How individuals in a Mentalization-Based Treatment Group

process and make sense of a Therapeutic Alliance Rupture

Literature Review

Empirical Research Project

Reflective Commentary

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DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.

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individuals with Borderline Personality Disorder.

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Abstract

Research has shown evidence of the capacity for mentalizing being compromised in individuals with Borderline Personality Disorder (BPD) whilst there is evidence of the positive effects of treatments that focus on repairing the mentalizing capacity in this group of patients, such as Mentalization-Based Treatment. As emotional regulation in close personal relationships is an area that is particularly impacted in individuals with BPD, this paper aims at exploring the therapeutic process in Mentalization-Based Treatment Group paying particular attention to how mentalization may be generated through this process. This is achieved through a review of the existing theoretical and research literature around this topic. This review aims to provide further knowledge to therapists and clinicians in the area and also to identify possible gaps in the literature and possibilities for further empirical studies.

Keywords: mentalizing, borderline personality disorder, mentalization-based treatment, group therapy, therapeutic process.

1.1 Introduction

Borderline Personality Disorder (BPD) is a pervasive and treatment resistant mental illness that affects an individual's view of self and others and capacity to emotionally regulate (American Psychiatric Association, 2013). It has a deep impact on personal relationships, particularly more intimate and close ones, such as parenting, which can lead to childhood emotional problems and the development of BPD in the next generation (Stepp et al, 2012). The BPD presentation and symptomatology has often been linked to attachment difficulties and impairments in the capacity for mentalizing self and others. Mentalization-Based Treatment combines individual and group modality of treatment aiming at repairing and enhancing mentalizing capacity and it has been found to be effective in treating BPD. The group modality (MBT-G) seems particularly relevant and challenging, as it would directly address the issues around closeness and trust in personal relationships that are so challenging for BPD patients (Bateman and Fonagy, 2016 and Karterud, 2015).

This review of literature aims to identify within the existing theory and research evidence how the group therapeutic process in MBT-G may generate mentalizing. Firstly, it will define and contextualise the theory of mentalizing, including non-mentalizing modes and psychopathology. The next section will present an overview of BPD and its links to mentalizing, also considering treatment recommendations. Following that, this paper will look at MBT and the evidence for this type of treatment prior to focusing on the group modality of MBT. Next, a theoretical overview of group process and process of change in group interventions within the MBT, psychotherapy and psychoanalysis literature will be explored.

Finally, there is a review of the existing empirical studies around the therapeutic process and mechanisms of change in in MBT and MBT-G.

1.2 Mentalizing and non-mentalizing

Mentalizing is the capacity to attend to states of mind in oneself and others. Allen (2006) pleads for the use of the verb mentalizing, rather than mentalization, as it emphasizes the action: "mentalizing is something we *do* – or fail to do" (p. 7). In the literature, mentalizing is often used as a synonym to Reflective Functioning (RF), although RF seems more often associated with the operationalized version of the concept of mentalizing, which can be measured using the Reflective Functioning Questionnaire (RFQ) (Fonagy et al, 2016).

Mentalizing is an active form of thinking and feeling about emotions. It concerns a range of mental states, including desires, needs, feelings, thoughts, beliefs, reasons, hallucinations and dreams; and it involves several cognitive operations, such as attending, perceiving, recognizing, describing, interpreting, inferring, imagining, simulating, remembering, reflecting, and anticipating (Allen, 2006). Bateman and Fonagy (2016) believe that the capacity to mentalize and to relate thoughts and feelings from the past to present experiences is essential for a sense of personal continuity. Allen (2006) makes a distinction between explicit and implicit mentalizing, that is, conscious and nonconscious. According to him, "when we mentalize explicitly, we do so consciously and deliberately; when we mentalize implicitly, we do so intuitively, procedurally, automatically, and non-consciously" (p. 10).

Mentalizing occurs in interactions and Allen (2006) sees it as being "at the heart" of human sociality as a species. Within interpersonal interactions, mentalizing happens as one person holds another's mind in mind as well as their own. According to Bateman and Fonagy (2016) "mentalizing is *seeing ourselves from the outside and others from the inside*" (p.5). Fonagy and Allison (2014) related the capacity to mentalize to the development of epistemic trust. Epistemic trust is an essential feature of the transmission of culture and life in society as it creates the possibility of accepting information communicated by others as being true (Sperber et al, 2010).

In this sense, there is a relation between the development of the capacity to mentalize and attachment. Attachment is a concept firstly developed by John Bowlby (1958) to describe the infant's innate need for security and the series of behaviours that bind the infant to the mother. This theory was later developed to incorporate the notion that children who have different parenting experiences develop diverse patterns of relating to others. These are known as attachment types which can be secure, insecure-avoidant, insecure-ambivalent and disorganized (Music, 2011).

Fonagy, Steele, Steele, Moran and Higgitt (1991) found that the infant's attachment security is predicted by the parents' capacity to understand their childhood relationships with their own parents in terms of states of mind. This indicates that infant secure attachment is linked to parents' capacity to mentalize themselves and others as developed in their relationship with their own parents. The authors further explain that the caregiver must have a capacity "to reflect on the infant's mental experience and re-present it to the infant translated into the language of action the infant can understand" (p. 207). Similarly, Luyten et al (2017)

showed that caregivers with high levels of insecure attachment have been found to have impairments in their capacity for Reflective Function, which becomes particularly evident in emotionally intense relationships such as the one with their own children.

Nonmentalizing modes occur when for whatever reason the capacity to mentalize fails. In such states, others may become dehumanized and be treated like objects (Allen, 2006). Nonmentalizing modes include *psychic equivalence mode, teleological mode*, *pretend mode* and *hypermentalizing* (Bateman and Fonagy, 2016). In the *psychic equivalence mode*, thoughts and feelings are experienced as being real and true. Thinking becomes very concrete and the person believes that their perspective is the only one possible. In the *teleological mode* states of mind, particularly in others, are only believed if the effects are physically apparent. In the *pretend mode,* thoughts and feelings are split from reality. It can lead to derealisation and dissociation. Finally, when *hypermentalizing* an individual may talk about states of mind without true meaning or connection to reality.

Insecure patterns and disorganized patterns of attachment can lead to a vulnerability to mental health difficulties in adulthood (Holmes, 2014). Childhood trauma and maltreatment have been linked to impaired mentalizing (Cichetti et al, 2003; Chiesa and Fonagy, 2014), which relates to psychopathology in adulthood (Wiejers et al, 2018). Bateman and Fonagy (2006a) consider that unstable or reduced mentalizing capacity is a central and fundamental characteristic of Borderline Personality Disorder (BPD). Therefore, nonmentalizing modes are common in BPD patients and developing their capacity to mentalize their emotional states and the ones of others should be an essential part of any treatment.

1.3 Mentalizing and Borderline Personality Disorder

The term 'borderline personality organization' was introduced by Otto Kernberg in 1975 in reference to a consistent instable pattern of functioning and behaviour, which also reflects a disturbed psychological self-organization (NICE, 2009). The DSM-V defines Borderline Personality Disorder as "a pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity beginning by early adulthood and present in a variety of contexts" (American Psychiatric Association, 2013).

According to the National Institute for Health & Clinical Excellence (NICE, 2018), the prevalence of BPD in the general population is just under 1%. Once the clinical population is considered the occurrence of Personality Disorders can be as high as 50% and BPD figures as the most prevalent type of Personality Disorder in non-forensic mental healthcare settings (NICE, 2009). Grant et al (2008) found that BPD has a lifetime prevalence of 5.9%. Their findings also indicate that the pervasiveness of BPD in the general population is greater than expected and that it is equally predominant among men and women. However, in mental health services there is a majority of women (NICE, 2018).

Judd and McGlashan (2003) suggest that the individuals who come to develop BPD present with a range of neurobehavioral vulnerabilities, which are then amplified by environmental factors. There is a correlation in the literature between childhood neglect and trauma and the future development of BPD (Johnson, Cohen and Brown, 1999; Judd and McGlashan, 2003, Holmes, 2003).

Johnson, Cohen and Brown (1999) followed 639 youths and their mothers for over 20 years in the United States. They conducted psychosocial and psychiatric interviews, which were then crossed over with state records. The results indicated that individuals who had suffered abuse and neglect in childhood were four times more likely to develop a PD as adults.

The common presence of early relational trauma in adults with BPD disorder is also linked to their disturbed patterns of relating in later life. Judd and McGlashan (2003) refer to this a form of 'internalized PTSD' that isn't triggered by a specific traumatic memory, but in the context of current relationships. According to them "the trauma is thereby recreated and relived rather than recalled, and the psychological and physiological stress reactions are part of the person's characteristic response set within relationships and a core feature of the personality" (Judd and McGlashan, 2003, p.13).

Holmes (2003) sees childhood disorganized attachment as a vulnerability factor for the presence of BPD in adulthood. In this sense, the relationship with an inconsistent caregiving figure in infancy leads to a similar pattern of approach-avoidance dilemma in later life personal relationships. This relates to Bateman and Fonagy's (2006a) idea that individuals with BPD present hyperactive attachment systems and their view of BPD as a disorder in the dimension of mentalizing (Bateman and Fonagy, 2016). Even though they highlight the role of early emotional neglect and a disrupted early social environment in the undermining of the development of full mentalizing capacities, they do not attribute a central role to trauma.

According to Fonagy and Bateman (2016), BPD involves three core features: emotional dysregulation, impulsivity and social dysfunction. Individuals with BPD

"have, schematic, rigid and sometimes extreme views, which make them vulnerable to powerful emotional storms and apparently impulsive actions, which create profound problems of behavioural regulation, including affect regulation" (Bateman and Fonagy, 2006a, p. 190). As stated before, these features relate to issues in the development of the mentalizing capacity that becomes undermined.

The authors also notice that, people with BPD may also be hypersensitive to external influences, rather than relying in an internal understanding. They tend to experience the states of mind of others as being overly influential (Bateman and Fonagy, 2016). They are very sensitive to other people's moods and, in attempt to protect the self, may try to exercise a rigid control over others' thoughts and feelings. There is also a lack of capacity to contextualize feelings, which leads to catastrophizing.

The individual's development of a sense of self is also affected in BPD. Kerr, Finlayson-Short, McCutcheon, Beard and Chanen's (2015) review of the literature surrounding the concept of self in BPD indicates that the lack of a formal concept of self has led to conceptual diversity and confusion. They emphasise the development of the self through the internalisation of interpersonal and sociocultural experiences. This can be linked to the notion that failures in mentalization may affect the development of epistemic trust (Fonagy and Allison, 2014).

According to Judd and McGlashan (2003), BPD patients have not developed a continuous sense of self, which is linked to a lack of consolidation of attachment modes that cannot be connected to form a coherent autobiographical memory. Fonagy et al (1991) distinguish between the *prereflective self* and the *reflective self*. According to them, the *prereflective self* undergoes experiences in

an immediate and unmediated manner, as sort of 'experiencing self'. The *reflective self,* on the other hand, adds another layer to the experience, observing and reflecting on mental reactions and experiences, both conscious and unconscious. It creates representations of one's feelings and thought, desires and beliefs. Along these lines, Allen (2006) has linked the capacity for mentalizing implicitly to the concept of *sense of self*. For him when mentalizing implicitly, one has a sense of one's own affects: "what it feels like to be me".

BPD patients have discontinuous sense of self (Judd and McGlashan, 2003) and lowered mentalizing capacity (Bateman and Fonagy, 2016). The gaps in the self's capacity to reflect and in its own representation can become very threatening for the individual, which often results in externalization (Bateman and Fonagy, 2016). This put together with a diminished ability to distinguish between one's own and other's mental states has a profound impact on how these individuals can manage interpersonal tasks, such as parenting children.

