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Doctoral Thesis

Experiencing health services and mentalisation-based treatment for borderline personality disorder: Service user perspectives

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Word Count

Thesis Section	Main Text	Abstracts, References, Tables and Appendices	Total
Thesis abstract	284	-	284
Literature Review	7,982	5,538	13,520
Research paper	7,992	5,652	13,644
Critical Review	3,835	589	4,424
Ethics Section	3,638	4,345	7,983
Total	23,731	16,124	39,855

Thesis Abstract

This doctoral thesis begins with a literature review that explores how individuals who meet criteria for borderline personality disorder (BPD) experience health services. Following a comprehensive literature search, a metasynthesis of 14 papers was conducted utilising Noblit and Hare's (1988) meta-ethnographic approach. Findings indicate that the attitudes of professionals are exceptionally important to service users but are often experienced by them as judgmental and dismissing. Service users highly value communication, consistency and input into their own treatment and sometimes search for containment and meaning within health services. Barriers to treatment are highlighted which include negative attitudes from professionals, lack of input into treatment and insufficient security and support for service users in the community. Implications for health services are explored.

The research paper that follows this is an interpretative phenomenological analysis (IPA) study on the experience of mentalisation-based treatment (MBT) for BPD from the perspective of adult service users. Seven participants were interviewed and findings illustrate that the group component of MBT was experienced as challenging and unpredictable. Trust was identified as key to benefitting from MBT and was much more difficult to obtain in group sessions than in individual therapy. However, participants attending MBT for longer than three months appeared to make progress with this. The structure of MBT generally worked well for participants but individual therapy was identified as the most important component and specific challenges were highlighted. All participants learned to look on the world differently due to MBT which resulted in a positive shift in experience for them. Implications for MBT are discussed in this paper. The subsequent section in this thesis is a critical appraisal that highlights key learning points and reflections from conducting the research paper.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from August 2013 to June 2014. The work presented here is the author's own except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name: Diarmaid Ó Lonargáin

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Date:

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Section One: Literature Review

The experience of engaging with health services from the perspective of individuals with a diagnosis of borderline personality disorder: a metasynthesis

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Abstract

Background: Borderline personality disorder (BPD) is associated with a range of difficulties including intense emotional experiences, interpersonal difficulties, self-harm and high rates of suicide. This highlights the importance of adequate health services for individuals who have received this diagnosis.

Aims: The aim of this study was to create an overview of how individuals who meet criteria for BPD experience health services by building on findings from previous papers and to highlight resulting implications for services.

Method: Noblit and Hare’s (1988) meta-ethnographic approach was utilised to synthesise 14 qualitative studies following a systematic literature search and critical appraisal.

Results: The following themes were identified: 'Attitudes from professionals: an integral part of the service experience', 'Valuing communication, consistency and personal input into treatment', and 'Engaging with services: the desire to feel contained and the search for meaning'.

Conclusions: Findings from this metasynthesis highlight a number of barriers to optimal care for individuals with a diagnosis of BPD. These include negative attitudes and stereotypes about BPD held by health professionals, lack of service user input into their own treatment and lack of support and security for service users in the community. Clinical implications and suggestions for future research are discussed.

Introduction

Borderline personality disorder (BPD) is a psychiatric diagnosis associated with a number of difficulties. According to the Diagnostic and Statistical Manual of Mental Disorders, these include difficulties in personality functioning (e.g. unstable self-image) and interpersonal functioning, intense and unstable emotional experiences, impulsivity and self-harm (American Psychiatric Association, 2013). This classification system of psychiatric disorders is widely accepted and forms the basis for treatment in health services worldwide. However, there is a history of debate around diagnosis and some have questioned its validity and reliability (e.g. Bentall, 2003; Boyle, 2007; British Psychological Association, 2013). For example, Bentall (2003) challenges the validity of diagnosis asserting that the DSM classification system is an invented one that compromises individual experience. He also emphasises the considerable overlap between several diagnoses, such as BPD and bipolar disorder, thus challenging the existence of separate disorders.

Although the topic of diagnosis is a controversial one that has been amplified since the publication of DSM-V (Welch et al., 2013), it is important and necessary to discuss the experiences of individuals with difficulties as described above in terms of the BPD diagnosis for a number of reasons. First of all, people who meet these criteria are frequently given a diagnosis of BPD which undoubtedly impacts their experiences both in the community and in the health system. Furthermore, access to services and treatment received is also greatly influenced by either the presence of this diagnosis or the acceptance that an individual meets criteria for the diagnosis.

Research on the aetiology of BPD has included neurobiological, cultural and temperamental factors (Keinenan et al., 2012). However, the literature indicates that psychosocial factors have a key role in helping to understand the origins of difficulties associated with BPD (Goodwin, 2005; Holm & Severinsson, 2008; Zanarini et al., 1997). Childhood trauma and neglect, dysfunctional parenting styles, mental health difficulties of family members and separation from parents are common experiences of individuals who have received this diagnosis (Bandelow et al., 2005; Keinenan et al., 2012; Kingdon et al., 2010). Childhood sexual abuse is particularly associated with BPD (McLean & Gallop, 2003) and is the most frequent reported adverse event by individuals with the diagnosis (Lieb et al., 2004). Zanarini and Frankenburg (1997) provide a multifactorial model of the aetiology of BPD. They argue that although persons with difficulties associated with BPD follow their own individual, unique pathway, the presence of three factors in particular are at the root of these difficulties: a traumatic childhood (allowing for the fact that this can vary considerably according to the individual), a vulnerable temperament and a triggering event or events.

Individuals who meet criteria for BPD can experience a multitude of intense emotional experiences. Research has found that this can include emotional lability with regards to anger and anxiety, and high levels of movement between depression and anxiety (Koenigsberg, 2002). Other common difficult experiences include shame due to past abuse (Crowe, 2004) and struggling with distress tolerance, emotional regulation and experiential avoidance (Iverson et al., 2012). Furthermore, interpersonal difficulties that may stem from negative views of others, negative expectations of others and reduced capacity for understanding the mental states of others are also prevalent (Bateman & Fonagy, 2006; Lazarus et al., 2014).

However, one of the most challenging traits associated with BPD from the perspective of services and professionals is the frequent occurrence of self-harm. Due to the complex nature of intent, self-harm is defined in National Institute of Health and Care Excellence (NICE, 2012) guidelines as “any act of self-poisoning or self-injury carried out by an individual irrespective of motivation" (p. 14) and up to 10% of individuals with a diagnosis of BPD die via suicide (Paris, 2002). Thus, due to the high risk attached to individuals who meet criteria for this diagnosis, as well as the considerable level of distress associated with BPD, it is paramount that health services are available to provide appropriate support.

NICE (2009) guidelines recommend that pharmacological treatment should not be utilised specifically in the treatment of BPD. A range of psychotherapeutic interventions are recommended including therapeutic communities, multi-modal psychological therapy programmes consisting of weekly individual and group therapy (i.e. dialectical behaviour therapy and mentalisation-based treatment) and individual therapy using appropriate models such as cognitive analytic therapy. NICE guidelines emphasise that a choice should be provided for service users. Furthermore, they outline a range of services which individuals with difficulties associated with BPD are likely to utilise. Due to the prevalence of self-harm emergency services are commonly accessed. Individuals with a diagnosis of BPD should be referred from primary care services to community mental health teams (CMHTs) when levels of distress and/or risk to self or others escalates; once this has been managed re-referral to primary care services should take place. Thus, drawing on a comprehensive evidence-base and acknowledging the lack of certainty in the literature, NICE guidelines suggest that difficulties associated with BPD are best managed in the community and inpatient services should only be utilised specifically for short-term crisis management and risk. Specialist personality disorder services from which expert knowledge and input can be drawn are also recommended.

Research indicates that professionals find it challenging and stressful to work with individuals with a diagnosis of BPD which can lead to negative attitudes towards them (e.g. Perseius et al., 2007; Rizq, 2012). Thus, providing treatment and support for individuals with this diagnosis can be a less than straightforward process. In order to inform service development and to understand the impact that factors such as stigma has on clients it is essential to develop a knowledge-base of client experiences of services. Rich, in-depth accounts of services are most effectively captured through qualitative research and an increasing amount of qualitative research of the experiences of individuals with a diagnosis of BPD has been published in recent times, including experiences of services (e.g. Fallon, 2003).

The purpose of this study was to create an overview of what it is like for individuals who meet criteria for BPD to engage with a range of health services such as inpatient services, community mental health teams (CMHTs) and accident and emergency services. It was deemed important to examine experiences across all types of services that people with this diagnosis typically access, thus determining common factors that are either helpful or unhelpful for clients. Consequently, a metasynthesis of qualitative research on such experiences was deemed appropriate. A further aim of this study was to create a fresh perspective on client experiences of services by merging a number of qualitative papers together, scrutinising the findings from a different view and thus building on previous findings. It was considered that this would have implications for health services that are accessed by individuals with a diagnosis of BPD.

Experiences of specific therapies were not considered in this metasynthesis. Whilst therapy is often a central component of services it is a very specific experience that involves working on particular aims and goals during a designated time. Furthermore, studies on therapy necessarily tend to involve an evaluative component as to whether the therapy has been effective or not (e.g. McSherry et al., 2012). The perceived usefulness of therapy may well vastly differ from wider service experiences such as transitioning between services and what it is like to receive input from a CMHT.

