hill and Castonguay (2017) delineate as crucial therapist

factors that can contribute to the therapeutic process and outcome. Whilst this relatively novel non-expert stance was empowering for some therapists, others appeared to find the transition more challenging with a desire to revert to the familiarity of therapies that focused on the past as a causal explanation for the present. Ultimately, we interpret this as some therapists developing a new therapeutic identity; some therapists can accommodate to the new identity as an MBT therapist whilst for others it is more of a struggle. It is important for future studies to disentangle potential mechanisms here e.g., whether therapists adhered to the model but felt uncomfortable due to less well-developed technical expertise, including whether this is the same for new and experienced MBT therapists.

In keeping with the notion of individualised experiences, the therapists in our study described different features or challenges of delivering the therapy. In some cases, these challenges were not specific to MBT nor work with this particular client group (e.g., the need for good supervision), whilst in other cases they were more common to personality disorder treatments more generally (e.g., the benefits of working as a multi-modal therapist). Finally, the need to avoid and minimise iatrogenic harm is a key focus of MBT, and whilst explicitly mentioned by only one therapist, it was implied by others through the need to create a strong therapeutic alliance.

Our final theme, 'Being a therapist in the group: seeing it all come together', reflects the centrality of the group (also identified by service users e.g., Gardner et al., 2019; Ó Lonargáin et al., 2017). Therapists' accounts of the normalising process were described by Yalom (1995) as an important group therapy factor. Therapists' experienced the group as being where MBT really 'comes together', which is at odds with some service users' accounts of therapy coming together in the individual therapy sessions (Ó Lonargáin et al., 2017).

Therapists' experience of positive emotions within the group focused specifically on their own use of humour as a strategy for helping service users to cope with distress in the group, and for coping with therapists' own emotions. Humour as a psychotherapeutic tool and a mechanism of change has long been recognised (e.g., Bloch, Browning & McGrath, 1983; Franzini, 2001; Knox et al., 2017; Mann, 1991) and discussed in relation to MBT (Brooks et al., 2020; Midgley, Ensink, Lindqvist, Malberg, & Muller, 2017), although the technique may not come naturally to all therapists and carries a host of risks (Franzini, 2001). Humour must fit with the therapists' personality and be responsive to the needs of the service user (Knox et al., 2017), otherwise there is the potential that service users could misunderstand humour. In the context of MBT, humour runs the risk of introducing iatrogenic harm by taking service users into a state of psychic equivalence ('because I feel it strongly, I believe it's real') if they overreact whilst under increased affective arousal, when misinterpreting humour.

The importance of building trust within the group featured in some therapists' narratives. Therapists were committed to using the group to move service users from a state of mistrust in others to develop a sense of epistemic trust (Fonagy & Allison, 2014) that allows them to trust and internalise new learning and apply it beyond therapy to their social world. According to Bateman, Campbell, Luyten and Fonagy (2018) this social learning is one of three processes or 'communication systems' that acts as a catalyst for therapeutic change.

Clinical and Research Implications

Our findings have implications for MBT research and clinical practice. First, mixed methods studies should endeavour to capture very early service user change using a broader range of outcomes and experiences that extend beyond the focus of RCTs (as described above). Second, these findings highlight how therapists might contribute to the success of

MBT or struggle to deliver it, which could impact treatment effectiveness. We therefore recommend that MBT trainers and in practice supervisors identify therapists who might feel less comfortable with the model technique and adoption of the not-knowing stance, with extra support put in place to support acclimatisation to the model. Therapists' who align well to the model could act as role models for those with less experience or who feel ambivalent or less confident when co-facilitating group therapy; the potential for iatrogenic harm due to difficulties learning/practicing MBT or adhering to the model, could be tempered by the additional presence of an experienced therapist since 'two heads are better than one' in group therapy (Kivlighan, Jr, London, & Miles, 2011, p.9). Notably, whilst we used a homogenous sampling strategy (Palinkas et al., 2015), some of our participants were relatively new to MBT practice whilst others had more experience (though those who were new to MBT also had a minimum of 7 years psychological and/or psychiatric service provision prior to using MBT), thus, our recommendations apply to experienced practitioners who may or may not be using MBT for the first time. Future qualitative research would benefit from therapist-focused explorations of specific groups of MBT practitioners based on level of experience (e.g., novice or experienced therapist) and/or mode of delivery (group, individual, or both), since this will allow the tailoring of recommendations towards a more specific type of MBT practitioner.