Parents with BPD would be particularly vulnerable to feelings of anxiety and, as discussed previously, are very sensitive to others' moods (Bateman and Fonagy, 2016). Stepp et al (2012) reviewed the literature concerning mothers with BPD and the impact their parenting has on their children, including the transmission of vulnerability of BPD. From the studies reviewed, the authors concluded that these mothers' parenting strategies oscillate between over-involvement and under-involvement. Their behaviour is characterized by extreme forms of inconsistencies, including intrusion, withdrawn and avoidant behaviours, and a fluctuation between hostile control and coldness.

The studies reviewed (Stepp et al, 2012) also indicated that these behavioural inconsistencies can create such an invalidating developmental

environment that may contribute to the development of BPD in the next generation. Dutton, Denny-Keys and Sells (2011) review of literature also found that BPD in parents has a strong relationship to ensuing childhood problems. This highlights the importance of treatment for individuals with BPD in helping to prevent an intergenerational cycle of mental health difficulties.

1.4 Mentalization-Based Treatment

In terms of interventions for BPD, Judd and McGlashan (2003) highlight the need for a developmental understanding of BPD. In their view, the aims of the treatment for this group of patients should be "to develop a more integrated and organized attachment system, foster emotional and behavioural regulation, elaborate cognitive structures, and establish a more cohesive sense of self or identity with improved self-esteem and greater self-agency" (p.157). They concluded that the most commonly used treatment for this group is a combination of psychodynamic, psychoeducation, cognitive-behavioural therapy (CBT) and psychosocial rehabilitative approaches.

Bartsch, Roberts, Davies and Proeve (2015) used a voluntary and anonymous online survey to gather clinicians' perspectives on parenting issues for individuals with BPD and their views in relation to the interventions available. One hundred and six professionals from various clinical backgrounds across Australia, USA, Canada and New Zealand answered the survey. The use of an online survey made it possible to reach a larger sample of clinicians across different countries and backgrounds, indicating that the issues parents with BPD face are similar in different contexts. Though the survey was extensive in its scope, it lacked the

detailed and more experiential depth that semi-structured interviews could have provided.   The results of the survey indicated that clinicians mainly identify Dialectical Behavioural Therapy (DBT) and attachment-based therapy as being the most effective treatments. These findings also highlighted the effectiveness of long-term and intensive treatments.

As seen, the capacity for mentalizing is related to attachment and mentalizing impairments are linked to vulnerability to mental health difficulties. Allen (2006) states that any effective therapy, including DBT, CBT and psychodynamic psychotherapy, promotes mentalizing. Bateman and Fonagy (2016) see BPD as a mentalizing disorder, which means that repairing and enhancing the capacity to mentalizing should be at the centre of treatment.

Mentalization-Based treatment (MBT) was first developed in the 1990s to treat patients with BPD. It was "designed to promote positive attitudes toward mentalizing (e.g., a spirit of inquisitiveness) and to enhance skill in mentalizing" (Allen, 2006, p.18). Kerr et al (2015) review of literature gives particular focus to the strong evidence of disturbances of several processes of the self in BPD patients. Their study included papers with a variety of treatments, but they highlight Mentalization-Based Treatment as a modality of treatment that specifically addresses an entity of the self.

According to Bateman and Fonagy (2006a), BPD patients have a poor awareness of their own and others' perceptions of mind and, therefore, are unlikely to benefit from insight-oriented therapies. MBT aims to help the patients to better regulate and control primitive modes of mental functioning. For Allen (2006, p.18) "the point of mentalization-based therapy is to enhance the patient's capacity to *generate insight* on the fly". It focuses on the patient's mind and helps to link actions

back to feelings by tracing a moment-by-moment process that led to the action (Bateman and Fonagy, 2006a).

The treatment must activate the attachment system, so the patient may develop the capacity to function psychologically in the context of interpersonal relationships. However, these patients are also particularly vulnerable to this activation. The therapist must sustain a balance between stimulating the attachment system at the same time as not overwhelming the patient and helping to maintain mentalizing. According to Bateman and Fonagy (2006a), this can be achieved by "encouraging exploration and identification of emotions within multiple contexts, particularly interpersonal ones, and helping the patient establish meaningful internal representations, while avoiding premature conscious and unconscious explanations" (p. 192).

There has been growing research evidence of the effectiveness of MBT in the past two decades. Bateman and Fonagy (2008) conducted an 8-year follow up of their original effectiveness randomized control trial (Bateman and Fonagy, 1999). They have compared the outcomes of BPD patients who had MBT to those who were treated as usual (TAU). They found that, even though the general social function remained impaired, the patients who had MBT showed overall better results. Only 13% maintained the BPD diagnosis, in comparison with 87% in the TAU group.

Vogt and Norman (2018) made a systematic review of 14 papers, including 11 original studies and three follow-up studies, which looked into the effectiveness of MBT for BPD patients. Their results indicated that MBT shows either superior or equal reduction in symptoms when compared to other forms of treatment. It is important to notice that MBT usually involves individual and group treatment and

that these studies have looked at the combined treatment. For the purposes of this literature review, the focus is on the group modality of treatment, known as MBT-G, and how mentalizing might be generated in the group context in isolation to the individual element of treatment.

1.5 Mentalization-Based Treatment Group

Mentalization-Based Therapy Group (MBT-G) is a manualised form of treatment with a validated adherence and quality scale, MBT-G-AQS (Folmo et al, 2017). It combines a psychoeducational aspect with elements from psychodynamic group therapies, such as allowing the group process to happen through free association. According to Fonagy and Bateman (2016), this is a delicate balance that must be kept, as if there is too much focus or the groups is left too free, nonmentalizing might occur.

Bateman and Fonagy (2016) argue for the potential of group psychotherapy for BPD. Their main argument in favour of using groups to treat BPD is that through the stimulation of complex emotional and interpersonal interactions the group provides a context to understand other's mental states at the same time as reflecting on the self. However, they also point to some of the risks of group therapy for BPD, as the level of arousal can create conditions in which emotions get out of control and attachment systems get over-stimulated. The clinician has to be very careful when structuring the group, so to minimize these risks. The treatment works as a 'training group' for interpersonal mentalizing, with the clinician managing the group, ensuring focus and facilitating mentalizing between the participants.

The interaction between the self and the other is a fundamental part of psychotherapy. For Fonagy and Bateman (2006) it "has the potential to recreate an interactional matrix of attachment in which mentalization develops and flourishes" (p. 415). They see that the therapist's mentalizing capacity fostering the patient's as the essence of the mechanism of change. The authors are mainly referring to individual psychotherapy, however it poses the question of how the interactions between self and other in group therapy, when there are many others present, facilitates change.

Kvarstein et al (2015) conducted a naturalistic, longitudinal study comparing the treatment effect of MBT and psychodynamic group treatment programme. Two hundred and eighty-one patients that took part on the psychodynamic treatment programme in the period of 1993 to 2013 had their outcomes analysed in comparison with the outcomes of sixty-four patients that were offered MBT after this form of treatment was started in 2008. The study found that both groups of patients showed improvements. However, the MBT group showed significantly lower drop-out rates and greater improvements of distress, interpersonal, global and occupational functioning.

A strong aspect of this study's methodology is that the competence and therapist's adherence to treatment was rated. Another strength is the large sample. However, the difference in number of patients in each treatment and the fact that the psychodynamic treatment was composed of diverse types of group intervention, whereas the MBT was a combination of group and individual treatment, limits the internal validity of this study. As with other effectiveness studies on MBT, it is not possible to isolate the effect of the MBT-G in this study. The argument for the effectiveness of MBT-G would have been stronger if the comparison had been

made between an MBT-G only treatment against a single modality of psychodynamic group therapy.

Still in relation to the comparison between MBT-G and psychodynamic group therapy, Kalleklev, and Karterud (2018) conducted a mixed quantitative and qualitative comparative study between the two approaches. The authors looked in detailed at a single session of MBT-G and of psychodynamic group therapy (PDG), in terms of adherence to the MBT-G-AQS (Folmo et al, 2017), Reflective Functioning (RF) and did a qualitative content analysis. It appears that the main purpose of this study was to give evidence of the unique characteristics of MBT-G, which has been criticised as being very similar to already existing types of psychodynamic group therapy. In this sense, the study successfully shows that, even though there are many similarities, the therapy process is different for each type of treatment.

Kalleklev, and Karterud (2018) found that in the MBT-G session the therapists were much more active and made more than double the number of interventions as the therapists in the PDG session. Also, the MBT-G interventions were more focused on mental states and more challenging of maladaptive patterns (demand interventions). The results also indicated that RF increased among some patients in the MBT-G, whereas there was less impact in the patients in the PDG. Considering that both types of treatment were evaluated using measures that are specific for MBT and its therapeutic focus, it could be expected that the MBT-G would show higher adherence and increase in RF. The specific characteristics of the PDG are not considered in this study, which is appropriate in the sense that the goal was to evidence that MBT-G is a unique type of therapy and with more possibility of generating improvement in the mentalizing capacity. However, this is

a very small study that focused in only one session of each treatment. Further larger scale studies would be necessary to give enough evidence of these results.

In MBT-G the group has the function of creating a 'training' space for mentalizing, by supporting the participants to keep hold of their own and several others' minds and emotions, trying to understand them at the same time as managing their anxieties under highly charged circumstances (Bateman and Fonagy, 2006b). The group focuses on mentalizing the experience in the relationship between people: "working on mentalizing interpersonal processes as they are demonstrated in the group takes the manifest aspects of the patient's relationships and looks at how they help or hinder the patient or are harnessed to find support in times of crisis" (Bateman and Fonagy, 2016, p. 367).

Karterud (2015) found the literature surrounding group therapy and BPD to be divergent. The argument in favour of this type of intervention is that the strength of group therapy is the focus on interpersonal relationships, which is one of the major struggles of individuals with BPD. For him, the direct and 'here and now' manner in which this can be addressed in a group could be highly helpful for these patients. Also, it may be easier to take the point of view and accept confrontation from a peer than the one from a therapist. However, a counterargument is that the group therapy magnifies an area of difficulty and individuals may get lost in the intense emotional atmosphere, as the therapist has less control of it than in individual work.

Euler et al (2018) conducted a pilot study considering how the tendency towards feeling socially excluded may affect the therapeutic alliance for BPD patients in MBT-G. Their findings were in line with the literature in terms of how individuals with BPD are prone to feel threatened of social exclusion, which may

affect their capacity to establish positive relationships in a group setting and keep a mentalizing stance. However, their study also indicated that even exclusion-prone patients tended to see the therapists as a more benign figure, which might be related to the focus MBT-G therapists put in working the therapeutic alliance. The study concluded with advice for clinicians to give patients a careful introduction before starting group therapy, which might help to balance their tendency to perceive others as threatening.

The fact that MBT-G is a more structured form of group therapy intends to make up for some of the limitations of group treatment for BPD patients. One of the main characteristics of MBT-G is that the clinicians encourage relational curiosity and make their own thinking explicit and transparent but make no interpretations about unconscious processes. According to Bateman and Fonagy (2016), differently from other forms of group therapy, the clinicians in MBT-G openly asks themselves questions and show that their mind can change. When there are two clinicians in a group, they work together in talking, questioning and challenging each other, with the objective of modelling the interactive process of mentalizing. The clinicians are also 'active' in maintaining the flow and structure of the session, going back to the topic in focus, and monitoring arousal levels, which must be neither too high nor too low.

Nevertheless, a qualitative study by Sagen Inderhaug and Karterud (2015) shows that it can be challenging for therapists to fully adhere to MBT-G principles when working with an emotionally stirred up group of patients. They looked at the video recordings of three MBT-G sessions aiming to further the knowledge of what kind of problems therapists encounter when conducting MBT groups. The four and a half hours of video data were transcribed verbatim and examined using thematic

analysis. The results showed that the therapists were faced with considerable difficulties managing the group, avoiding the behaviour and the content of what the patients brought to become too chaotic. The authors found that in this particular group the therapists could not stand as authoritative leaders, which resulted in some patients taking central positions in the group, dominating the discourse and the process. The themes presented relate to the principles of MBT-G the therapists in this group struggled to fully adhere to. The authors point out that the material analysed was from three consecutive sessions so the findings might not be valid overtime for the same group. In this case, looking at sessions at different time points in the treatment may have added strength to the analysis.