Method

The purpose of a metasynthesis is to merge qualitative studies on a particular topic together in order to enhance information and knowledge in that area. This should lead to more certainty and clarity (Downe, 2008) and "produce a new and integrative interpretation of findings that is more substantive than those resulting from individual investigations" (Finfgeld, 2003, p. 894). Although there are different forms of metasynthesis, the meta-ethnographical approach designed by Noblit and Hare (1988) is most commonly used (Downe, 2008) and has been described as “the most influential method for synthesizing qualitative research” (Shaw, 2012, p. 15). Noblit and Hare propose a series of steps for conducting a meta-ethnography which were adhered to as follows:

Getting Started

The rationale for this metasynthesis is explained in the introduction.

Deciding what is Relevant to the Initial Interest

Noblit and Hare (1988) emphasise the importance of determining what types of papers are of interest to the meta-ethnography. This is also explained in the introduction but inclusion criteria in full were as follows: (1) the primary aim of the paper was to explore the experiences of individuals who either have a diagnosis of or meet criteria for BPD (2) data must have been analysed utilising a recognised qualitative methodology (3) data must have been organised into themes (4) at least one theme must have partial or full content on service users' general/broad experiences of a health service/health services (5) the paper must be in English and (6) the paper must be published in a peer-reviewed journal. The following exclusion criteria were applied: (1) papers regarding experiences of forensic services (2) papers/themes that focus solely on experiences of therapy (3) papers that integrate experiences of service users with other individuals (e.g. professionals) within the same themes.

Once these criteria were determined a search of the following search engines was conducted: a number of EBSCO databases (Academic Search Complete, PsycINFO, AMED, CINAHL, Medline, PsycArticles), Web of Science and PubMed. The following search terms were entered: Borderline* OR BPD AND qualitative OR phenomenol* OR IPA OR narrative* OR “discourse analysis” OR discursive OR thematic* OR “grounded theor*” OR "content analysis" OR "focus group*" OR interview* OR “constant comparative” OR ethno* OR hermeneutic* OR heuristic* OR "lived experience*" AND psychiatric OR service* OR system* OR community* OR CMHT OR CPDS OR "primary care" OR inpatient* OR hospital* OR CPA OR care OR specialist OR setting* OR therap* Or psychotherap* OR treatment* OR intervention* OR pathway* OR "A & E" OR "A and E" OR accident OR emergency OR residential AND perception* OR perspective* OR experienc* OR view* OR opinion* OR response* OR journey* OR insight* OR narrative* OR voice* OR understanding* OR attitude*. No article published after 31st March 2014 was considered.

A total of 939 English language peer-reviewed articles were found on the EBSCO databases (following removal of duplicates), 667 were found on Web of Science and 660 on PubMed. The author read the title of each article. Abstracts were read if it was deemed from the title that the article may meet criteria for the metasynthesis. Following this search 48 articles were considered to be possibly suitable. Each of these articles was read by the author and 34 articles were excluded for not meeting criteria. For example, the Katsakou et al. (2012) paper was excluded as the only service-related themes focused on experiences of therapy. The studies by Briand-Malenfont et al. (2012) and Dammann et al. (2011) did not contain relevant themes. The Hummelen et al. (2007) and Langley and Klopper (2005) studies organised experiences of service users and professionals within the same themes.

Thus, it was deemed that themes had been determined during analysis according to both groups' experiences rather than service users specifically, consequently unduly influencing interpretation and the collation of themes. In the Therien et al. (2012) paper it is difficult to discern the degree into which participant experiences were influenced by having psychotic symptoms or by having a diagnosis of BPD as there is an equal focus on both. The Perseius et al. (2005) paper was excluded as it utilised the same data as Perseius et al. (2003) and no new relevant themes emerged from this paper. Therefore, 14 papers were chosen for the metasynthesis and these are outlined in table 1.

[insert table 1 here]

There is divided opinion regarding the importance of critical appraisal for quality prior to synthesising studies. Campbell et al. (2003) view appraisal as an important process in excluding studies due to poor quality before the synthesis takes place and Atkins et al. (2008) contend that better quality papers enhance a metasynthesis. However, Noblit and Hare (2008) challenge the need for critical appraisal at all and Sandelowski et al. (1997) argue that it should not form the basis of excluding papers due to lack of consensus regarding the definition of quality.

For this metasynthesis the Critical Appraisal Skills Programme (1999) checklist was utilised for a quality check on each paper. This consists of 10 questions relating to quality, although the first two questions are for screening. Similar to other metasyntheses (e.g. Murray & Forshaw, 2013), the final eight questions were not utilised to exclude studies but rather to determine the quality of each paper according to a scoring system developed by

Duggleby et al. (2010). Each of these sections was rated according to the following scores: weak (1), moderate (2) and strong (3). Thus, each paper was rated out of 24 as a means of providing a guide to the quality of the synthesised papers. The areas that were rated and the scores for each paper are outlined in table 2.

[insert table 2 here]

Reading the Studies

Each study was read and re-read several times one by one in chronological order according to publication date. The author made a note of key concepts or themes in each paper from the results/findings and discussion sections. This became the raw data for the study.

Determining how the Studies are Related

Each study was read a few more times in chronological order, and the author made a list of all the relevant themes/concepts that were identified for each study. Britten et al. (2002) refer to these themes as second-order constructs (i.e. the interpretations of the study's author). The second order constructs for each paper are illustrated in table 3. Either identical or similar language to the original study was utilised at this point. Noblit and Hare (1988) refer to three ways that studies can be related to each other: reciprocal translation, refutational synthesis and line of argument synthesis. Reciprocal translation occurs when the studies contain common themes and concepts. Following scrutiny of the second order constructs in each of the studies, that was deemed to be the case for the applicable studies for this metasynthesis. Therefore, it was deemed that reciprocal translation would be applied which involves creating a new set of themes by mapping the original themes into one another.

[insert table 3 here]

Translating the Studies into One Another.

Similarities between the studies were identified by the author and were mapped onto each other, thus maintaining the original theme of each study but in relation to the themes from other studies that were similar. Malpass et al. (2009) state that a minimal amount of interpretation is required at this point in order to elicit the intended meanings of the authors of each study, but no further interpretation took place thus ensuring that second order constructs were maintained. Albeit, this was in a different form as the themes were now translated into one another. Table 4 provides a list of these translations.

[insert table 4 here]

Synthesising Translations.

According to Noblit and Hare (1988) "synthesis refers to making a whole into something more than the parts alone imply" (p. 28). The interpretations of the author of this metasynthesis were introduced at this stage and the translated themes were pulled together into new third-order constructs (details are illustrated in table 5). This resulted in three new themes which are outlined in the findings section.

[insert table 5 here]

Expressing the Synthesis.

Although Noblit and Hare (1988) describe several ways in which meta-ethnographic syntheses can be expressed (e.g. videos, art) the written form was considered the only suitable method for this metasynthesis.

Credibility of Findings

The credibility of the findings was enhanced by the methodological rigour demonstrated in the majority of synthesised papers (see table 2) although there were also limitations such as lack of reflexivity in some studies (e.g. Nehls, 1994). In order to further enhance credibility the author attempted to bracket his personal assumptions and beliefs about how BPD is commonly perceived in health services during analysis.

Findings

Following the synthesis of the papers three core themes were identified and are described in-depth as follows:

Attitudes from Professionals: An Integral Part of the Service Experience

This theme, which features in 12 of the synthesised papers, focuses on the prominent impact that attitudes from professionals have on participants' experiences of services. Some participants felt that staff in services had rigid ideas about those with a BPD diagnosis as being difficult to work with, feeling that they would be treated differently had they received a different diagnosis (Nehls, 1999). The traits associated with BPD made sense to participants and learning about BPD was not necessarily problematic for them as it enhanced their understanding of their difficulties, but the prejudice and judgements that they faced from staff was difficult for them (Holm & Severinsson, 2011; Nehls, 1999; Rogers & Dunne, 2011; Walker, 2009). One participant recalled attending an Accident and Emergency service due to a suspected infection but was immediately judged by staff as having self-harmed even though this was not the case. Staff did not seem to be able to see beyond her diagnosis of BPD and her history of self-harm and she was not listened to as a result (Walker, 2009). Another participant was told by staff that individuals with other diagnoses such as schizophrenia had no control over their actions but that people diagnosed with BPD did have control, thus placing blame on the latter as being intentionally difficult (Rogers & Dunne, 2011).

This lack of understanding regarding BPD led to one participant being informed that they were only given this label as there was no other label to cover them (Rogers & Acton, 2012). Furthermore, some participants felt isolated in services due to their diganosis, "it was a dustbin label…it was just a diagnosis where you don't fit into other categories" (Horn et al., 2007, p. 262). They felt that BPD was not taken seriously by professionals and that another diagnosis would have resulted in them receiving appropriate care as the BPD label seemed to trigger lack of compassion in staff members. Indeed, a participant relayed being told that he did not have a mental illness following his diagnosis of BPD and felt that he was forced out of a service as a result (Horn et al., 2007).

Being judged and/or dismissed also manifested in other ways. Participants utilising a preventive admissions programme felt that staff provided limited time and attention (Koekkoek et al, 2010) and some participants felt invisible to professionals (Holm & Severinsson, 2011). A participant in another study recalled how a staff member ridiculed them when they shared that they jumped from a tree in order to self-harm (Rogers & Acton, 2012) whilst others experienced rejecting comments from staff members, "As far as I'm concerned I don't want nothing to do with you no more" (Rogers & Dunne, 2013, p. 42). Furthermore, service users regularly found staff to lack understanding of more specific difficulties. Many participants in a range of services found that professionals judged them as manipulative and attention seekers due to self-harming behaviours (Fallon, 2003; Nehls, 1999; Perseius et al., 2003). It was felt that staff completely misunderstood their reasons for self-harming, “everybody thinks that we are harming ourselves to get attention, but we are not, we are harming ourselves because life hurts so damned much" (Perseius et al., 2003, p. 223).