Limitations

There are limitations to this study. Therapists' accounts were retrospective and may suffer from recall bias, especially if reflecting on experiences over longer timeframes. Related to this point, we also did not assess the role of length of therapist experience, technical expertise nor model adherence (or lack thereof), all of which may impact the therapeutic context (Hill et al., 2017; Owen & Hilsenroth, 2014) and contribute to the unique lived experience as an MBT therapist. Moreover, as this is a qualitative study our findings

lack statistical probability generalisability. Yet our findings have inferential generalisation (Lewis et al., 2014) i.e., transferability to other clinical settings where MBT is delivered (Smith, 2017), and will be of interest to novice as well as experienced MBT therapists. It is noteworthy that some of our themes/core issues do indeed reflect those identified in previous analyses of therapy sessions in other clinical settings (e.g., the potential challenges in adopting a 'not-knowing' stance have been documented in the study of Norwegian MBT therapists: Inderhaug & Karterud, 2015).

Our small sample size is typical in IPA and our homogenous sample (MBT therapists who also had experience practising prior to MBT) is a strength (Smith, 2017), permitting an examination of unique nuanced experiences and the shared context within which these experiences occurred. Yet, there may be characteristics of our sample that we were not aware of (e.g., whether practitioners were trained in and/or exposed to other personality disorder therapies at any time), and these may have shaped our themes. Moreover, our focus on commonality and divergences of experiences could have diminished the idiographic focus (Noon, 2018), and the use of focus groups could have further compounded this issue. We mitigated against this through formulating interview questions that drew out therapists' subjective experiences of MBT, and how they made sense of service user change. As our theme of 'change' focused more heavily on the latter, future research should endeavour to decompartmentalise change to better understand experiences of the journey travelled by both persons in the therapeutic encounter. Winship and Hardy cogently argue however, 'the deciphering of the subjective experience is a process akin to de-coding a dream.' (p.312).

Conclusion

This paper is an illustration of MBT as a method in that the comprehensive explorations of the therapist's subjectivity is not that far removed from what the therapist does with the client. Our findings highlight therapists' individualised experiences and the

challenges of delivering MBT that could impact their practice. The emergent themes viewed through a phenomenological lens also provide a perspective of service use change that is enriched by the idiosyncrasies of the other person in the therapeutic encounter: the therapist.

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Table 1:

Summary of Demographic Features of Therapists

Focus group or one-to-one interview	**Occupation**	**Years or mean years (*SD*) as an MBT therapist**	**Years or mean years working in Psychological or Psychiatric care (*SD*)**	**Administers individual MBT, group MBT or both**
One-to-one interview 1	Consultant Clinical Psychologist	5	20	Both
One-to-one interview 2	Clinical psychologist	2 ½	9	Both
Focus group 1 (4 participants)	n = 1 Medical psychotherapist n = 1 Psychiatrist n = 1 Clinical psychologist n = 1 Principal adult psychotherapist	6.00 (2.83)	17.00 (8.16)	n = 3 Both n = 1 Group
Focus group 2 (3 participants)	n = 2 Clinical psychologists n = 1 Psychological therapist n = 1 mental health nurse/personality disorder case manager	4.00 (4.25)	17.75 (11.44)	n = 1 Group n = 1 Individual n = 1 Both
Focus group 3 (5 participants)	n = 2 Clinical psychologists n = 1 Psychotherapist n = 1 Personality disorder case manager	3.33 (1.55)	24.00 (4.40)	n = 1 Both n = 4 Individual

Table 2

Superordinate and Subthemes

Superordinate themes	Subthemes
Experiencing the challenges and complexities of being with service users during MBT	Experiencing and working with individuals with a BPD diagnosis
	Other service user traits
	Building the therapeutic relationship
Being a therapist in the group: seeing it all come together	The power of shared experiences
	The impact of the group: pain versus humour in the room
	There is a male in the room: reflections on a gendered diagnosis
	Learning to trust us, and each other
Being on a journey of discovery and change	How it feels to help others change
	The point and nature of change
	Service users' mode of transport: discovering that the vehicle is different for each
	Recovery markers and change catalysts
	Learning for life/MBT and the real world

Superordinate themes	Subthemes
Being an MBT therapist: a new way of working and developing a new therapeutic identity	Applying and working with the model
	A dichotomy of hopes and expectations for MBT
	Being with other therapists
	My skills and attributes
	Supervision: boy, do we value it!