1.6 Mechanisms of change in MBT-G

As seen, the literature seems to indicate that the group process and the interaction between participants can be at the same time an area of fragility and the mechanism of change for MBT-G. In this sense, Fonagy and Bateman (2016, p. 366) see that "mentalizing models are uniquely valuable in complex interpersonal situations involving, for instance, care and concern, conflict potential deception, or irrationality", which are very likely be present in a group setting which tends to stimulate early attachment patterns. However, they also point to the possibility that in such an intense interpersonal situation there can be a hyperstimulation of such patterns and the risk is that nonreflective internal working models may take over.

In relation to group dynamics, Bion (1961) distinguished between the *work group* and the *basic assumptions group*. The *work group* functions towards a task,

which is the reason why it was formed. It requires voluntary cooperation and some degree of mental capacity to remain in the task, that is, connected to reality. *Basic assumptions* are mental activities connected to powerful emotional drives that obstruct and divert the work of the group. Bion described three basic assumptions - fight-flight, dependency, pairing – and believed that the therapist should interpret them when they happen so some insight could be generated in the group.

Karterud (2015) compares Bion's concept of basic assumptions to Jaak Panksepp's neuroaffective theory. For him, the idea of fight and flight would be more related to rage and fear, which are both very present in BPD patients. Also, he sees the dependency groups as being related to the primary emotions of separation, distress and care. These may appear in the group when the attachment systems are activated both in the patients and in the therapist, which, according to Fonagy and Bateman (2006), is one of the mechanisms of change in MBT.

Karterud (2015) also draws from Foulkes' (1973) concept of group matrix to further understand the group process in MBT-G. The matrix is defined as a dynamic, invisible and hypothetical web of communications and relationships of a particular group that influences the participants. For Foulkes (1973) the 'social' aspect of the group is at the same time internal and external to the individual. Karterud (2015) understands that great part of the communications that happen between two or more people in the matrix takes place in an unconscious or nonverbal level.

For him, MBT-G has the objective of developing "the group as a norm-and culture-bearing system (matrix) where the individual attributes of each member can be played out and where important events, either as reported from outside life or as manifested in the here and now, are subjected to collective reflection" (p.42).

Still based on Foulke's perspective, he sees the group functioning as a 'resonance box' for experiences that had remained uncommunicated and may now resonate with others in the group or with the group as whole. Listening to other people creates a resonance in the individual, which activates different memories and emotions. Through this, "there may be initiated a symbolizing and communicative process which lends words and meanings to experiences that previously were devoid of words and meanings" (Karterud, 2015, p.88).

As shown, the objective of MBT-G is to increase the participants' ability to mentalize in close relationships. The focus is to understand the emotional reaction; to invite curiosity about why the members of the group are reacting in the way they are. This may be achieved through "a dynamic interplay between 'there and then' and 'here and now'" (Karterud, 2015, p. 65), with the situations that are being talked about in the 'there and then' being co-related to events in the 'here and now' of the group. For Karterud (2015) events in the 'here and now' are especially potent therapeutically. According to him, emotional reactions, misunderstandings and unwarranted beliefs should always be commented on or challenged as they happen. In a well-functioning work group, the participants would do that themselves, otherwise, the therapist should take the initiative.

This links to Fonagy and Bateman (2006) view that the activation of the attachment system in MBT may happen through a range of unconscious techniques by the therapist. For them, this activation occurs through

> (1) the discussion of current attachment relationships, (2) the discussion of past attachment relationships, (3) the therapist's encouragement and regulation of the patient's attachment bond to him or her through the creation

of an environment that assists with the patient's regulation of affect, (4) the therapist's attempt to engender attachment bonds between members of the group in the context of group therapy (Fonagy and Bateman, 2006, p. 424).

This creates a paradoxical situation in relation to the patient's attachment pattern that allows mentalizing to happen for negative emotions and social and moral judgments. Also, the therapist's interest may encourage the patient's interest in the minds of others in the group and on their own mind as well. Supporting the patient to continue mentalizing when the attachment system has been activated for negative emotions may help to create a move towards a "pattern of arousal within these systems closer to that characteristic of a secure attachment" (Fonagy and Bateman, 2006, p. 424).

In summary, from a theoretical perspective it is expected that the mechanism of change in MBT-G relates to the activation of the attachment system by creating a space with intense close interpersonal relationships. At the same time, the group should create a safe enough space, so not to emotionally overwhelm the participants, which would risk nonmentalizing modes taking over the group. The activation of the attachment system at the same time as mentalizing is maintained, even when thinking about negative and difficult emotional experiences, aims to create a move to a pattern of relating closer to secure attachment. This may be particularly present when the 'here and now' situations in the group are put in focus and mentalized by the therapist and patients. It is expected that the development of a capacity to reflect on and mentalize the 'here and now' emotional states and interactions in the group will be translated in a capacity to mentalize past situations and interactions outside the group.

1.7 Empirical evidence for the therapeutic process and mechanisms of change in MBT-G

As seen, there is relevant quantitative evidence of the effectiveness of MBT for BPD (Vogt and Norman, 2018, Bateman and Fonagy, 2008; Kvarstein et al, 2015) and that the improvement of the mentalizing capacity is an important mechanism of change for these patients (Meulemeester et al, 2018). However, the empirical evidence for the mechanisms of change and the therapeutic process in MBT is still limited.

Even so, it is important to notice that there has been more attention given to this area in recent years, with a noticeable increase of empirical papers about MBT being published. In relation to the type of MBT therapy - individual and/or group - investigated by these studies, Lonargáin, Hodge and Line (2017), Hodge and Line (2017), Morken et al (2019a) and Gardner et al (2019) all looked at MBT programmes composed of both individual and group MBT treatments. Folmo et al (2019) focused only on the individual treatment. Johnson et al (2016) looked at a MBT programme in which the group element was a group-based art therapy, and not MBT-G. Inderhaug and Karterud (2015) and Flood (2017) are focused on the MBT-G. Flood (2017) has investigated a group only MBT programme.

Lonargáin, Hodge and Line (2017) interviewed a group of 28 participants that were currently in MBT treatment composed of one individual and one group therapy session per week. The semi-structured interviews were analysed using IPA. The results showed that all participants identified the group as being intense and difficult at some point and that most participants felt this as a continued experience. Participants also reported finding it easier to build trust in individual

sessions, whilst in group sessions this was found to be a much more challenging process. Only those attending for five or six months or more reported starting to perceive benefits to the group.

Similarly, in Flood's (2017) study many of the participants reported a difficulty in trusting others with their feelings and said the group aspect of the programme had been a source of fear prior to commencement, even though the majority of participants expressed very positive attitudes towards the programme. Morken et al (2019a) and Gardner et al (2019) papers highlighted participants' experience of the group as a context that could broaden their perspective. Both papers have also identified that participants found it positive being with other members of the group considered to have similar difficulties to themselves. In relation to the participants' experience of the therapists in the group context, Flood (2017) reported that participants found situations in which they were challenged by the therapists to be beneficial. Likewise, Morken et al (2019a) found that even though patients found it difficult when therapists put the focus on the relationship between patient and therapist this was found to be an important element in exploring ruptures and which contributes to making patients feel safer.

It is important to notice that none of these studies aimed at examining the therapeutic process of MBT and to identify the mechanisms of change. The paper by Flood (2017) aimed to identify change in interpersonal problems and symptomatic distress after a group only MBT intervention, whereas Lonargáin, Hodge and Line (2017), Morken et al (2019a) and Gardner et al (2019) aimed at gaining a further sense of the patients' experience of treatment.

In contrast, Morken et al (2019b) looked to explore the patients' experience of the psychological change process following an MBT treatment. This study used

semi-structured interviews of 13 female patients with BPD and comorbid substance abuse disorder. The results showed that patients experienced meaningful change after treatment. This was related to them feeling an increased capacity to reflect on their own mental sates and the ones of others and an increased experience of agency over their own mental states. The study concluded that mentalizing the self and the other is a central mechanism of change. However, it is not possible to gather from this study how this change happens, as the focus was on patients' experience of change post treatment and not in the therapeutic process in itself.

Inderhaug and Karterud (2015) used a qualitative approach to investigate a MBT-G focusing on the therapists' interventions and how they managed the group. This study used thematic analysis to examine video data of the group sessions transcribed verbatim and highlighted the challenge for therapists when faced with considerable difficulties managing the group, which resulted in the group becoming too chaotic. Karterud (2018) did a follow up of this study, as it was found to have disappointing results in terms of therapists adhering to the MBT-G guidelines. The more recent article shows a MBT-G with high adherence to MBT-G-AQS (Folmo et al, 2017) in terms of the therapists' interventions and ability to create a working group in which mentalizing is facilitated. By using an observer-based method, these two studies give a livelier sense of what happens during the therapeutic process in itself and the therapists' interventions in the room. However, similarly to the patient experience studies, they also don't explore the process and mechanisms of change in place.

The study by Folmo et al (2019) specifically focused on the process of change in MBT. This paper looked at the interaction between therapeutic strategy, alliance and epistemic trust and how it may foster or hinder the therapeutic process

in MBT. As mentioned before, this study focused only on the individual aspect of MBT comparing and analysing two high adherence and two low adherence sessions with IPA. They found that the therapists in the high rated sessions were more active in challenging maladaptive patterns in a transparent and empathetic way, keeping the focus on mentalizing. This seemed to facilitate therapeutic alliance and a productive therapeutic process. On the other hand, the low rated therapists tended to avoid confrontation, becoming more supportive in an attempt to amend the challenging relational atmosphere. This attitude coincided with weaker therapeutic alliance and lower therapeutic progress.

The authors of this study hypothesized that the process of challenging maladaptive patterns could potentially increase the patient's epistemic trust. This would allow the therapy to work on three levels:

> First, the patient's trust in the therapist allows her to learn new content about mental states of self and others. Secondly, the therapy foster mentalization through a process of reflecting mental states. Thirdly, the new content and reflection relaxes a hypervigilance in social situations, which in turn opens for new social learning (Folmo et al, 2019, p.148)

This study has a strong methodology and internal validity, having made extensive use of reliability checks. As a qualitative IPA study, there are limitations in terms of generalizability due to the small sample, which was also taken from four different treatments. Further studies would be helpful in noticing if similar results can be found across larger samples.

Even though this study only looked at individual treatment, it is possible to hypothesise that the results might also apply to the therapeutic relationship and mechanism of change within the group modality of MBT, as both have the same focus and therapeutic strategies in common. However, for this to be confirmed there would need to be further studies looking specifically at the therapeutic process and the mechanisms of change in MBT-G. It would be important to observe how therapists manage and confront maladaptive patterns with multiple patients in a group and whether mentalizing is generated in this way. Another relevant question that is still to be explored by qualitative studies is how the interactions between multiple members of the group may play a part or not in facilitating mentalizing.

1.8 Conclusion

This review of literature explored the relation between mentalizing and Borderline Personality Disorder. It looked at the principles of Mentalization-Based Treatment, considering both a theoretical perspective and the empirical evidence for the effectiveness of treatment. The main objective of this paper was to specifically examine the literature around Mentalization-Based Treatment Group, with a focus on the therapeutic process and mechanisms of change for this group of patients.

As it has been shown, the literature points to a close link between impairments in the mentalizing capacity and the symptomatology of BPD. In this sense, repairing and enhancing the capacity to mentalizing should be at the centre of any treatment for this disorder. MBT was developed as a dual modality treatment

including individual and group therapy with the aim of supporting BPD patients to develop their mentalizing capacity. As seen, there is strong evidence in the literature of the effectiveness of MBT for BPD patients. On the other hand, much less is known about how MBT works, that is, what are the therapeutic process and mechanisms of change involved. This is even more marked when specifically considering the group modality of treatment in isolation.