A number of participants emphasised the importance of just being listened to by professionals. Some recognised that during times of crisis there was a limited amount that professionals could do but to “just listen and hear and respond from inside” would be considered very supportive (Nehls, 1999, p. 290). A participant felt that nursing staff in accident and emergency services rigidly maintained their medical role which resulted in a lack of emotional support when all they needed was for them to listen (Fallon, 2003). A number of participants who had been attending a community mental health service and had specific case managers reported very positive experiences with them, identifying their ability to listen and to be there for them as a key support (Nehls, 2001). Merely having somebody to share experiences with was highly supportive for them. Furthermore, the practical assistance and collaborative style of support that their case managers provided, together with their lack of judgement, led to participants feeling valued and respected. Support was also provided for participants in other ways. For example, arriving at a specialist personality disorder service where a professional was able to explain BPD to a participant following frustrating experiences in previous services was very helpful to them, "After all these diagnoses thrown at me, she sat there within 2 minutes and told me what was wrong with me” (Rogers & Dunne, 2013, p. 42). Another participant, following a history of self-harm, attributed their desire for recovery to support from and positive relationships built with staff members (Straker & Waks, 1997).

Valuing Communication, Consistency and Personal Input into Treatment

Participants' experiences of treatment were considered in 12 of the synthesised papers and they particularly valued open communication, consistency and input into their own treatment. These aspects of treatment were often lacking resulting in frustration among participants. Some participants described being hospitalised during times of crisis and feeling powerless when their desire to be discharged was denied when they felt that the crisis had passed (Miller, 1994) whilst others felt upset and angry when severe limits, such as discharge or committal, were set in services as a deterrent to self-harm (Straker & Waks, 1997). Participants also expressed frustration when given a choice between voluntary admission and being sectioned. This was considered a coercive process for participants as the term 'voluntary' became a misleading and inaccurate description in situations in which they felt that they had no options (Rogers & Dunne, 2011).

In contrast to this other participants felt that the treatment they were receiving was insufficient. Certain participants felt that services were only interested in removing destructive behaviours such as self-harm and once this was achieved had little interest in supporting them to become aware of the cause of such behaviours (Nehls, 1999). Some staff members completely focused on potential external triggers of self-harm when the participant felt that such triggers were immaterial and internal processes and feelings were much more relevant (Straker & Waks, 1997). Moreover, many participants found psychiatric care to be ineffective and an over-reliance on medication was common, "they just poured medicines into me, so they could have peace and quiet on the ward" (Perseius et al., 2003, p. 223). This sometimes caused adverse effects as one participant described a negative impact on both physical and mental health due to this over-reliance (Rogers & Dunne, 2013). On other occasions participants found that services did not know how to treat them and a strong emphasis on safety lead to some participants feeling constrained in inpatient services (Perseius et al., 2003).

Furthermore, it seemed to some participants that information about their diagnosis was being withheld from them which sometimes resulted in confusion, "there seemed to be no reason for the label…there's no meaning to the label" (Horn et al., 2007, p. 260). This may have been due to the negative association that professionals have about the label (Fallon, 2003). Participants also struggled to receive information about their prescribed medication, sometimes only being told about side-effects after they had been taking the medication for some time (Rogers & Dunne, 2013). On other occasions they were just given medication without any explanation, "They don't say why that particular [drug] or anything - they just give them to you" (Rogers & Acton, 2012, p. 344). Whilst a lack of choice and information regarding treatment occurred in both community and inpatient settings some participants found inpatient settings to be particularly coercive (Rogers & Acton, 2012).

This lack of input into treatment has manifested itself in other ways. Some participants felt that they were never asked what they wanted (Perseius et al., 2003) and others felt powerless due to nursing staff making all the decisions for them (Holm & Severinsson, 2011). Care Programme Approach (CPA) meetings, where the care and treatment of participants was being discussed, often took place without them being present; when they were present they regularly found that they were told about decisions that had already been made rather than being given an input into their own treatment (Rogers & Dunne, 2013).

However, some participants reported more positive accounts of their treatment and being involved in their own care was central to this. Certain participants found an openness and honesty at their CPA meeting that resulted in them collaboratively creating realistic long-term goals; others who had been hospitalised due to self-harming behaviours appreciated being involved in their discharge (Fallon, 2003). Furthermore, participants who were engaging in preventive psychiatric admissions were involved in the negotiation process prior to this resulting in them feeling that their needs were recognised (Koekkoek et al., 2010). Moving to a specialist personality disorder service was a rewarding experience for some participants as they were "desperate to find their own recovery pathway" and were given a choice regarding whether or not medication would be a part of their care plan (Rogers & Acton, 2012, p. 346).

A further part of treatment that was highly valued by participants was consistency. When this was lacking it triggered discomfort and uncertainty in service users (Perseius et al., 2003; Straker & Waks, 1997) and some felt betrayed when they were passed from staff member to staff member (Perseius et al., 2003). Certain participants, who described their journey through the mental health system in the UK, found it very disruptive when consistency was absent during the CPA process. For example, they described having to attend a series of rushed outpatient appointments and regularly meeting different doctors, thus interfering with their ability to build rapport. They relayed the need to have one main coordinator for CPA meetings in order to maintain continuity and emphasised the value of staff training by specialised staff such as psychologists or psychiatrists (Fallon, 2003). This desire for continuity, in particular staff consistency, resulted in some participants finding it extremely difficult to move to a specialist service even though they felt that it was a positive step forward for them, "I'm frightened to death" (Rogers & Dunne, 2013, p. 41). Conversely, it was a very rewarding and positive experience for participants when that consistency was in place. Service users who had a case manager for several years greatly appreciated the fact that they were consistently available, "He's there if I need to talk to him, and he's there if I don't need to talk to him. So it's just the best relationship" (Nehls, 2001, p. 8). This was one of the reasons why these participants considered it to be preferable to have a case manager rather than a therapist as therapy was only available for one hour per week.

Engaging with Services: The Desire to Feel Contained and the Search for Meaning

Some participants utilised services as a way to contain emotional distress and search for meaning; this theme is represented in eight of the synthesised papers. During crisis episodes when service users were unable to manage their distress and when the risk of self-harm was high many participants felt that services were effective at providing adequate support (Fallon, 2003; Straker & Waks, 1997). One participant compared hospital to “a safe haven where you didn’t have the pressures that you do outside” (Straker & Waks, 1997, p. 195). Some participants benefitted from brief hospital treatment plans typically lasting between 48 and 72 hours which were perceived by participants as a safe place where their distress and period of crisis was contained, "I feel a tremendous relief when I get on the unit and turn in my pocket knife and the extra pills I have…It's just, the place is pretty safe, you know" (Nehls, 1994, p. 5).

For other participants, safety during crisis episodes was often found by having a key person to contact. Participants highly valued flexibility and the availability of a range of services and clinical psychiatric nurses were often contacted as they were deemed more flexible and accessible than other professionals (Fallon, 2003). If these participants did have a range of services available during periods of crisis they tended to contact the person with whom they had the most positive relationship. Accident and Emergency services were often contacted for safety, even though participants had had negative experiences with staff there. Service users highly valued a smooth admission to hospital but this was much more difficult when interacting with a duty psychiatrist rather than their usual care team (Fallon, 2003).

This emphasises the importance of familiarity and approachability for participants in order to feel contained.

Hospital had other purposes for participants during times of crisis and distress. Some service users considered it to be a place of respite where they could relax (Koekkoek et al., 2010; Miller, 1994; Nehls, 1994). This was a containing experience for them when things were very difficult for them in the community. Being in the hospital setting removed pressures and obligations that existed elsewhere, "you don't have to smile, don't have to laugh, you don't have to talk, you don't have to participate in anything" (Koekkoek et al., 2010, p. 131). Some participants felt contained in other ways. The familiarity of the hospital surroundings was comforting for one participant and it was a nurturing environment for others that not only provided safety but also human contact and kindness (Nehls, 1994).

Furthermore, the hospital setting became a source of meaning for participants as this was absent elsewhere in their lives. However, participants were eager not to become addicted to the hospital experience and to create meaning for themselves in the community also, "I need to develop my life enough so that I won't need the hospital for friendship and safety" (Nehls, 1994, p. 7). This was often perceived as challenging due to lack of support for difficulties associated with BPD in the community (Nehls, 1994) and some participants felt they did not get enough support after discharge, especially after long periods in inpatient services (Rogers & Dunne, 2011). On other occasions, however, service users were able to find meaningful activities in the community with support from the hospital on discharge (Nehls, 1994). Participants who had engaged in preventive psychiatric admissions were prepared for discharge and often found it easier to settle back in the community due to the knowledge that they would be able to return to hospital in the near future, thus providing continuity and predictability (Koekkoek et al., 2010).

Travelling through the health system resulted in an ongoing movement between different services for many participants, thus creating varying degrees of independence and stability at different times (Fallon, 2003). Thus, feeling contained and settled could often depend on how responsive services were to the needs of participants and specific circumstances relating to service environments. Some relevant factors are addressed in the themes described above (e.g. input into own treatment, interactions with staff). Other factors were also relevant. Being in the same environment as other service users prone to challenging and disruptive behaviours could be unsettling for some (Koekkoek et al., 2010) and other participants reported perceiving a lack of safety in the hospital setting at times, "I woke up and there was four blokes standing at the bottom of my bed, and not one of them was a member of staff" (Rogers & Dunne, 2011, p. 230). Conversely, other service users in hospital settings were often perceived as supportive and containing and participants found it easier to talk to them about their difficulties (Koekkoek et al., 2010). Moreover, moving from more generic services to a specialist personality disorder service was a settling and containing experience for some. Participants felt that they entered an environment where staff understood personality disorder and there was a range of interventions available rather than just medication, "If I was to have a problem I could speak to someone rather than - without knowing that the first thing they're going to suggest is giving me meds" (Rogers & Acton, 2012, p. 344). However, despite these benefits to a specialist service there was also the knowledge that the purpose of such a service was to eventually support the client to move on from the service which could be unsettling and uncontaining, "If it's all left under one service and you're discharged from that service, then you're left high and dry" (Rogers & Dunne, 2013, p. 41).

Thus, as participants travelled through a range of services finding meaning and feeling contained was hugely important to them. Services were highly valued by participants when they supported them to achieve this but when absent participants continued searching in an attempt to create more positive, stable and fulfilling lives.

Discussion

This study synthesised 14 papers in order to explore the experiences that individuals with a diagnosis of BPD hold about health services. Participants from these papers felt judged and labelled by professionals in health services and sometimes experienced prejudice. They often experienced a lack of empathy and understanding from professionals and found that people with other diagnoses, such as schizophrenia, were treated more compassionately. Participants described a number of qualities within health services that they highly valued, in particular consistency, communication and input into their own treatment. Although such qualities were often absent some participants were able to draw on their positive impact when they did occur. For certain participants health services were utilised as a means of containing distress and finding a sense of meaning in their lives.

Exploring Negative Attitudes of BPD among Health Professionals: Implications for Services

The findings in this study that allude to tensions between health professionals and individuals with a diagnosis of BPD are consistent with reports in previous research (Millar et al., 2012; Weight & Kendall, 2013; Woollaston & Hixenbaugh, 2008). Personality disorder in a broader sense is a stigmatising label that is considered more difficult to treat and more challenging than other diagnoses (Mason et al., 2010; Stalker et al., 2005). However, Nehls (2000) suggests that BPD may be associated with more stereotypes than any other diagnostic label and she draws attention to associated judgements and labels such as "not sick, manipulative and noncompliant" (p. 62). Self-harm is frequently utilised as a coping strategy and a release for emotional distress (Cameron, 2007; Haines et al., 1995) but this does not seem to be fully understood or recognised by professionals in the synthesised papers.

Participants refer to a lack of understanding among professionals regarding emotional factors that may underlie self-harming behaviours and they emphasise a focus on potential external triggers or the belief that self-harm is a representation of manipulative and/or attention seeking behaviour.

Participants in this study appeared at times to feel that the only obstacle to being treated with compassion was the BPD label. They felt that they were considered to be intentionally difficult whilst people with other diagnoses, such as schizophrenia, were treated with more empathy due to the perception that they had limited control over their actions. This fits with findings from research that focuses on staff perceptions of BPD. Woollaston and Hixenbaugh (2008) found that nurses deemed individuals with a diagnosis of BPD to be manipulative and dishonest. Other research suggests that nurses react with less empathy to people with BPD in comparison to other diagnoses (Fraser & Gallopp, 1993). Furthermore, Markham (2003) found that staff felt more negatively about clients with BPD when compared to those with schizophrenia or depression.

As previously mentioned, there are those who question the validity of the diagnostic classification system in its entirety (e.g. Bentall, 2003; Boyle, 2007). However, there are also researchers who single out BPD as a problematic diagnosis within the diagnostic system due to its lack of clarity as a diagnosis, its association with trauma and its overlap with posttraumatic stress disorder (McLean & Gallopp, 2003; Tyrer, 1999). The findings in this metasynthesis suggest that similar doubts about the validity of BPD exist in many health professionals and participants sometimes felt that they were given the BPD diagnosis as they were perceived to not fit within any other diagnostic category, thus leading to a participant referring to BPD as a "dustbin label" (Horn et al., 2007, p. 262). When one takes into account the dominance of the diagnostic framework for understanding mental illness it is possible that an inability to fit individuals neatly into this system leads to negative assumptions and judgements. Because the diagnosis seems to be considered less real than other diagnoses this may well fuel the assumption that someone with this diagnosis is in some way less genuine than those with other diagnoses such as schizophrenia or bipolar disorder.

Another factor that should be considered is the demanding environment that many health professionals work in, sometimes resulting in burnout and compassion fatigue (Clark & Gioro, 1998; Neville & Cole, 2013; Phelps et al., 2009; Ray et al., 2013). These attributes are associated with emotional exhaustion, depersonalisation and apathy (Collins & Long, 2003; Lim et al., 2010). Furthermore, research has found that staff find it more difficult to work with BPD than other mental health diagnoses (James & Cowman, 2007) and that professionals find it stressful working with BPD (Rizq, 2012). Thus, it seems reasonable to postulate that working under challenging circumstances and holding the belief that a particular group (in this case, individuals with a diagnosis of BPD) are intentionally making the work environment even more demanding will lead to negative attitudes among health professionals.

Social identity theory (SIT) (Tajfel & Turner, 1979; Tajfel, 1981) could be a useful framework to enhance understanding of this process. SIT postulates that individuals identify with specific groups (i.e. the in-group) in order to preserve or augment self-esteem and comparison to other groups (i.e. out-groups) is a part of this process. Negative comparison opens up the possibility of prejudice and stereotyping and can result in in-group bias which leads to an “us versus them” conceptualisation of behaviour. Thus, working in a demanding and often stressful environment may create a necessity for an in-group in order to enhance self-esteem and identity. Furthermore, this apparent perception that individuals with a diagnosis of BPD are intentionally creating difficulties for professionals places them in the out-group or the ‘other’ group. Tajfel and Turner (1979) highlight that not all out-groups are considered for comparison by in-groups and that specific factors such as similarity, proximity and situational relevance determine which groups are compared. The latter two factors apply to most service users but some health professionals may view people with a diagnosis of BPD as similar to themselves due to their perceived control over their actions. This differentiates the BPD diagnosis from other labels that are associated with behaviours that challenge, such as schizophrenia. Therefore, being part of the BPD out-group may lead to assumptions, judgements and stereotypes about its members from professionals.

Consequently, fostering an understanding of behaviours associated with BPD could enhance empathy and considerably reduce stereotypes and assumptions among professionals. The National Institute for Mental Health in England (2003) recommend training for professionals of all levels of experience on personality disorder to support them to work with this diagnosis and progress is currently being made with this. The Knowledge and Understanding Framework (KUF) training was designed for this purpose and results in a recent study (Davies et al., 2014) suggest that this training enhances understanding of personality disorder among professonals and reduces negative emotional reactions towards service users at both the immediate and three month post-training stage. Capability of working with personality disorder also improved immediately post-training but had reverted back to pre-training levels at three months post-training. Therefore, Davies et al. (2014) recommend that ongoing support is required to consolidate the impact of training. However, the encouraging results from this study suggest that staff training should be an integral part of reducing stigma and stereotypes and should also be viewed as an important tool for breaking down barriers between professionals and individuals with BPD.

Examining the Needs of Service Users: Implications for Services

Research has found that service users resent when they are not involved in their own treatment planning, recommending service user input into each stage of treatment and that they should be involved in the evaluation of the quality of services (Howard et al., 2003). This correlates with findings in this metasynthesis that illustrate that service users with a diagnosis of BPD value clear and open communication as well as input into their own treatment. Furthermore, research has found that health professionals and service users frequently set different goals in treatment and when a discrepancy between priorities and lack of communication exists treatment can be adversely affected (Hansen et al., 2004; Junghan et al., 2007). Thus, it appears that the care of individuals with a diagnosis of BPD would be maximised when service users are involved in their own treatment.

Collaborative care programmes have been found to be effective in the care of individuals who have received other diagnoses such as depression and bipolar disorder (e.g. Bauer et al., 2006; Gilbody et al., 2006) and Stringer et al. (2011) suggest that this approach may also be effective for severe BPD. Furthermore, findings from this metasynthesis indicate that service users considered internal processes to be much more related to self-harm behaviour than potential external triggers, something that was not understood by professionals. This fits with Warner and Spandler's (2012) view that focusing on specific behaviours as a successful outcome (i.e. a reduction in self-harm) is of limited value unless contextual factors and the goals and needs of the service user are taken into account. Therefore, services should strive to include service users with a diagnosis of BPD in their own treatment and incorporate them as integral to treatment planning.

Another important finding from this metasynthesis refers to the desire of participants to feel contained in services and attachment theory is perhaps a useful way to understand this. Attachment theory postulates that an infant needs security from a primary caregiver from where they can explore the outside world in the knowledge that they can return to a secure base when necessary. The quality of this relationship with a primary caregiver becomes internalised and generalised and in adulthood individuals continue to strive for this secure base from where exploration can occur (Bowlby, 1988). This seems like a particularly useful way to understand the search for containment and security among service users with BPD as this diagnosis is associated with insecure attachment due to typically traumatic childhood experiences (Fonagy & Bateman, 2007). In fact, Johansen (1984) also drew on attachment theory to try to understand the inpatient experiences of individuals with BPD. He emphasises the importance of being able to build an alliance with staff and the 'goodness of fit' between service users and staff as highly relevant to creating a secure base from which their surroundings can be explored.