There have been recent important developments in this area of research, with an increase in the number of qualitative studies or mixed methodology studies about MBT. The majority of these are self-report patient experience studies, that explore how patients have experienced treatment and the change in their presentation. Also, most of these papers include both the individual and group modalities together. There have been two papers found that use a qualitative approach to look the group aspect of MBT. These are observation-based papers that focused on the therapists' adherence to treatment guidelines and, therefore, don't pay particular attention to the mechanisms of change. Only one of the reviewed papers aimed specifically at looking at the mechanisms of change in MBT. This study looked only at the individual aspect of MBT, but it gives solid grounds for further studies exploring the mechanisms of change in the group aspect of treatment.

In summary, the review of the literature has identified that how mentalizing might be generated in MBT-G is an area to still be explored. Further studies in this area would be very relevant for adult therapists and MBT therapists, but also for the field of Child and Adolescent Psychotherapy when considering what is known about the impact of parental BPD on children's mental and emotional health and the risk of child maltreatment linked to reduced parental mentalizing capacity.

A recently published study (Byrne at al, 2019) looked at the Lighthouse MBT Parenting Programme, which is an MBT parenting intervention for families where children are at risk of maltreatment. Weekly group therapy for parents is a central part of this programme. The results of the study suggested that the Lighthouse Programme may be effective in improving parenting confidence and sensitivity, but there were no significant changes in the parents' mentalizing capacity. According to the authors, this may be due to the fact that this group of parents scored very low in the Reflective Function scale at baseline and that this measure might not be sensitive enough to capture treatment change at the lower end of the scale. However, considering that the parents have expressed noticing and valuing the changes after treatment, further studies using a detailed qualitative approach to look at the therapeutic process might be able to identify moments in which mentalizing is being generated and how this is happening.

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Part 2: Empirical Research Project

Title: How individuals in a Mentalization-Based Treatment Group for parents at

high-risk of child maltreatment process and make sense of a rupture.

Candidate number: GCXC6

Word Count: 8312

Abstract

Aim: This study aims to examine the process of resolving a therapeutic alliance rupture in a Mentalization-Based Treatment Group (MBT-G) for parents at high-risk of child maltreatment. The objective is to observe whether and how reflective capacity might be generated through this process. **Method:** An observer-based exploratory qualitative design is used to look at video recording data of the group therapy sessions. The participants are the parents and facilitators that were verbal in discussing the rupture event in the group. The video data was transcribed verbatim, divided into three time points and analysed according to the Narrative Process Coding System (NPCS). **Results:** There was an overall increase in reflective capacity through the three time points for the group as a whole, with some variance for individual participants. **Conclusion:** Despite some limitations due to its design and quality of the data analysed, this study shows that through the direct discussion of a therapeutic alliance rupture over a considerable timespan reflective capacity was increased for participants of this MBT-G.

Keywords: mentalizing, childhood maltreatment, mentalization-based treatment, group therapy, therapeutic alliance rupture, therapeutic process.

Impact Statement

This study is a small qualitative study that aimed to expand on the understanding of how members of a MTB-G process and resolve a rupture in the therapeutic alliance and whether this leads to moments of increased reflective capacity for the participants. The study used data from the Lighthouse Programme, which is a NHS parenting intervention for families where children are at risk of maltreatment using an MBT approach based on the one developed for BPD.

The review of the relevant literature has shown that there is increasing evidence of the effectiveness of MBT but there still little known qualitatively in terms of its mechanisms. Similarly, for the field of therapeutic alliance rupture-repair, the literature indicates that the process of solving ruptures is a powerful mechanism of change for individual treatment, but this process is yet to be understood in relation to group therapy. The current study helps to address both gaps in the literature.

A preliminary study looking at the outcomes of the Lighthouse Programme has shown promising results. However, the quantitative measures applied did not show significant change in Reflective Functioning for the group of parents before and after treatment. The current study, by using a qualitative approach, highlighted a moment in which reflective capacity is increased in the group, which might help to inform the Lighthouse clinicians about their practice and help them to further support this challenging clinical population.

Parenting programmes are a common and increasing practice within the NHS and children's services and professionals involved in these might be informed by this study. In a larger scale, the current findings are in line and support other

promising studies for this modality of parenting programme which could impact on future funding and further dissemination of this type of treatment.

Moreover, other clinicians can also be informed by the results. Child and Adolescent Psychotherapists working with individual parents and adult group psychotherapists might gain from the understanding of how reflective capacity might be generated for this population.

2.1 Introduction

2.1 .1 Mentalizing, parenting and child maltreatment

Mentalizing or Reflective Functioning (RF) is the capacity to attend to states of mind in oneself and others. It is an active form of thinking and feeling about emotions. Mentalizing occurs in interactions as one person holds another's mind in mind as well as their own. Fonagy and Allison (2014) related the capacity to mentalize to the development of epistemic trust, which is an essential feature of the transmission of culture and life in society as it creates the possibility of accepting information communicated by others as being true (Sperber et al, 2010). On the other hand, *nonmentalizing modes* occur when for whatever reason the capacity to mentalize fails. In such states, others may become dehumanized and be treated like objects (Allen, 2006).

The literature points to a link between the capacity to mentalize and attachment. There is indication that a secure attachment is related to parents having had the possibility of developing a capacity to mentalize oneself and others' in their relationship with their own parents (Fonagy et al, 1991). Caregivers with high levels of insecure attachment have been found to have impairments in their capacity for RF, which becomes particularly evident in emotionally intense relationships such as the one with their own children (Luyten at al, 2017).

When there are failures in the mentalizing capacity the gaps on the self's ability to reflect can be felt as very threatening for the individual, which often results in externalization (Bateman and Fonagy, 2016). This put together with a diminished

ability to distinguish between one's own and others' mental states has a profound impact on the task of parenting children. According to Howe (2005), the relationship between a parent and a child is emotionally demanding and may potentially bring about feelings of helpless, anxiety and of being under threat, which trigger the psychological process in parents who maltreat. Berthelot et all (2019) have found that RF indirectly mediated the association between child maltreatment and psychological symptoms.

2.1.2 Mentalization-Based Treatment Group, therapeutic process and mechanisms of change

Mentalization-based treatment (MBT) was first developed to treat patients with Borderline Personality Disorder, usually combining both individual and group therapy. It was "designed to promote positive attitudes towards mentalizing (e.g., a spirit of inquisitiveness) and to enhance skill in mentalizing" (Allen, 2006, p.18). Over the years, several quantitative studies have given evidence of the effectiveness of this modality of treatment for BPD (Vogt and Norman, 2018, Bateman and Fonagy, 2008; Kvarstein et al, 2015). As it aims to restore and enhance the mentalizing capacity, it has been used in parenting interventions, with the view that it could affect positively parents' relationship to their children and reduce the risk of abuse and neglect. MBT interventions for mothers have shown an increase in maternal reflective functioning in comparison to a control group (Luyten et al, 2017).

Mentalization-Based Therapy Group (MBT-G) is a manualised form of treatment (Folmo et al, 2017) which combines psychoeducational aspects with

elements from psychodynamic group therapies. Through the stimulation of complex emotional and interpersonal interactions, the group provides a context to understand others' mental states at the same time as reflecting on the self. In this sense, the group has the function of creating a 'training' space for mentalizing, by supporting patients to keep hold of their own and several others' minds and emotions, trying to understand them, at the same time as managing their anxieties under highly charged circumstances (Bateman and Fonagy, 2016).

For Karterund (2015), the direct and 'here and now' manner in which interpersonal relationships can be addressed in a group is highly helpful. However, the author also presented the counterargument that individuals may get lost in the intense emotional atmosphere, as the therapist has less control of it than in individual work. Inderhaug and Karterud (2015) have used a qualitative approach to investigate a MBT-G focusing on the therapists' interventions and how they managed the group. This study highlighted the challenge for therapists when faced with considerable difficulties managing the group, which resulted in the group becoming too chaotic.

Despite there being strong quantitative evidence of the effectiveness of MBT, still very little is known about its mechanisms (Vogt and Norman, 2018). This is even more so when specifically considering MBT-G. In recent years, however, the number of qualitative studies about MBT has increased. These are mainly focused on patient experience using direct self-report methods (Johnson et al, 2016; Lonargáin, Hodge and Line, 2017; Flood, 2017; Morken et al, 2019a; Gardner et al, 2019; Morken et al, 2019b).

It is important to notice that none of these studies aimed at examining the therapeutic process and mechanisms of change of MBT. Nevertheless, the

qualitative nature of the analysis brings to light some aspects of the therapeutic process as experienced by the patients. A common finding of the studies in relation to MBT-G is that the participants have reported finding the group treatment challenging (Johnson et al, 2016; Lonargáin, Hodge and Line, 2017; Flood, 2017; Morken et al, 2019a; Gardner et al, 2019). Morken et al (2019b) looked to explore the patients' experience of the psychological change process following an MBT treatment. The study concludes that patients have experienced meaningful change after treatment and that mentalizing the self and the other is a central mechanism of change. However, it is not possible to gather from this study how this change happens.

The study by Folmo et al (2019) specifically focused on the process of change in MBT. This paper looked at the interaction between therapeutic strategy, alliance and epistemic trust and how it may foster or hinder the therapeutic process in individual MBT. The authors found that therapists being active in challenging maladaptive patterns in a transparent and empathetic way and keeping the focus on mentalizing seemed to facilitate therapeutic alliance and a productive therapeutic process. They hypothesize that the process of challenging maladaptive patterns could potentially increase the patient's epistemic trust.

Even though this study only looked at individual treatment, it is possible that the results might also apply to the therapeutic relationship and mechanism of change within the group modality of MBT, as both have the same focus and share therapeutic strategies. However, it would be important to further explore how MBT-G therapists manage and confront maladaptive patterns with multiple patients and whether mentalizing is generated in this way. Another relevant question that is still

to be investigated by qualitative studies is how the interactions of multiple members in a group may play a part or not in facilitating mentalizing.

2.1.3 Therapeutic alliance rupture and repair

Ruptures in the therapeutic alliance are defined as tensions or breakdowns in the collaborative relationship between patient and therapist (Safran, Muran and Eubanks-Carter, 2011). The manoeuvres used in order defend against the distress and avoid the open expression of emotions and needs in the event of a therapeutic alliance rupture are termed rupture markers and can be of two types: *withdrawal* and *confrontational* (Newhill, Safran and Muran, 2003). Withdrawal markers often involve the patient becoming less engaged in the therapy, disconnected from emotional experience or over compliant. On the other hand, confrontational markers involve dismissive remarks or a more open opposition or criticism to the therapy or the therapist.

It is considered that a therapeutic alliance rupture is repaired or resolved when patient and therapist go back to working together in therapy with a strong affective bond. Working through alliance ruptures is considered to be an essential component of psychotherapy and is often seen as a mechanism of change in itself (Miller-Bottome et al, 2018). Eubanks, Muran and Safran's (2018) meta-analysis found that the literature points to a moderate relation between rupture resolution and positive patient outcome. However, it is important to notice that the model for therapeutic alliance rupture-repair has been developed for individual therapies and studies in this area have been focused on individual treatment.

Burlingame et al (2011) pointed that alliance in group therapy involves the individual patient-therapist alliance, patient-patient alliance and the alliance of the group as a whole. Lo Coco et al (2019) also raised the issue of the several layers of relationships happening in therapeutic groups and how they affect alliance. They reviewed the empirical research literature on group alliance, with the aim of exploring whether the rupture-repair model is suitable to be applied in this context. Their conclusion was that this is an important area for research, but up to this point there has been a lack of consistency in the literature and a scarcity of alliance-rupture studies about group therapy.

2.1.4 The Lighthouse Programme

The Lighthouse Programme is a MBT parenting intervention for families where children are at risk of maltreatment. The programme's structure "aims to enhance parents' capacity to mentalize and in particular to mentalize their children, to enhance attunement in parent-child relationships, to promote secure attachment and reduce Disorganization and to reduce risk of harm and risk or trans-generational transmission of psychopathology including BPD traits" (Byrne, 2016, p. 3).

A recently published study evaluating the results of the programme (Byrne at al, 2019) suggested that the Lighthouse Programme may be effective in improving parenting confidence and sensitivity, but there were no significant changes in parents mentalizing capacity as rated by the Reflective Functioning Scale. According to the authors, this could be related to the RF coding system used not being sensitive to treatment changes at the lower end of the scale, where most

parents in the programme scored. The report used a small sample of parents who have been through the programme and, therefore, can't be generalised. However, its results are promising of good outcomes in relation to the programme.

It is important to notice that even though the quantitative measure in this study didn't show significant change in the mentalizing capacity, the qualitative interviews indicated some evidence of improvement in this area. Further studies using an observer-based qualitative approach to look in more detail at the therapeutic process might help in understanding whether and how mentalizing is generated by this therapeutic approach.

2.1.5 Aims for this study

Taking in consideration the literature around MBT-G, it is possible to postulate that, by functioning as a 'training' space for mentalizing under charged circumstances, MBT-G operates in the border of rupture. Therefore, the repairing and making sense of the ruptures in the group could figure as an important element in the therapeutic process. Furthermore, both the understanding of the therapeutic process in MBT-G and the therapeutic alliance rupture-repair model in groups are areas still to be further studied by empirical research.

By using a qualitative approach to look into how individuals in a MBT-G process and make sense of a rupture, this study might add to the understanding of the process of development and change in mentalizing capacity during treatment. This study's research question is whether the discussion and resolution of a rupture in a MBT-G suggests an improvement of reflective capacity for the group members that take active part in the discussion. The focus is on exploring the shifts and/or

developments in reflective capacity across two sessions in a therapeutic group as the participants process a rupture in the therapeutic alliance. The aims are to specifically look at

- How the facilitators support the group of parents in processing the rupture;
- How individual parents respond to the rupture;
- How individual parents process the rupture.

2.2 Methodology

2.2.1 Context

This study draws upon data collected from the Lighthouse MBT-Parenting Programme. This service is offered by the National Health Service (NHS) in the UK as part of a Specialist Child and Adolescent Mental Health Service (CAMHS). It includes psycho-education, group therapy and individual treatment aiming to support families where child maltreatment is present. The data has been collected from the group therapy part of the programme, which consists of 20 weekly group sessions for parents based on the MBT-G approach for BPD. Each session is 2 hours long and has a pre-defined theme or task related to mentalizing and/or parenting that the therapists use to guide the accounts brought by the parents.

The participants are all couples or single parents who have in most cases experienced childhood neglect or abuse themselves, resulting in severe personality problems, other mental health difficulties or substance abuse. Some of these parents already have their children placed in foster care, while others are at risk of having their children removed from their care by Social Services.

2.2.2 Design

This is qualitative exploratory process study with the purpose of investigating how the parents and facilitators in a MBT-G process and make sense of a therapeutic alliance rupture, which is defined as a "tension or breakdown in the collaborative relationship between patient and therapist" (Safran, Muran and Eubanks-Carter, 2011, p. 80). Taking into consideration the multi-layered quality of therapeutic alliances in groups (Burlingame et al, 2011 and Lo Coco et al, 2019), this study will focus on the alliance and rupture between the parents and the group facilitators. The selected data was transcribed verbatim and divided into three time points, which were then analysed using Narrative Process Coding Systems (NPCS) (Angus, Hardtke and Levitt, 1996).

2.2.3 Participants

The participants are the parents and facilitators from a group treatment at Lighthouse Programme. The data in this study is from a later therapeutic group than the one used in the Byrne et al (2019) paper. However, all the procedures of data collection and measures used are the same.

This study includes all facilitators and parents present in the group session at the points being analysed. The group is composed of 4 facilitators and 11 parents, out of which there are 4 couples and 3 single parents.

Facilitators

There were 4 facilitators present in the group sessions. However, F1 and F3 were the main participants in the discussion of the rupture, with F2 being also involved during T3, but less vocal.

- F1: Clinical lead. Child and Adolescent Psychotherapist.
- F2: Trainee Clinical Psychologist.
- F3: Consultant Clinical Psychologist.

Parents

All parents are referred to the Lighthouse Parenting Programme by social services or court. The families are considered high risk in terms of child maltreatment. All parents in this study are under Child Protection orders from Social Services. There were 11 parents in the group; however, for the purpose of this study only the ones that were vocal about the rupture during the time points were considered. Below there is a summary of these parents including number of children, reason for referral and social services status pre and post group.

- Marie: Single parent. 1 child under child protection order in relation to mother's ability to assess risk in relation to her partner. There were no specific concerns in relation to her parenting. Good involvement and outcome post-group as the level of involvement from Social Services was stepped down.

- Sasha: Attends the group with her partner. 1 child under care proceedings, placed in foster care due to non-accidental injury and failure to protect. This was particularly attributed to father. Good involvement and outcome post-group as the level of involvement from social services was stepped down.

- Tash: Single parent. 2 children under care proceedings, placed in kinship care due to non-accidental injury, which the mother denied. Good involvement and outcome post-group, with children reunified with mother and family discharged from social services.

- Sharon: Single parent. 1 child under child protection order due to historical violence and substance misuse. Good engagement with the group and good outcome post group with family being discharged from social services.

- Theo: Attends the group with his partner. 1 child under child protection order due to suspected Fabricated or Induced Illness (FII). Parents overall found it difficult to engaged with the group, which they found unhelpful. However, the outcome post-group was positive as the child showed progress and as the level of involvement from social services was stepped down.

2.2.4 Data

All the group sessions, with the exclusion of the first one, were filmed and the videos as well as the summaries of each session written by the facilitators were made available for research. The videos were watched individually and during

group research supervision. Through that a moment of therapeutic alliance rupture stood out in the final part of session 9, during which there is a clear disagreement between the parents and the group facilitator. This moment of rupture was selected for further analysis as it seemed particularly relevant because the discussion of this event carried on during the next group therapy session.

The remaining of the session 9 and session 10 were watched with the intention of identifying the moments in which the therapeutic alliance rupture was being talked about in the group. Through this three time points around and after the rupture, in which this event is being explicitly discussed, were identified and transcribed verbatim.

The beginning of each time point was marked by the rupture or by a return to the theme of the rupture brought by the parents or facilitators. The ending of each time point was marked by the end of the session, a comfort break or a clear change in therapeutic task. The selection and division of the three time points was discussed and agreed with the research supervision group, research supervisor and the Lighthouse Programme Clinical Lead. Due to the quality of the audio in the videos and the difficulty to capture the sound in a large group when members are talking at the same time, some parts of the video were hard to understand. Some of these passages were marked in the transcription as [inaudible], if they could not be deciphered by the author or members of the research supervision group.

2.2.5 Data analysis

The verbatim data was analysed using an adaptation of the Narrative Processes Coding System (NPCS) (Angus, Hardtke and Levitt, 1996), which has

been shown to be a reliable and useful method of qualitative analysis in multi-participant contexts (Laitila et al, 2001 and Seikkula, Laitila and Rober, 2012). Moreover, it allows for the identification of shifts in the narrative process modes, including a reflexive analysis mode, which is appropriate to recognise when reflexivity is happening in the therapeutic session.

NPCS is a two-step process which enables the researcher to subdivide therapy session transcripts into topic segments according to content shifts in verbal dialogue and to further subdivide and characterize these topic segments in terms of the narrative process code (Angus, Hardtke and Levitt, 1996). The three narrative process codes are:

1. external description of events

2. description of emotional experiencing

3. reflexive analysis of current, past and/or future events and emotional experiencing.

According to the NPCS manual (Angus, Hardtke and Levitt, 1996), when the focus is on the reflexive analysis or interpretative mode, the individual attempts to make sense of their own feelings relating to the self, others and events. Some cues to identify the reflexive process mode are when the individual examines their own behaviour in situations or relationships; plans future behaviour alternatives; examines own thinking in situations; explores the meanings of expressed emotions in situations; discusses patterns in own behaviour and/or that of others; and is self-questioning. As it can be noticed, the concept of reflexive analysis in NPCS is closely aligned with the concept of metalizing or RF and, therefore, seems

appropriate to shed light into the moments in which mentalizing happens within the group.

For the purpose of this study, the material was not divided into topic segments, as only passages in which the topic being discussed is the rupture were selected for analysis. This was done so shifts in the narrative process code being used in discussing the same topic at different time points could be identified. Therefore, passages within the same time point in which the topic being discussed was other than the rupture were excluded from analysis.

The NPCS manual specifies that the length of a sequence coded with the same narrative mode should be of 4 sentences or more. Sequences shorter than that should be incorporated to either the preceding or following sequence and coded according to the predominant mode. However, this was adapted in this study to include all shifts in narrative process mode, even the ones shorter than 4 sentences. This was done with the purpose of having a clearer picture of all shifts and oscillations on the narrative code being used by the participants. It is felt that this adaption is important due to the specific clinical population considered in this study, in which there is an inconsistent mentalizing capacity, and also the nature of the group therapy, which may involve shorter or longer exchanges between the various participants. The choice of including all shifts in narrative process mode, even the shorter ones, hopes to capture the changes in the group functioning in general but also in more detail the process for each participant.

2.2.6 Ethical considerations

This study is part of a larger project that was granted ethical approval by the NHS Trust's Research and Development Department as a quality improvement service evaluation. The present qualitative study has been specifically included in the approved proposal form. All participants gave permission for the sessions to be recorded and were also given detailed information of how the videos might be used for further research, to which they consented.

The sensitivity of the material has involved further ethical implications, which included the safe transportation of the data in encrypted devices or through the secure Anna Freud Centre system. Due to the qualitative nature of this study, some personal information and verbatim vignettes were needed to illustrate the analysis and make sense of the group process. Therefore, in order to preserve the participants anonymity, all names and identifiable information have been changed and personal information was kept to the minimum necessary for the study.

The author of this study is a Child and Adolescent Psychotherapist in doctoral training with no formal MBT training. She was not involved in the delivery of the therapeutic group and only had contact with the data through the recorded videos. However, due to her clinical experience with a similar group of clients and the intensity of emotions displayed in the video data, there might have been an unconscious tendency to identify with the group facilitators. The author also had no previous experience of using NPCS as a method of analysis. Therefore, to ensure the credibility of the results, passages of the transcribed material were coded both by the researcher and a colleague to provide intercoder reliability. This

piece of research was not done in isolation, with regular discussions with the research supervisor and supervision group being an essential part of the process.

2.3 Results

This section presents the results of the analysis of the transcribed video data. The material was divided into three time points (T1, T2 and T3) and analysed according to the narrative process codes (Angus, Hardtke and Levitt, 1996). The three categories are: *description of external events, description of emotional experiencing* and *reflexive analysis*. Each time point is firstly considered as a whole according to the overall narrative process. This is followed by a more specific focus on the narrative process codes used by the facilitators and by the parents. Five parents were identified as being vocal about the topic of the therapeutic alliance rupture and the passages in which they participate were analysed.

Table 1 below summarizes the findings. It shows the increase of *reflexive analysis* across the three time points. As it can be seen, during T1 external description of events is the most present narrative process code (44.4%). During T2 there is a close balance between external description of events (36.8%) and reflexive analysis (38.4%). By T3 reflexive analysis becomes the predominant narrative process code being used (95.5%). The facilitators' row also shows a gradual increase in the use of reflexive analysis from T1 (34.5%) to T2 (45.6%). At T3 the facilitators almost exclusively used reflexive analysis (99%). Among the parents, Theo shows the greatest increase of use of reflexive analysis across the three time points examined.

	T1			T2			T3		
	External events	Emotional exp	Reflexive analysis	External events	Emotional exp	Reflexive analysis	External events	Emotional exp	Reflexive analysis
Overall	44.4%	30.8%	24.8%	36.8%	24.4%	38.4%	4%	2%	95.5%
Facilitators	29%	36.5%	34.5%	27.8%	26.6%	45.6%	1%	--	99%
Marie	55%	30%	15%	85%	15%	--	--	--	--
Theo	100%	--	--	65.3%	34.7%	--	--	--	100%
Tash	--	--	--	26%	35.3%	38.6%	--	--	100%
Sasha	--	--	--	8.8%	--	91.2%	--	--	100%

Table 1. Predominance of narrative process codes at each time point.