The search for containment and security in services among participants in the synthesised papers appeared to involve a search for a secure base and this primarily occurred in inpatient services. For many individuals with a diagnosis of BPD services are their only support or point of contact and it is thus natural for them to seek security there during times of crisis or severe distress. Participants hugely valued consistency and continuity in services which supported them to feel even more secure and safe. As previously stated, NICE (2009) guidelines recommend that inpatient services should only be utilised short-term for service users with a diagnosis of BPD and that they should return to the community once periods of crisis or high distress have passed. However, the findings from this study indicate that this was often very difficult for participants due to insufficient services and support in the community. Therefore, from an attachment perspective, their secure base was often completely removed without an adequate replacement.

Preventive admissions appears to have worked particularly well for participants because following discharge they were able to settle in the community in the knowledge that they would be returning to the secure base again within a few weeks. In contrast, it was much more difficult for service users who lacked that secure base on discharge. This highlights the need for discharge planning procedures in inpatient services that ensure that adequate support is available for service users in the community following discharge. An ability to adhere to NICE guidelines and keeping the use of inpatient services to a minimum would appear to be dependent on the presence of a secure base in the community. Findings in this study suggest that this is often lacking. Therefore, an emphasis on adequate community supports for individuals with a diagnosis of BPD should be a central part of service planning going forward.

Strengths and Limitations

A strength of the metasynthesis was that it provided an opportunity to examine existing research from a fresh perspective through the creation of third order constructs. However, this also entailed a limitation as the necessary additional layer of interpretation further removed the themes from participant experiences. A strength of including a wide range of health services in the metasynthesis was that it enabled an overview of common experiences in different contexts, thus providing clinical implications that are relevant across a range of services. However, a resulting limitation is that it was not possible to explore in detail specific dynamics contained within individual settings. A further limitation in this study was that analysis was completed by one researcher only thus impacting the credibility of findings.

Future Research

Future qualitative research should explore professionals' beliefs about stigma and stereotypes associated with BPD focusing on their thoughts on the origins of such stigma and, if they hold any stereotypical views, where they acquired these beliefs. This could help to inform future staff training on BPD. Quantitative and qualitative research should continue to explore the impact of training courses such as KUF on the beliefs that professionals hold about BPD and their confidence working with individuals with this diagnosis. Future research should further examine the impact of collaborative approaches on individuals with a diagnosis of BPD through quantitative and qualitative research.

Conclusion

In conclusion, an examination of themes elicited in this metasynthesis suggest that negative attitudes and stereotypes held by professionals about BPD present a considerable barrier to care for individuals with this diagnosis. Further barriers to their care include lack of service user input into their own treatment and a lack of support and security for service users in thecommunity. Health services should place an emphasis on providing training on BPD for professionals that enhances understanding, awareness and thus empathy. Moreover, health services should use collaborative approaches to treatment and an emphasis should be placed on providing appropriate supports for people with a BPD diagnosis in the community.

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Table 1: Features of Metasynthesis Papers

Paper No.	Author(s) & Year of Publication	Country	Sample	Qualitative Approach	Primary Aim of Paper
1	Nehls (1994)	USA	n = 5 (previously diagnosed with BPD or met diagnostic criteria for BPD); age range not specified	Heideggerian hermeneutics	To understand participants' lived experiences of brief hospital treatment plans
2	Miller (1994)	USA	n=10 (8 women) individuals who met diagnostic criteria for BPD; age range 21-50 years	The life history method	To learn about participant experiences of BPD & its treatment
3	Straker & Waks (1997)	South Africa	n=5 women with a diagnosis of BPD; age range 22-25 years	Thematic analysis	To explore participants' phenomenological experiences of limit setting regarding self-damaging acts
4	Nehls (1999)	USA	n=30 women who met criteria for BPD; age range not specified	Interpretive phenomenology	To learn about the experience of living with a diagnosis of BPD

5	Nehls (2001)	USA	n=18 individuals (17 women) who met criteria for BPD; age range 33-51 years.	Interpretive phenomenology	To explore participant experiences of case management services
6	Fallon (2003)	UK	n=7 (4 female) individuals with a diagnosis of BPD; age range 25-45 years	Grounded theory	To learn about how participants experience mental health services
7	Perseius et al. (2003)	Sweden	n=10 women with a diagnosis of BPD (age range 22-49 years) and 4 DBT therapists	Qualitative content analysis	To explore the perceptions of service users and therapists of providing and receiving DBT
8	Horn et al.(2007)	UK	n=5 (4 female) individuals with a diagnosis of BPD; age range 23-44 years old	Interpretative phenomenological analsysis	Individuals’ experiences of the label BPD
9	Walker (2009)	UK	n=4 women with a diagnosis of BPD and a history of self-harm; age range not specified	A ‘performance’ approach (Langellier) and ‘narrative	To explore the experiences of women with a diagnosis of BPD who self-harm

				thematic' approach (Reissman)	
10	Koekkoek et al. (2010)	Holland	N=8 women with a diagnosis of BPD; age range 24-61 years	Thematic analysis	To determine the impact of preventive psychiatric admission on individuals with severe BPD
11	Rogers & Dunne (2011)	UK	n=10 individuals (9 female) with a diagnosis of BPD; age range 21-45 years	Thematic analysis	To learn about the inpatient experiences of individuals with a personality disorder
12	Holm & Severinsson (2011)	Norway	n=13 women with a diagnosis of BPD; age range 25-53 years old	Thematic analysis	To explore how recovery can lead to change in suicidal behavior
13	Rogers & Acton (2012)	UK	n=7 (6 female) with a diagnosis of BPD; age range 21-43 years	Thematic analysis	To explore the perspectives and opinions of people with a diagnosis of BPD of medication as a treatment for

					BPD
14	Rogers & Dunne (2013)	UK	n=7 (5 female) with a diagnosis of BPD; age range 21-61 years	Thematic analysis	

Table 2: Quality Scores of Metasynthesis Papers based on CASP

Study	Research Design	Sampling	Data Collection	Reflexivity	Ethical Issues	Data Analysis	Findings	Value of Research	Total Score
Nehls (1994)	2	2	2	1	1	2	2	2	14
Miller (1994)	3	2	3	3	2	3	2	2	20
Straker & Waks (1997)	2	1	2	1	1	1	2	2	12
Nehls (1999)	3	3	3	2	1	3	3	3	21
Nehls (2001)	3	3	3	2	1	3	3	3	21
Fallon (2003)	3	2	2	1	3	2	2	2	17
Perseius et al. (2003)	2	3	3	2	3	3	3	3	22
Horn et al.(2007)	3	3	3	3	2	3	3	3	23
Walker (2009)	3	3	3	2	3	2	2	2	20
Koekkoek et al. (2010)	2	3	2	1	2	2	2	2	16
Rogers & Dunne (2011)	2	2	3	3	2	2	3	2	19
Holm & Severinsson	3	3	2	3	3	3	3	2	22

(2011)									
Rogers & Acton (2012)	2	3	2	3	3	3	3	2	21
Rogers & Dunne (2013)	2	2	2	3	3	3	3	2	20

Table 3: Second-Order Constructs Identified in Metasynthesis Papers

Study	Second-Order Constructs
Nehls (1994)	Safety, Protection against self-harm, Short-term safety, Hospital as respite, Justifying respite in hospital, Hospital as family and friends, Finding meaning in hospital, Breaking addiction to the hospital, Longing for a life outside of hospital, Limited safety, Hospital and community life: finding a balance, The community: "I don't fit".
Miller (1994)	The purpose of hospitalisation as respite, Lack of control/helplessness, Fearing the repercussions of disclosure.
Straker & Waks (1997)	Lack of control, Severe limit setting: negative consequences, Fear as a deterrent for self-harming, Feeling pressure due to limit setting in services, Support from professionals, The hospital as a "safe haven", Lack of understanding from professionals, Lack of understanding, Lack of consistency, Sharing feelings with staff.
Nehls (1999)	Being judged by professionals, Professionals: "it's just attention seeking", Feeling dismissed by professionals, Professionals: "preconceived and unfavorable opinions" of BPD, The BPD label: adversely affecting treatment, Being marginalised by the BPD label, Living with the perception of being manipulative by professionals, Self-harm: "lack of a shared understanding" with professionals, Wanting to be understood by professionals, Professionals' perceptions of self-harm: adverse consequences, Access to care as "intentionally limited", Wanting to be listened to by professionals, Assuming that care will be lacking, Wanting to be listened to by professionals,