2.3.1 Time point 1 (T1)

T1 takes place during the second half of session 9 and lasts until the end of the session. The overall predominant process code used at this time point is *external description of events* (44.4%). *Description of emotional experiencing* appears in 30.8% and *reflexive analysis* in 24.8% (Table 1).

T1 starts with the moment of rupture. F1 gives an example saying that if a child does not express any distress even when visibly hurt it is recommended to pick the child up and acknowledge the pain, which would support the child to become more secure and independent. He moves from an *external description of events* to *description of emotional experiencing* and then to *reflexive analysis* (example 1). There is a miscommunication when Marie responds using *external description of events* (example 1) with the understanding that F1 had said that one must pick a child up every time they fall over. From that Marie shifts to using *description of emotional experiencing* (example 1) when she expresses her feeling that she is being told she is doing something wrong. This moment has been identified as a therapeutic alliance rupture as Marie verbalises feeling criticised by F1, which constitutes a tension in the collaborative relationship between patient and therapist (Safran, Muran and Eubanks-Carter, 2011). Example 1 below demonstrates this moment.

Example 1 – Moment of rupture

F1 – […] description of emotional experiencing) Because if you fall over and you cut your knee, even as a grown-up, it's gonna hurt. So what we would say to you to do

would be to catch the child and say 'that looks really sore' 'no no, I'm fine' 'no no, that looks really sore, because if I fell over like that I think I'd be upset' […]

Marie – (external description of events) [*inaudible] Sammy (child) [inaudible], […] he bounces all the time, like I'd be forever, I'd have to carry him right in front of me, if I was to comfort him every time he fell over because he literally bounces 24/7]*

[…]

Marie – (description of emotional experiencing) *It's really hard, coz [inaudible] quite difficult, as if I'm doing everything wrong. Coz like, this one, I mean, for me that's my way of dealing with it with Sammy.[…]*

Facilitators at T1

F1 and F3 are the most active facilitators and the predominant codes used are *description of emotional experiencing* (36.5%) and *reflexive analysis* (34.5%) (Table 1). *Reflexive analysis* is mainly present at the beginning of T1. In the moment just after the rupture there are attempts by the facilitators to promote reflection on what is happening in the group, but this is quickly followed by a return to *description of external events* by the parents. This can be seen in the example 2 below:

F3 - […] (reflexive analysis) *maybe F1 reminding everyone that we have that relation with the authorities as well]*

Marie - […] (reflexive analysis) *actually just made me realise […] that just it's something that is a bugbear for me. […]* (shift to description of external events) *He (child) looked around to check if I'm still around and ran off playing. I'm not gonna run after him and check him.*

As seen in the example above, when F3 links Marie's upset to what had been said earlier in the session about the facilitators having a relation to the authorities, Marie responds with a brief moment of *reflexive analysis,* which is immediately followed by a return to *external description of events*. From that point, both F1 and F3 use *external description of events* in questions to clarify what a participant has said or *description of emotional experiencing* when asking questions about how the parents are feeling.

Parents at T1

The most active parents in discussing the rupture in T1 are Marie and Theo (Table 1). Marie is the most vocal of all parents. She predominantly uses *description of external events* (55%) (example 1 and 3), intercalated by moments of *description*

of emotional experiencing (30%) (example 1) and, as mentioned above, brief moments of *reflexive analysis* (15%) followed by a return to *external description of events* (example 2). Theo uses only *description of external events* (example 3).

Example 3 below demonstrates Theo and Marie using *external description of events*.

Example 3: End of T1

Theo- <u>(external description of events)</u> *I'm fine, yeah. A bit bemused of the way it is presented at the moment, coz, uh, the way it looks going by what you're saying that an entire generation has been bringing up their children wrong. […] So, you're saying an entire section of society has been doing it wrong for years.*

[…]

Marie – <u>(external description of events)</u> *[…] it comes across very almost sort of black and white, this is what we, this is what the programme says this and we're like 'what? This is not every day normal life' […].*

Other members of the group were active in discussing the manners in which one comforts a child but did not get involved in discussing the topic of the rupture and therefore were not included in the analysis of T1.

2.3.2 Time point 2 (T2)

T2 takes place at the beginning of session 10, one week after T1. This moment is defined by a return to the discussion about the events in the group from the previous week and the topic of the rupture. What marks the beginning of T2 is F1 asking Marie how she felt after the previous session and the end is marked by a clear change in therapeutic task as the facilitators introduce the theme to be discussed during that session.

There is a greater balance between the three process codes at this time point. *Reflexive analysis* is used in 38.4% of T2, while *external description of events* appears 36.8% of the time and *description of emotional experiencing* 24.4% (Table 1). It is likely that the predominance of *reflexive analysis* at this point is related to the long passages of the facilitators using this narrative code.

Facilitators at T2

F1 and F3 are the most active facilitators and the predominant code used is *reflexive analysis* (45.6%), with a balanced presence of *description of external* events (27.8%) and *description emotional experiencing* (26.6%) (Table 1).

Description of external events is mainly used to both clarify events narrated by the parents and to recall the events of the previous week by pinpointing the exact moment when the rupture occurred. *Description of emotional experiencing* is used to describe the facilitators' own feelings as well as to mark the emotional experiencing of each parent.

At the end of T2, F1 and F3 alternate in taking extended turns in the dialogue (example 4), in a way of summarising the discussion while making links between the event of the rupture within the group and the emotional experience of the parents. The process code in use at this point is *reflexive analysis*.

Example 4 below demonstrates F1 and F3 alternating in taking long turns using *reflexive analysis* to summarise and explain the events in the group.

Example 4: Facilitators summarising events (reflexive analysis)

F1- […] in all of us, we have this mechanism, because, in situations of high stress or high anxiety, where fears are kind of roused, we're going to shift, understandably, to making interpretations of what is happening to us in light of our feelings. So, the moment that we feel criticised or undermined, the next thing out of that person is gonna sound like another criticism. Even though, to an objective observer, it sounds quite neutral, yeah? Does that make sense?

F3- And I think, F1, it is fair to say, because everyone is in this room because they are so desperately in love with their kids and wanna do the right thing. I think it makes it even more sensitive to think you're being criticised because you care so much. […]

Parents at T2

The most active parents in discussing the rupture in T2 are Marie, Theo, Tash and Sasha (Table 1). Marie uses predominantly *description of external events* (85%). During the discussion she becomes upset and leaves the room, which means that she does not take part in the whole of the discussion. Theo also makes predominant use of *description of external events* the beginning (65.3%) (example 5) and there is a shift to description of *emotional experiencing* (34.7%) at the end of T2. Tash alternates between the 3 codes in a balanced way. She uses mainly *reflexive analysis* (38.6%), followed by *description emotional experiencing* (35.3%) and *description of external events* (26%). Sasha predominantly uses *reflexive analysis* (91.2%) (example 5).

Example 5 below demonstrates how Theo, making use of *description of emotional experiencing*, and Sasha, using *reflexive analysis*, start to make sense of the rupture event with support from the facilitators.

Example 5: Making sense of the rupture

Theo – […] (description of emotional experiencing*) I was quite disturbed by it.* (shift to description of external event) *I got a friend, who's actually a health visitor, and I spoke to the health visitor and she was like really shocked as to why we were being told to go down those routes.*

F1 – (<u>description of external event</u>*) so it felt like it was being presented as if this must happen.*

Sasha - (<u>description of external event</u>*) Like you must pick them up and cuddle them and physically do it, like I think that's how it came across.*

[…]

F3 – […] (<u>shift to description of emotional experiencing</u>*) So the misunderstanding was the sense of being that, this F1, F4, F2 and I were saying 'you do it our way or you're a bad parent'?*

[…]

Sasha - (<u>reflexive analysis</u>*) […] to me as it was just a miscommunication between how we took it and how it was sort of being presented and I think it was a bit unclarity on both sides and I think with emotions then getting more worked up it was then getting harder and harder for everyone to see the miscommunication.*

The example above introduces the notion that a misunderstanding happened, which led to the therapeutic alliance rupture. Tash and Sasha were absent in the data analysis of T1, even though they were present and active in the session, as they did not join the discussion about the rupture in itself. However, in T2 they are both very present in using *reflexive analysis* to make sense of the events at T1.

2.3.3 Time point 3 (T3)

T3 takes place at the middle of session 10, after the presentation from F1 about the theme of this session. T3 starts after a discussion about certain themes and words that might work as emotional triggers and the facilitators link that to the rupture, re-starting the discussion. T3 ends with F1 summarising and reflecting on the whole discussion. After that the group takes a comfort break. The predominant process code used in T3 is *reflexive analysis* (95.5%)(Table 1).

Facilitators at T3

F1 and F3 are the most active facilitators, but with more participation from F2. The predominant code used is *reflexive analysis* (99%) (Table 1). T3 starts with F1 and F3 taking turns in using *reflexive analysis* to link F1's statement at the beginning of T1 to the parents' emotional experience, thinking of it as a trigger that led to the rupture (example 6). They also use *reflexive analysis* when generalising this experience to other events in people's lives.

Example 6: F1 and F3 taking turns

F3 – (reflexive analysis) […] that's really helpful. I'm just saying, sometimes, not when the heat is on, but like the group so courageously said 'actually, what happened last weeks is a trigger for us; being told we're getting it wrong. That was really upsetting'.

And last week it was too hot to talk through, but this week people have come back and said 'this is why we don't agree']

F1- (reflexive analysis) *[…] Is it fair to say that I might have been seen in a different light suddenly? […] so, in that moment, suddenly seems that I, or the team, or the system, is saying 'this law [inaudible] is how it is '. So, would that be an example of that, without meaning to, I triggered, uhm, memories of being criticised, of being judged, of being told you're a bad parent, that you're doing it wrong? […]*

Parents at T3

The most active parents in discussing the rupture in T3 are Theo, Tash and Sasha (Table 1). Marie is not in the room and therefore does not take part in T3. *Reflexive analysis* is the process code used by these three parents at this time point (example 7). It is also noticeable that there is a greater presence of turn taking between different parents and facilitators and a joint constructing of a reflective understanding of the events in T1 (example 7). Important to notice that Sharon, who had been silent during the T1 and T2, voices in T3 that she hadn't heard what F1 said in the moment of rupture in the same way as the other parents seemed to have taken it.

The example 7 below shows how Tash and Theo revisit the event of the rupture making sense and reflecting on what emotional and mental states might have led to the parents' reaction.

Example 7: Re-thinking the rupture

Tash – (reflexive analysis) *I just think it's miscommunication, because you didn't actually say, you didn't say that anybody was doing anything wrong. […] You didn't say anything about 'this is how it should be done'. You're literally giving an example, but I think people took it personally,[…]*

F1- (reflexive analysis) *Did something, when that happen, that I kind of stepped on sensitive nerves, that meant that on that moment I was going to be seen in a certain way? Did that happen?*

Tash- It's because of your position in the room…

F1- That's right…

Tash – because you are …

F1- We are professionals…

Tash – (reflexive analysis) *You are professionals. I think, say if somebody else had said it, I don't think it would've been taken… I think it's just because of the position you're in [inaudible].*

Theo –<u>*(reflexive analysis)*</u> *I think it is right to assume that not long before that you made a comment about you do make reports, and you are a professional…*

F3 – That's very important.

Theo – <u>(reflexive analysis)</u> You said that in the same sort of section made it sort of directed...

It is possible to observe in the example 7 above that there are multiple participants reflecting on the event of the rupture together. Tash reflects back on the event of the rupture and, as F1 asks her *reflexive analysis* questions about it, she continues with the reflection, thinking of what previous events and emotions might have contributed to the misunderstanding. Theo then adds to this by thinking of how the circumstances in the group might have led to the parents' response. It is noticeable that the turn taking between the parents and the facilitators is quite short and it appears that this is how the facilitators are supporting the parents own reflexive analysis of the situation.