	Experiencing prejudice from professionals, Feeling misunderstood by professionals regarding self-harm, The meaning of self-harm for clients, Dialogue with professionals as therapeutic, Longing to be listened to.
Nehls (2001)	Feeling "treated like a person", Feeling listened to, Feeling valued, The importance of being listened to, Respect and companionship, Case managers: providing a variety of services, Case managers as a lifeline, Providing support with life-skills, Case managers as "indefinitely available", Valuing commitment, Experiencing conflict in a positive manner, Enhancing sense of self-sufficiency, Case management as more valuable than therapy.
Fallon (2003)	Diagnosis: lack of communication, Seeking help during crisis, Mixed accessibility from services, Reducing distress through flexibility, Feeling undeserving of care due to negative attitudes, Lack of "emotional support", Finding a balance between risk and independence, Relationships as the key to feeling safe, Feeling included in care, The importance of consistency, Containing distress through relationships, Moving through the system, Lack of communication, The importance of feeling included, "Being passed from pillar to post", Ongoing movement through the system, Self-harm and stigma, CPA: feeling included, Feeling understood, Consistency.
Perseius et al. (2003)	Lack of respect from staff, Lack of input into treatment, Discontinuity and betrayal, Psychiatric care as ineffective.
Horn et al. (2007)	Professionals withholding information, Professionals as experts, Feeling rejected by services, Not fitting in mental health services, Rejecting services.
Walker (2009)	Feeling judged by professionals, Being treated differently, Uncaring interactions with health professionals, Being

	judged by professionals.
Koekkoek et al. (2010)	Psychiatric admission facilitating time-out, Mixed views of professionals, Other BPD patients as supportive, Feeling in control of treatment, Confrontations with other service users, Adapting to discharge, Feeling steady due to preventive admissions.
Rogers & Dunne (2011)	Negative staff reactions due to PD label, Service users dismissed by staff, Feeling dismissed, The power of sectioning, Prejudice from staff due to diagnosis, Negative experience of ‘voluntary admission’, Joint decision making, Lack of support at discharge, Lack of safety with other patients, Waiting too long for admission, Staff and peer support, Lack of activities.
Holm & Severinsson (2011)	Involuntary hospitalisation: Feeling violated, Feeling powerless, Gaining insight through psychology, Lack of trust from professionals, Experiencing stigma, Experiencing trust and belief from professionals.
Rogers & Acton (2012)	Lack of understanding from staff, Negative attitudes from staff, Medication: feeling like guinea pigs, Confusion from professionals regarding correct treatment, Feeling rejected by staff, Lack of information regarding medication, Over-emphasis on medication, Changing to a specialist service: a positive experience, Lack of input into treatment, Becoming involved in treatment plan, Coercive treatment, Finding one’s own treatment pathway.
Rogers & Dunne (2013)	Lack of input into treatment, Lack of progress, Lack of consistency as challenging, Specialist service: feeling involved in own care, Fear of being abandoned, Lack of understanding, Feeling understood, Lack of information

	regarding treatment, Lack of signposting from staff, Lack of information regarding medication side-effects, Follow up: thinking about confidentiality, Lack of follow-up information, Excluded from care plan, Lacking a voice into care, Service reliance on medication: “I feel like a guinea pig”, A long wait for psychotherapy, Psychotherapy as a treatment: lack of options.

Table 4: Translated Themes

Theme No.	Translated Theme (Identified from Second-Order Constructs)	Metasynthesis Papers Containing Theme (According to Numbers Attributed in Table 1)
1	Accessing services to feel safe	1, 3, 6
2	Hospital as respite	1, 2, 10
3	Hospital as family & friends	1
4	Finding a balance between risk and independence	1, 6, 10
5	Breaking addiction to the hospital	1
6	Lack of control/Feeling powerless	2, 3, 11
7	Fearing repercussions	2, 3
8	Feeling judged & dismissed by professionals	4, 6, 7, 9, 10, 11, 12, 13
9	Lack of understanding and/or trust by professionals	3, 4, 12, 13, 14
10	Lack of care	4
11	The importance of being listened to	3, 4, 5, 6

12	Feeling valued and respected	5
13	Professionals and/or peers as supportive	3, 5, 10, 11, 12, 14
14	The importance of consistency	3,5, 6, 7, 14
15	Lack of communication and/or information	6, 8, 13, 14
16	Moving through the system	6, 11
17	The importance of feeling included	6, 10, 11, 13, 14
18	Psychiatric care as ineffective/Lack of progress and/or options	7, 13, 14
19	Feeling rejected by services/Not fitting in	8
20	Professionals as experts	8
21	Difficulties with other service users	10, 11
22	Lack of activities	11
23	Changing to a specialist service: A positive experience	13
24	Fear of being abandoned	14
25	Lack of input into treatment	7, 12, 13, 14

Table 5: Final Themes/Third-Order Constructs

Third-Order Constructs	**Second-Order Constructs Utilised**
Attitudes from professionals: An integral part of the service experience	Feeling judged & dismissed by professionals Lack of understanding and/or trust by professionals The importance of being listened to Feeling valued and respected Professionals and/or peers as supportive Feeling rejected by services/Not fitting in
Valuing communication, consistency and personal input into treatment	Lack of control/Feeling powerless Lack of care The importance of consistency Lack of communication and/or information The importance of feeling included Psychiatric care as ineffective/Lack of progress and/or options

	Professionals as experts
	Lack of input into treatment
Engaging with Services: The Desire to Feel Contained and the Search for Meaning	Accessing services to feel safe
	Hospital as respite
	Hospital as family & friends
	Finding a balance between risk and independence
	Breaking addiction to the hospital
	Fearing repercussions
	Professionals and/or peers as supportive
	Moving through the system
	Difficulties with other service users
	Lack of activities
	Changing to a specialist service: A positive experience
	Fear of being abandoned

Appendix 1-A: Instructions for Authors for Journal of Mental Health

Instructions for Authors

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form.

Submissions

All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at http://mc.manuscriptcentral.com/cjmh . New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

Keywords

Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice.

Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association , and all references listed must be mentioned in the text. Within the text references should be indicated by the author’s name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:
a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. Magnetic Resonance Imaging, 18 , 351–355.
b) For books:

Powell, T.J. & Enright, S.J. (1990) Anxiety and Stress management . London: Routledge
c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry & F. Watts (Eds.), A Handbook of Skills and Methods in Mental Health Research (pp. 75–89). London:Lawrence Erlbaum.

Illustrations should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Accepted papers

If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt.

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Section Two: Research Paper

Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives

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Abstract

Background: Previous research indicates that mentalisation-based treatment (MBT) is an effective therapeutic programme for difficulties associated with borderline personality disorder (BPD). However, there is no published qualitative literature that highlights service user experiences.

Aims: The primary aim of this qualitative study was to learn about the experiences of individuals who attend an MBT programme for BPD.

Method: Seven adults (five female and two male), who were recruited via three separate NHS Trusts, were interviewed. Participants were attending an intensive out-patient MBT programme for BPD for between three and 14 months. Data was analysed using interpretative phenomenological analysis (IPA).

Results: The following four themes were identified: experiencing group MBT as unpredictable and challenging, building trust: a gradual but necessary process during MBT, putting the pieces together: making sense of the overall MBT structure, and seeing the world differently due to MBT: a positive shift in experience.

Conclusions: Participant experiences of change facilitated by MBT largely align with Bateman and Fonagy's (2006) suppression of mentalisation model of BPD. Participants also refer to specific factors that may be disruptive to mentalisation capacity during the programme. These factors, in addition to implications for MBT and suggestions for future research, are discussed.

Introduction

Mentalisation-based treatment (MBT) is a therapeutic programme that was designed for individuals with a diagnosis of borderline personality disorder (BPD) by Bateman and Fonagy (2006), although it has since been presented as a potential treatment for people with other diagnoses, such as antisocial personality disorder (McGauley et al., 2011) and eating disorders (Skarderud & Fonagy, 2012). Several difficulties are associated with BPD such as persistent suicidal behaviour, volatile interpersonal relationships, an unstable sense of identity and intense emotional experiences (American Psychiatric Association, 2013). Childhood traumas, such as sexual, physical and emotional abuse and neglect, have been strongly associated with a BPD diagnosis (e.g. Sansone & Sansone, 2007; Huang et al., 2010). The MBT model draws on the idea that childhood trauma disrupts an individual's capacity to mentalise (Bateman & Fonagy, 2006), which essentially involves the ability to understand one's own mental states, such as thoughts and feelings, and the mental states of others (Allen et al., 2008). This disturbance to mentalisation capacity, in turn, continues into later life and according to Fonagy and Bateman (2006) should be understood in the context of attachment theory.

Attachment theory is premised on Bowlby's assertion that infants seek to find security from their primary caregiver and assumes that a secure attachment with the primary caregiver has a positive impact on one's mental health and future relationships, whereas an insecure attachment is considered to have an adverse effect on these domains (Bowlby, 1973). Internal working models created during infancy create a set of expectations regarding the relationship with the primary caregiver and future relationships, become generalised and seem to have an enduring impact on an individual into adulthood (Bowlby, 1988; van Ijzendoorn, 1995). Fonagy and Bateman (2007) place the attachment figure at the centre of the development of the ability to mentalise arguing that this stems from feelings of being understood by the primary caregiver. They hold that disruption to the attachment relationship, in turn, has an adverse impact on the individual's ability to mentalise. Enhancing the capacity to mentalise is thus the central component of MBT which is intended to support the service user "to find out more about how he thinks and feels about himself and others, how that dictates his responses, and how errors in understanding himself and others lead to actions in an attempt to retain stability and to make sense of incomprehensible feelings" (Fonagy & Bateman, 2007, p. 93).

MBT is a manualised approach and two separate programmes were devised for BPD: a day hospital programme and an intensive out-patient programme. In the day hospital programme a combination of individual and group therapy is utilised, service users attend for five days per week initially and the treatment continues for 18-24 months. The out-patient treatment consists of one individual and one group therapy session per week for 18 months. Both manualised MBT programmes recommend separate therapists for individual and group therapy (Bateman & Fonagy, 2006). A pretreatment group of eight to 12 sessions is recommended consisting of psychoeducation on mentalisation, BPD, attachment and other topics relevant to MBT (Karterud & Bateman, 2012).