2.4 Discussion

The objective of MBT-G is to increase the participants' ability to mentalize in close relationships, which can be facilitated through the discussion of an event within the group. For the purpose of this paper the focus is on a therapeutic alliance rupture that arose during the session. The results of this study (Table 1) indicate that there was an increase in the presence of *reflexive analysis* narrative code across the three time points. This suggests that through the process of resolving the rupture reflexivity has been generated for some of the participants, which can lead to mentalizing.

The findings also show a gradual increase in the use of *reflexive analysis* by the group facilitators. By noticing how the facilitators made use of each narrative mode, it is possible to consider that they were adapting to the responses of the group and scaffolding reflexivity. That is, they increased their reflexivity as the group became more able to sustain it, as it was also noticeable an increase in use of *reflexive analysis* throughout the three time points when considering the group as a whole. However, this does not reflect the journey of each individual parent. Among the parents, Theo shows the greatest increase of use of *reflexive analysis* across the three time points. Tash and Sasha don't take part in T1 and already show higher levels of *reflexive analysis* in T2. Marie is the only participant that doesn't show a shift towards an increase in *reflexive analysis*. She left the room and was not present during T3.

An important characteristic of MBT-G is that clinicians are 'active' in maintaining the flow and structure of the session, going back to the topic in focus and monitoring arousal levels, which must be neither too high nor low. The division in three time points

for this study reflected the natural flow and breaks in the sessions, which shows how the facilitators encouraged the discussion about the rupture as well as interrupted it and then brought it back later, which might have worked as a strategy to regulate the levels of emotional arousal in the room and facilitate the increase in reflexivity. This is in line with the literature around MBT-G. Morken et al (2019a) also found that, even though patients found it difficult when therapists put the focus on the relationship between patient and therapist, this was found to be an important element in exploring ruptures which contributes to making patients feel safer. Similarly, Kalleklev and Karterud (2018) noticed that a gradual increase in RF coincided with a series of challenging interventions by the therapist scaffolding mentalizing over a considerable timespan.

When exploring an event that happened within the group, in the 'here and now', the focus is to understand the emotional reaction; to invite curiosity about why the members of the group are reacting in the way they are. According to Bateman and Fonagy (2016, p. 5) mentalizing "helps us to understand misunderstandings by recapturing the mind states that led us to misapprehensions". This can be seen happening across the three time points, as the facilitators lead the group back to the event of the rupture making links with the theme of non-mentalizing and emotional triggers that is the topic of that session. In this sense, they help the parents to be curious about what led to the rupture and to understand their states of minds and emotional reactions.

Another strategy the facilitators used was taking long turns between themselves (example 5) to make an analysis of the events in the group, which seemed

to both model mentalizing and offer understanding. This is in accordance with the literature that points that one of the main characteristics of MBT-G is that the clinicians encourage relational curiosity and make their own thinking explicit and transparent (Bateman and Fonagy, 2016). It is also important to notice that there were times in which the facilitators encouraged and engaged in very short turn taking with the parents (example 6), which appeared to support the parents own mentalizing in T3.

In terms of the process of making sense of the rupture in relation to the parents, the results show a mismatch between the narrative process code being used by Tash and Sasha and Marie and Theo in T2. Tash and Sasha show straight away more use of *reflexive analysis* in T2. However, they were not directly involved in the rupture event and the discussion in T1. Marie and Theo who were the most active participants in T1, during which *external description of events* and *emotional experiencing* were more predominant.

One possible explanation for this is that Marie and Theo having been more involved in the discussion in T1 found that the return to the discussion in T2 more emotionally stirring than Tash and Sasha, who perhaps had more distance from it. It is relevant to notice from the transcriptions of the passages in which Marie is very active that she tends to take extended turns in the dialogue when compared to the other parents. There is also high emotional arousal, which can be noticed in non-verbal signs, in the frequent speaking over or interrupting other members of the group and a disruption in the rhythm of the conversational turn taking. In T2, Marie leaves the room, which could have been related to her still feeling too emotionally stirred up and therefore her capacity to mentalize at that point was compromised.

This is an example of how different participants responded differently to the discussion in the group and the strategies being used by the facilitators. This is one of the challenges of group work, as participants may be in different states of mind, which is made evident by the different narrative process being used. In Theo's case it might be possible to think that Tash and Sasha's more reflective position, alongside with the interventions by the facilitators, helped him get to a more reflexive or mentalizing mode as seen in T3.

It is important to consider the complex and multi-layered nature of alliance in a group context (Burlingame et al, 2011 and Lo Coco et al, 2019). While for Theo, the reflexive position adopted by the other parents seemed helpful, for Marie, the mismatch with the group members and facilitators seemed to have led to a further rupture, as she felt the need to leave the room. In this sense, it is also relevant to notice that many parents that were present in the group did not take part in the discussion of the rupture. This is particularly evident in the example of Sharon, who is able to voice a different perspective from other participants in T3, when there was much less emotional arousal. It is possible to postulate that in a group context different participants might exhibit different rupture markers (Newhill, Safran and Muran, 2003). Marie and Theo's responses in T1 exemplify confrontational markers, whereas the other participants might have been showing withdrawal markers. This was not examined in the detail in this study, but it raises the question of how the silent participants were processing the events in the group.

2.5 Strengths and limitation

This study adds to the understanding of the therapeutic process in MBT-G and the therapeutic alliance rupture-repair model in group therapy, both areas that have been so far scarce in terms of empirical qualitative studies. The use of an observer-based method allowed for more distance and objectivity. However, as Eubanks, Muran and Safran (2018) noticed, observer-based measures are limited by the fact that observers are not participants in the therapeutic relationship and therefore may miss how hurt, misunderstood, or distant the patient or therapist feels. In this sense, this study only captures the experience that was verbally shared by parents and facilitators in the moments observed in the video data. This is a limitation in terms of understanding the more subjective experience of the participants and also it does not include the experience of the participants that didn't verbalize their thoughts on the rupture, which doesn't mean that they were not active in processing the events in the group.

As seen, the quantitative measures used in previous research about the Lighthouse Programme (Byrne et al, 2019) have shown no significant change in terms of RF, but the qualitative measures seemed to indicate some improvement in mentalizing. The current study adds to this evidence by exploring in detail a segment of the group therapy in which reflective capacity has increased for the participants. However, this is limited by the fact that this study has only looked at the three selected time points, which means that its findings may not give a comprehensive understanding of this treatment group and as a qualitative process study using a small sample, it's findings cannot be generalized.

Further studies examining other rupture-repair episodes in this type of group treatment would help to confirm the importance of addressing ruptures in group treatment for generating reflective capacity. Also, studies using post-treatment self-report measures, such as interviews, with a focus on the rupture-repair events would help to get a sense of a more subjective experience of the participants and also to capture the experience of those participants that were not actively verbal in discussing the event during the sessions. Further post-treatment studies would also help to inform if the mentalizing generated during the sessions has long-term effects in the mentalizing capacity of the participants and whether it gets translated to other circumstance and relationships in their lives.

2.6 Conclusion

The present study aimed to shed light upon the detailed process of generating mentalizing in an MBT-G for parents at high-risk of children maltreatment through the resolving of a therapeutic alliance rupture. The data was divided into three time points, corresponding to the process of resolving the rupture, and analysed using NPCS to investigate shifts in the participants' use of *description of external events, description of emotional experiencing* and *reflexive analysis*. Given its qualitative design, this study has some limitations and might not reflect long-term changes in the participants mentalizing capacity. However, the results show that, through the direct discussion of a therapeutic alliance rupture over a considerable timespan, reflective capacity

increased for some participants who also seemed to have gained some understanding about their emotional responses at the time of the event.

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Part 3: Reflective Commentary

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3.1 Introduction

In this paper I reflect on my journey through the UCL Doctorate in Independent Child and Adolescent Psychotherapy, with emphasis on my experience of conducting an empirical research at the Anna Freud National Centre for Children and Families (AFNCCF) alongside the clinical training at British Psychotherapy Foundation (*bpf*). The incorporation of research within the four years of the clinical training is a recent and important development and I was part of the third-year cohort.

I embarked on the training in October 2016, knowing that it would be a long path ahead. The clinical training in child and adolescent psychotherapy is a four-year intense training with vast opportunities for professional and personal development, as it combines a Child and Adolescent Mental Health Service (CAMHS) NHS placement four days a week, clinical and theory seminars, clinical supervision and personal analysis. Alongside this, we were also given the opportunity of learning about research and were asked to do our own empirical project using the data from one of the projects running at the AFNCCF.

With two colleagues, I was allocated to do research on the Lighthouse Programme. This was not my first option and, in the beginning, I felt out of my depth as I was not very familiar with research and with this subject and programme. My research project was focused on the Lighthouse MBT-Parenting Programme, which consists of a manualised Mentalization-Based group treatment for parents in cases where there has been child maltreatment. This is a high-risk population and most parents attend this group as part of child protection plans. A unique characteristic of

this programme is the use of 'sea journey' metaphors to illustrate types of attachment, mentalizing functions and emotional experiences (Byrne, 2016). Looking back, I noticed that some of these metaphors could also relate to my experience of doing a research and a clinical training. I will use some of these metaphors as guides to reflect on my experience through different stages of this process.

3.2 On the raft

At the start of the training I had little knowledge or experience of empirical research. My experience of writing my MA dissertation was of writing a more theoretical and observational piece, based on the material I had gathered through my own work experience. I regarded research in psychotherapy as being important and was excited about the opportunity, but this came from a rational instance rather than an emotionally invested one, as I was much more attracted by the clinical aspects of the training.

Midgley (2004) approaches the gap between research and clinical practice in child psychotherapy. He quotes a study by Darlington and Scott (2002 in Midgley 2004) in which psychotherapists' associations to the word 'research' included ideas such as hard, cold and objective. My own ideas about research in this initial phase were not far from this. I was aware of the political importance of research for child psychotherapy in terms of protecting and promoting its space within the evidence-based practices. However, I imagined it as something disconnected and possibly even

limiting and reducing of the nuanced and subjective aspects of psychoanalytic clinical practice.

Being part of the integrated training programme was vital in this sense, as the teaching at the Anna Freud Centre was developed with the intention of addressing the gap between research and clinical practice. There was a clear sense that the research teaching staff was prepared to support trainees that, like me, came to the training expecting to become clinicians and not necessarily researchers. In our first year, we had lectures that gave me a basic and fundamental knowledge on research methodology. In the Journal Club seminars, we read research papers that were relevant for psychotherapy and had the opportunity to discuss and learn how to criticise and understand research in a livelier manner. We also had the chance to create a 'mock' research project which put us in touch with a more creative and, perhaps, playful side of research. Some of this new learning about research, such as the fundamental of statistics and types of research, still came across to me as being dry and distant. However, the more practical aspects of the teaching, such as creating the 'mock' project and then developing my own clinical audit throughout my first year, helped to bring research closer to my reality.

Nevertheless, when in our second year of the course we were allocated to our research projects and started working on our own research proposals I felt lost. My year group was divided and allocated into two already existing research projects: the IMPACT study and the Lighthouse Programme. We were asked for our preferences, but not everyone could be allocated to their chosen project. This was my case, as my first choice had been the IMPACT project, based on the fact that I was more familiar

with the original study. As I was allocated to a project that neither I or my training colleagues were familiar with, there was an increased sense of impotence and uncertainty.

Being able to join an ongoing project had many practical advantages during an integrated doctoral clinical training. It meant that the data had already been collected and was available and it also spared us from having to go through the lengthy process of ethical approval within the NHS. This saves precious time in a busy trainee's life. Another positive aspect was that it put me in contact with a very interesting NHS programme that I would not have known about, which helped me to develop an interest in the area. On the other hand, in the beginning it was challenging to engage and feel motivated to create a project in an area that hadn't been chosen and in which I did not have much knowledge or familiarity with the data. In this sense, the initial phase of creating my project felt at times like the Lighthouse metaphor of the 'Sea Journey': unknown, unpredictable and at times risky.