As previously stated, the aim of MBT is to stimulate mentalisation capacity in service users. In individual sessions therapists are aware that stimulating feelings is likely to destabilise the attachment system of the service user. Thus, the therapist remains in close emotional proximity to the client by probing, questioning and stimulating feelings until the client is about to lose mentalisation capacity. At this point distance is created by the therapist in order to decrease emotional arousal by reducing the intensity of the session and thus maintaining mentalisation capacity. When the client resumes mentalising the therapist can return to emotional proximity (Bateman & Fonagy, 2012).

The primary aim of group sessions is to provide a platform for learning how to mentalise in a group environment. Thus, whilst mentalisation capacity will inevitably be lost by service users (and therapists) at times during group interactions there is an emphasis on detecting such instances, exploring and understanding them, and regaining the ability to mentalise in the group environment (Karterud & Bateman, 2012). Furthermore, learning to maintain mentalisation capacity and manage anxiety during stressful circumstances is highlighted as key to group sessions. This would not be possible to achieve during individual sessions alone thus resulting in concurrent individual and group psychotherapy being central to MBT (Bateman & Fonagy, 2006).

The evidence-base, mainly consisting of randomised controlled trials (RCTs), suggests that MBT is an effective treatment for difficulties associated with BPD such as self-harm, interpersonal functioning, suicidal behaviours and depression (Bales et al., 2012; Bateman & Fonagy 1999; Bateman & Fonagy, 2009; Rossouw & Fonagy, 2012). Research also indicates that improvements can remain for at least five years post-treatment (Bateman & Fonagy, 2008), thus highlighting the potential long-term benefits of MBT. Recent guidelines and reviews (National Institute of Health and Care Excellence, 2009; Stoffers et al., 2012) refer to encouraging research regarding MBT as a treatment for BPD. Furthermore, their reference to the small evidence-base for MBT has been partially addressed by the two subsequent RCTs cited above (i.e. Bales et al., 2012; Rossouw & Fonagy, 2012).

RCTs are generally considered to be the *gold standard* in quantitative methodology (Salmond, 2008). However, the restrictive nature of the scales and questionnaires used in these studies left little room for participants to provide detailed accounts of their experiences of MBT as a therapy. Learning about such experiences could be a relevant factor in developing the therapy further and understanding if there are elements of the therapy that could be enhanced to optimally meet the needs of service users. A qualitative approach would be best suited to facilitate learning about these experiences. To the chief investigator's knowledge, no qualitative research has been published to date exploring service user experiences of MBT; thus, a qualitative method was employed in this study. The study examined service user experiences of intensive out-patient MBT while they were still engaging in the programme. The primary research question was to discover how adults with difficulties associated with BPD experience intensive out-patient MBT?

Method

Design

Interpretative phenomenological analysis (IPA) was chosen as the qualitative method for analysing data for this study. IPA is concerned with the lived experiences, meanings and perspectives of participants whilst acknowledging that they cannot be entirely accessed. Therefore, it involves a double hermeneutic because it holds that the participant is attempting to make sense of his or her experiences of the world, and the researcher then endeavours to make sense of these interpretations (Smith, 2004; Smith et al., 2009).

IPA is utilised to scrutinise major life experiences of individuals and generally involves the use of homogenous samples. However, its idiographic focus also results in in-depth analysis of individual participant experiences in addition to determining more collective themes and interpretations. Therefore, IPA is interested in both similarities and differences of participants so that despite the discovery of shared themes the voice of the individual is not lost. The semi-structured interview is considered the most effective data collection method in IPA studies due to the flexibility that it allows in eliciting participant experiences (Smith et al., 2009; Smith & Osborn, 2008).

Sampling and Participants

Purposive rather than random sampling was employed in order to facilitate recruitment of a clearly defined, relatively homogenous group. In order to facilitate in-depth, rigorous analysis of each individual transcript IPA studies typically utilise small samples. Many IPA studies have a sample size of between five and ten (Smith, 2004), although numbers can vary depending on specific factors, such as the richness of data (Smith & Osborn, 2008).

Inclusion criteria were: attending an intensive out-patient MBT programme for BPD for at least two months and no longer than 15 months (a diagnosis of BPD was not required as some UK MBT groups do not have this as a requirement), over 18 years of age, capacity to consent. The sole exclusion criterion was an inability to speak English fluently. Attending MBT for between two and 15 months was chosen as an inclusion criterion in order to ensure that participants had time to settle into the treatment, build therapeutic relationships and describe their experiences as well as avoiding potentially strong emotions stimulated by therapeutic endings. Luyten et al. (2012) outline how the ability to mentalise is disrupted within relationships that are less secure. This suggests that mentalisation capacity is likely to be disrupted at the beginning and at the end of therapy as the therapeutic relationship is less stable at these times. Therefore, excluding individuals who were merely settling into a MBT programme and also those who were close to the end increased homogeneity among participants.

Participants were recruited from four separate MBT groups within three separate Trusts in the UK. A MBT therapist from each Trust identified individuals who met criteria resulting in 28 potential participants for the study. Each potential participant was handed a recruitment pack by a MBT therapist in their Trust and was invited to contact the author if interested in taking part. In addition, following a request from a therapist, the author was available to discuss the research with interested parties following a group session for one of the above MBT groups. Nine potential participants expressed an interest in participating. Two of these individuals decided not to take part and seven participants in total were recruited (see Table 1 for demographic details).

Insert Table 1

Procedure

Ethics.

Ethical approval for this study was obtained from a regional National Research Ethics Service (NRES) committee in the UK. The research and development departments in each of the three relevant Trusts also provided approval. Each participant provided informed consent. All personal names cited in this report are pseudonyms in order to protect the anonymity of participants and other parties. Furthermore, information that the chief investigator deemed could potentially identify participants to others was not included. Participants were fully debriefed following the interview.

Data collection.

Participants were given the option of being interviewed either in an appropriate service in the community (such as a GP service) or in a room within the relevant Trust. The latter option was chosen by all participants. A topic guide was used to guide semi-structured interviews. Each participant signed the consent form prior to commencement of the interview. The average duration of interviews was 60 minutes. The author created a brief reflective diary following each interview to highlight his potential biases and assumptions and to reflect on the progress of each interview. All interviews were recorded and transcribed verbatim.

Analysis.

Drawing on guidelines provided by Smith et al. (2009) the author began analysis by reading and re-reading the initial transcript several times. He then proceeded to make exploratory comments on the left-hand column from the beginning to the end of the transcript. These comments consisted of descriptive, linguistic and conceptual or interpretative statements. They represented the initial thoughts of the researcher in relation to how he felt the participant was making sense of his or her experiences of MBT. The reflective diary was reviewed in order to bracket assumptions and biases as much as possible. Once this was completed, emergent themes were created by the chief investigator on a column to the right of the transcript. Emergent themes consisted of phrases that were deemed to capture an aspect of the transcript. They were determined from the content of exploratory comments and from the main transcript. Appendix A contains an extract from the initial transcript with exploratory comments and emergent themes.

The next stage involved grouping emergent themes from the initial transcript together where similarities and connections were apparent, thus creating a small number of superordinate themes. Furthermore, a written piece was produced about each superordinate theme in order to capture the main elements of the theme (see appendix B for sample superordinate theme from initial transcript). This process was repeated for each of the remaining six transcripts. The idiographic component of IPA was adhered to as analysis of each transcript involved bracketing themes and findings from prior transcripts so that their influence on the process was minimised. The chief investigator achieved this by examining each transcript on its own merit and analysing purely according to the data contained within.

Once each transcript was analysed individually the chief investigator began to search for commonalities and connections across transcripts. All of the emergent themes from each transcript were included and were grouped together according to similarities and connections. The chief investigator re-read the exploratory comments relating to each emergent theme from each transcript during this process. This formed an integral part in the production of group or final superordinate themes which are presented in the findings section. Furthermore, the chief investigator re-read the superordinate themes of each individual participant to ensure that the idiographic element of IPA was present in the group superordinate themes. Appendix C illustrates how the final superordinate themes were produced from all participants' emergent themes.

Credibility and validity.

Research validity refers to the extent to which a piece of research does what it intends to do and the use of supervision was an important part of enhancing validity for this study. As a trainee clinical psychologist, the chief investigator received supervision from both an academic and field supervisor during each stage of the research (apart from analysis, which was supervised solely by the former). Drawing on criteria outlined by Yardley (2008) further steps were adhered to. A clear and defined paper trail for each part of the analysis is contained in Lancaster University. Criteria, suggestions and guidelines in the literature for conducting an IPA study were followed (or adapted where appropriate) with rigour in order to ensure that the findings from this study were produced with transparency. Furthermore, as mentioned above, a reflective diary was prepared following each interview in order to maximise the effectiveness of future interviews and to bracket the author's assumptions as much as possible.

Findings

Following analysis four themes were derived from the data as outlined below:

Experiencing Group MBT as Unpredictable and Challenging

All participants reported experiencing group MBT as a very intense and difficult environment at some stage and this experience continued on an ongoing basis for the majority of participants. Most of the participants described only wanting individual sessions and some did not see the purpose of group MBT. Six of the participants attended a rolling MBT group where members joined and left the group on a continuous basis. All but one of the participants (i.e. Laura) described joining such a group to be difficult thus taking them time to settle as a result, "At first I…felt a bit distant…bearing in mind that there were people already in the group…So I felt a bit out of me depth. And it took me about two month to engage…" (Kevin). Ruth appeared to have found this experience very challenging stating that she was "invading" the group. Laura, however, seemed to have developed strategies that enabled her to blend in quickly with the new group. She reported having an ability to act in a way that concealed her insecurities, and the metaphor of wearing a shoe appeared to emphasise an ability to adopt this stance with relative ease, “it's like a shoe, you know. It's easier to walk around…thinking and acting that way…than to let my insecurities out…all the time.”