In our small research supervision group, we started to watch the video data that we would be using and came up with preliminary ideas of what our research questions might be. The Lighthouse programme uses the metaphor of 'exploration' to think about a child's delight in their own curiosity. It is a very optimistic and hopeful state of mind. However, the pressure of time can make it hard to feel free to explore. Besides, at times I felt quite literally 'out of my depth', as if trying to come up with a research question without enough foundations to sustain it. Issues with data access meant that we only had very limited and occasional access to our data for many months, which I

think contributed to this experience as it made an immersion in the data not possible at this stage.

My first research question was *'How parents in the group reflect on themselves?'* which was soon modified to '*How the group dynamic enables reflection on the sense of self?'* This was a first step towards what became my final question, as it already considered the group and the interactions between its members. However, at this initial stage I found I didn't yet have perspective of the long learning process that takes place in coming up with a question and the need to keep it somehow open, as it will change with new ideas, new papers read and more contact with the data. At that point, I might have had some hope of trying to find a 'short cut' for the long free and changing process of formulating a research question. Also, keeping the question as close as I could to psychoanalytic concepts might have been a way of staying within what a knew, but also perhaps a reaction to a still somehow present sense of research as something hard, cold and objective, that needed to be avoided.

This experience seems to me linked to the metaphor of the 'raft'. In the Lighthouse programme, the idea of the 'raft' is used to refer to avoidant attachment in children; a state of feeling lost and not looking to be found. It involves a level of protective disengagement. In this sense, a 'raft' gives one something to hold on to when 'out of one's depth' but it also involves floating in the surface with no real contact with what lies underneath. It might feel safe, but it is also limiting. This is a very familiar state of mind that I noticed in children and parents in my clinical practice, getting in the way of genuine and spontaneous interactions. It can also affect clinicians when faced with very disturbing emotional states. As I have been exploring, it seems that it

also might have somehow coloured my 'researcher state of mind' when approaching the initial steps of creating a research.

3.3 Adventure in Rough Seas

Another one of the Lighthouse metaphors is the idea of 'rough seas', which is used to describe the moment when a child feels lost and calls out for help, looking to be found. This image is helpful in representing the next stage of my research journey, in which I felt lost and confused, but also had plenty of support from my supervisor, teachers and training colleagues in finding my way to a richer and more integrated experience.

The main task of our second year of research was to write the literature review. I had to learn how to do database search, which is something I had very little experience with. I found it challenging but at the same time a very involving task. There was something fascinating about trying out different combinations of key words, like the working out of a puzzle, that could be very consuming. At times I needed to remind myself to stop and stay with the material I had already found.

As mentioned before, there were difficulties with the permission for data access, which meant that at this point most of my contact with the video data was still limited to our monthly supervision. In this sense, I was working on my literature review based on my first question and felt that it was still disconnected from the data. The process of reading papers and organizing ideas for the literature review was very helpful in terms of opening up my ideas about what I really wanted to explore in my research. A

lot of what I was reading about mentalizing and MBT was new to me. I also came to realise that my initial idea of exploring how the parents reflect on their sense of self was too abstract as I struggled to find a way to operationalize the concept of sense of self using the psychoanalytic literature.

The Research Workshop seminars offered the opportunity to discuss our research project with more people, which helped to open things up and bring new perspectives. I started to consider incorporating mentalizing to my research, as my data was of a Mentalization-Based Treatment. Being already quite interested in the group modality of treatment, I began to wonder about if and how the interactions between various participants and facilitators might help to generate mentalizing in such high-risk clinical population.

The occasional meetings with the Lighthouse Clinical Lead during our research supervisions were also very helpful in clarifying aspects of the programme and in bringing its clinical aspects to life. During my second year of training, my work in CAMHS had picked up and I was working with more cases. Many of the children and young people I was seeing had been victims or had witnessed abuse in their early years. I also started working weekly with a parent, which was a new experience. This meant that I became more interested in the data I was using from a clinical perspective, as it reflected some of the experiences I was having in my clinical training.

The data access was still problematic, requiring more forms and permissions. Once this was sorted, we should have had remote access to the videos. However, the video files proved to be too heavy for remote access, sometimes having no sound or freezing. Another solution was found, but I also found technical difficulties with it. In

the end, the best solution for me was to watch the videos at the Anna Freud Centre. This created an issue of finding the time to be at the centre, which could be difficult as my out of London CAMHS placement meant that I had already about 4 hours of daily commute on top of all my training activities. It was essential for me to make sure I used the times before supervision and seminars to watch the videos.

Thinking of exploring how the interactions in the group generated mentalization, I started watching the video for a session during which a heated discussion about the group in itself had happened. This led me to realise that this discussion was about an event in the previous session in which there was a misunderstanding between the parents and the group facilitators. Following both sessions, I noticed that there seemed to be a process of working through a difficult moment in the group relationships. I noticed how the facilitators used what happened to help the parents to think about their emotional responses. This connected to something that I was finding fascinating in my clinical work: how thinking of misunderstandings or working through difficult moments in the therapeutic relationship could be strengthening for the alliance and also promote very rich emotional thinking.

I came to define the 'misunderstanding' as a moment of rupture, which led to my final question *'How do individuals in a MBT-G process and make sense of a rupture?'* I felt this was much closer to the data and to the Lighthouse programme in itself, but I also felt I was now working on more solid ground.

After defining which parts of the data I would actually need, I started transcribing the videos. This was an incredibly time-consuming and at times very frustrating activity. The quality of the videos made some passages very difficult to hear

and understand. Besides, the fact that this was a large group meant that participants would at time speak over each other, which made the material hard to transcribe.

Another important task at this point was to define which method of analysis I might be using. The challenge was to find a method that could incorporate the many participants in a group treatment. In supervision, we were introduced to Narrative Process Coding System (NPCS). NPCS seemed appropriate, as it had been used to analyse family therapy sessions and larger group settings (Laitila, Aaltonen, Wahlström and Angus, 2001; Seikkula, Laitila, and Rober, 2012). Also, the third narrative process mode, *Reflexive Analysis,* had a conceptual closeness to the idea of mentalizing, which was relevant to my project.

3.4 Illuminating beam

Having completed the transcription, I started analysing the data. It felt like a very different experience having the verbatim transcripts in front of me instead of the videos. As a clinician, watching the videos was a very enriching experience but also a difficult one, as I had chosen a particularly difficult moment in the relationship between the parents and the group facilitators. Emotions in the parents were very stirred up, which at times made it hard to watch, especially coming from a perspective of knowing what it felt like to be a therapist in the room when those intense feelings were around. I was aware of a sense of siding with the facilitators. On the other hand, as an observer, I had more of a distance from which I could notice what was happening and my own responses to it.

The written transcripts gave me a new perspective, but it also felt like an overwhelming amount of data. At this stage, it was fundamental to have the help from my research colleagues and supervisor in getting some reliability to how I was applying the method of analysis. As I started to analyse the transcripts using NPCS I could see new meanings unfolding. Some of my first impressions were confirmed but I also had some unexpected findings.

The Lighthouse programme is founded upon the metaphor of the 'illuminating beam'. This is the shaft of light in a lighthouse that guides the ships to safety. In terms of mental processes, in the Lighthouse programme this idea is used to represent a mode of wanting to know, being attentive, curious and imaginative. That also reminds me of the idea of negative capability that Bion (1970) developed from Keats writing: "being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason" (Keats, 1817 in Ferro, 2018). For Bion, this is a capacity to tolerate not knowing, being in doubt, which can create an openness to make actual sense of what is in front of oneself and links to the idea of 'learning from experience' (Bion, 1962).

I felt that the process of coming up with the results and then making sense of them in a discussion was a very creative and rich process. I noticed a greater sense of involvement and 'ownership' of my project, in contrast with my early 'on the raft' sense of trying to keep a distance from something that felt somehow imposed on me.

It is interesting to notice how my development as a researcher and as a clinician have informed each other. As I mentioned before, I felt that I started to feel a connection to my project coming from a clinical interest in the subject. However, with time I started to observe how much I could see of the Lighthouse programme and of

my findings reflected on my clinical practice. Besides, thinking of how I began this journey with a sense of distance and disconnection from research, it is fascinating to realise how closely aligned my final project ended up being to elements that I find particularly interesting in clinical work. Even though the language is different, I believe my project touches on psychoanalytic concepts: looking at a rupture caused by a misunderstanding involves also thinking of projection and in examining how this is processed by the group and facilitators is also thinking of work in the transference.

Thinking back to the beginning, I realise that my idea of what research consisted of was limited to a vague notion of quantitative research and it did not include qualitative approaches. When I thought of research my immediate association would probably have been to large-scale studies and complex statistical analyses. Large RCT studies, such as the 'IMPACT study' (Goodyer et al, 2017), are essential in terms of their potential influence on policies and NICE guidelines. However, I came to learn that there is much more than numbers on the data collected in these studies. I have learnt this through my own experience, but also through hearing about the experience of my training colleagues conducting their own qualitative projects.

Midgley (2004) reflects on the position of the clinician-researcher "between the 'Scylla' of large-scale, quantitative research and the 'Charybdis' of the single-case, clinical case study". For him, qualitative studies may be a manner of navigating the middle way. There are limitations, as qualitative studies won't be regarded in the same 'gold standard' as large RCTs or have the same impact in policies and guidelines. However, they can bring the clinical process to life in a more systematic and operationalized way than classic single case studies.

Nevertheless, Midgley (2004) also points out that qualitative approaches are not the 'easy option', as they are time-consuming, intensive and challenging. This was my experience with the long process of watching data, transcribing and analysing. Moreover, the findings are very limited in the sense of how much they can be generalised, which can feel frustrating after such a great amount of work throughout three years. I have also found that, even though my research ended up incorporating many of the clinical aspects I am interested in, my initial intention of capturing the group process and its dynamic could not be achieved in my final project. This was greatly due to my choice of method of analysis, which allowed for many interesting findings, but it was limited in regard to this aspect.

I believe that this speaks to the fact that 'navigating the middle way' in 'rough seas' is not a simple task. An important learning that came with conducting this empirical project was the impact of choices. Most of what constitutes a research is the choices, even if very well founded, made by the researcher. With each choice come many possibilities of findings but also limitations on what can be found.

Also in this sense, navigating between the 'researcher' and the 'clinician' in one's own mind can be a challenge. During the very busy training, at times it felt like having different personas and having to make sure that there was enough time for each. I found the Research Workshop weeks at the Anna Freud Centre extremely useful in making sure I had allocated time to think of my project away from my clinical work and other training demands. Another challenge was negotiating the writing of research papers and clinical papers. These felt for me like very different tasks, requiring different languages.

On the other hand, I also found many convergences between the 'researcher' and the 'clinician'. As I mentioned before, I initially felt that my clinical interests guided my choice of subject and, later on, I observed how my research informed me clinically. Moreover, I noticed that the attitude to approaching a theme and the data is very close to the mental instance of a clinician in the room with a client. In many ways these are similar states of mind that involve curiosity, emotional investment and a wish to explore things further, or a 'illuminating beam', if keeping to the Lighthouse metaphors.

3.5 Conclusion

In this reflective account I have described my experience of doing a joint doctorate and clinical training in Child and Adolescent Psychotherapy. I explored how daunting this felt in the beginning and my initial sense of disconnection to research and my own project. This gradually changed as my project became 'my own'. I looked at how challenging this process was, but also how I also felt it led me to question my assumptions about research and to a greater sense of convergence between research and clinical practice.

 Being so involved in an empirical project at the same time as training clinically gave me a much more emotionally invested knowledge of research. I believe that this kind of knowledge is only possible through experience. It felt very frustrating at times, but I wouldn't have learnt about it in the same way if I hadn't gone through this process. I would also like to mark that this journey was only possible thanks to the support of

my supervisor, seminar leaders, colleagues and the carefully designed doctoral programme that integrated clinical training and research in four years.

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