The group appeared to be an unpredictable and uncomfortable place for participants that could present with various challenges at different times. These challenges seemed to relate to a perceived lack of safety and potential threat. Sarah spent much of her time expecting to be judged by the other group members and Jo was anxious about the possibility that group members could repeat outside what is shared within the group. Furthermore, John continued to experience an intense anxiety prior to each group session due to fears about how the group would react to him, though he acknowledged that these fears had not been realised.

Challenges also existed for participants in a much more overt manner. During her first group session, Ruth reported that she struggled with “hard hitting” topics such as suicide and Sarah recalled finding it "difficult and scary" when she thought another group member was criticising her. In the early stages of her time in the group, Laura struggled with one of the group members who she found “direct” and “intimidating” while John’s current experience of the group was adversely affected by one of the group members, “…she's very aggressive…she's one of those people who, if you say something to her then she thinks it's um…get in her hair…even if it's a compliment.” In addition John struggled to contribute in group sessions due to the “battle of words” among group members to find space to talk.

Similar to John, Lisa found that some group members did most of the talking and that she did not get an opportunity to contribute which often results in her feeling worse after a group session. Ruth found group situations difficult in general and sometimes felt frustrated due to her lack of contribution, "Sometimes it's a bit of a struggle because…I can leave the group thinking, 'I've just wasted an hour and a half where I could have said something'". This was also a challenge for Sarah and she worried that the other group members were "going to be sick of me" if she did speak. Although Kevin now felt confident engaging it took him several months to do so as he initially felt "out of my depth" and apprehensive. Jo also reported struggling during the initial stages but that she was determined to contribute as she had not done so during a previous therapeutic group she was involved with.

Many other challenges existed within the group for participants. Sarah sometimes worried about offending other group members while Jo felt “adrift” from the rest of the group as she felt different to the other group members. Lisa reported that when she began the group she felt abandoned as she was supposed to be joining the rolling group with another new member who did not attend. She described feeling “lost” and unsupported when she joined the group, which was compounded by the absence of her individual therapist during the initial stages. When Kevin was experiencing difficulties in his personal life he sometimes found the group “invasive” as the facilitators tended to encourage him to get involved in the group when he felt unable to do so.

Building Trust: A Gradual but Necessary Process during MBT

Learning to trust and feel comfortable with both therapists and group members appeared to be an essential process for all participants in order to make progress during MBT. Sarah described how she initially worried about being judged by her individual therapist. She did not like her direct style at first but she developed trust in her as she got to know her better, “I’ve realised now how really caring she is…and that she has to do that…and it’s for my benefit…I’m not being told off.” Jo viewed her individual therapist as a kind and patient person who “seems to care” and she highly valued the consistency that she demonstrated during sessions. Despite being uncertain initially, Laura became “unbelievably comfortable" with her therapist which enabled her to open up and discuss personal difficulties.

Ruth struggled with trust in general and felt that it had to be built gradually over time. However, she described learning from her individual therapist the importance of mutual trust, referring to her realisation of the benefits of openness and honesty during therapy as a “light bulb moment”. John, Lisa and Kevin also seemed to find individual sessions very supportive and were able to freely express personal difficulties there, thus suggesting that they had enough trust to do so, “It's a lot better for me…because if I have got a problem I can just, you know, voice it" (Lisa).

Participants appeared to perceive building trust in group sessions as a gradual and more difficult process. Kevin identified trust as essential to the group because he felt that individuals would not open up without that trust. It took Sarah about six months before she started to open up in the group and building trust was a key factor in this. After gradually seeing evidence of the group being supportive of her she had learned to trust the group, although she was still finding it a difficult and uncomfortable place to be. Being in a group with people with similar difficulties was described as a "dream come true" by one participant (John) and was also a key factor in supporting other participants to build trust. Furthermore, Laura described group members as respectful and supportive and "…quite aware of not wanting to…hurt each other" following the departure of a member of the group whom she found intimidating. This may suggest that the group, in her view, was potentially an unsafe place where people could hurt each other which was possibly exacerbated due to the change associated with rolling groups.

Six of the participants attended rolling groups and the majority of them referred to this as a negative aspect of the group component due to the arrival of new members. Kevin found this disruptive and believed that it interfered with the trust that had already been built up between the group. Trust taking time to build appeared central for most participants, "it's a long process of opening up and being able to trust people enough to talk" (Sarah). Therefore, this willingness to openly express oneself in the group seemed to be impeded by the arrival of new members as the process of building trust had to begin again, "…you just end up closing up again…because there's somebody new there" (Lisa).

All of the participants were able to build enough trust with their individual therapists for them to feel that they were benefitting from individual sessions. Participants who also had their individual therapist in group sessions (Kevin, Sarah and Jo) generally valued this. Sarah described her individual therapist as an "ally" amidst the unpredictability of the group and this helped her to feel more comfortable there. Although the group was still a potentially difficult place for all participants the majority had reached a point where they could see a valuable purpose to the group, and building trust appeared to be central to this. However, John and Lisa reported minimal benefit from the group. This may be because they had only been attending MBT for three months whereas the others had been attending for between five and fourteen months. Sarah, Jo, Kevin and Ruth stated that it took them several months before they felt safe enough to start opening up in the group thus emphasising the importance of time for building trust.

Putting the Pieces Together: Making Sense of the Overall MBT Structure

All participants attempted to make sense of the overall MBT programme by reflecting on how the different aspects of the programme worked together. As well as thinking about their experiences of the combination of individual and group sessions most participants also reflected on their preparation for MBT as each participant engaged in an introduction to MBT.

The structure of this introduction differed for different participants. Six of the participants reported attending introductory sessions for three to four weeks and this worked well for the majority of them. Jo described feeling that it prepared her for the full programme as she got to know her individual therapist and knew what to expect from MBT. Ruth found that learning some mentalisation techniques assisted her preparations for the group. The main benefit for Laura was a practical one as it prepared her for attending therapy on a weekly basis. Lisa also found what they learned to be too basic but she enjoyed the task-oriented structure of sessions.

However, John described a much different type of introduction as it was more intensive, it lasted for longer (i.e. 12 weeks) and there was a five week gap between the introduction and full programme. He had to take in a lot of information, he stated that 12 weeks without one-to-one support was too long and he seemed to have found the lack of continuity between the introductory course and the full programme disruptive, " It took me about four or five weeks to get into it and then…um…it took me four or five weeks to get out of it…and now it's taken eight to twelve weeks to get back into it."

All participants found individual therapy to be a very helpful therapeutic experience and considered it to be the core component of MBT, "that is where it all comes together" (Kevin). As well as feeling comfortable to freely express themselves in these sessions they were also where participants learned how to apply mentalisation in their daily lives. Moreover, there were some topics that participants preferred not to bring to the group but individual sessions were still available to discuss these. The individual sessions had an added benefit as participants were sometimes given the courage there to bring these topics to the group. Moreover, all participants strongly valued the designated space that they had during individual sessions, "…you feel really satisfied…because…there's no interruptions…and…you can talk about anything" (John).

However, the majority of participants also seemed to view group sessions as a very important part of MBT despite the unpredictability and challenges associated with these sessions and in some cases because of this as challenges could present opportunities for learning. The main value in group sessions appeared to centre on the ability to reflect on these sessions during individual sessions. This had added value for Jo as her individual therapist was also present in group sessions, "…the group sessions often seem…kind of extra…difficult… But, they're…kind of more like…real life…that's potentially useful…because…Jane, who's my individual therapist, she sort of sees me in real life type situations…". Moreover, Laura perceived group sessions as a "stepping stone" between individual sessions and the outside world because strategies that had been learned in individual sessions could be tested out in group sessions before doing so outside. The majority of participants emphasised the importance of having individual sessions very soon after group sessions. When this did not happen it seemed to impede the ability to reflect on the group which was deemed extremely important by participants. For Sarah, a long gap in between sessions could lead to rumination whilst Kevin and Lisa reported forgetting important events that occurred in the group by the time individual sessions came about. A long gap for Ruth resulted in her lamenting the absence of her "safety net" following group sessions.

However, John and Lisa's main difficulty with the group was the lack of space for everyone to speak and the tendency of certain group members to dominate discussion in their groups. John found interaction between group members to be very useful but felt that this was lacking due to the tendency of some individuals to speak for long periods. Lisa believed that the group lacked structured tasks and that equal time should be designated to everyone. Once again, the fact that John and Lisa had only been attending MBT for three months may have been a factor here as it took many of the other participants up to six months to fully settle into the group. Nonetheless, it is also possible that Lisa's inclination towards a more structured approach may have continued to provide challenges regarding her experience of group MBT, "…it needs more structure, it needs something more to it…".

Further useful aspects of MBT cited by some participants included having two therapists during group MBT in order to gain different perspectives and having clear communication between therapists in individual and group sessions.

Seeing the World Differently due to MBT: A Positive Shift in Experience

All participants described experiencing positive change through MBT and they appeared to make sense of this as an ability to see the world in a different way. This included events, other people, therapy and parts of themselves such as emotions. Becoming more aware of internal processes during individual sessions assisted Lisa to think about personal situations where she had not been mentalising in a new, more balanced way and this was an insightful experience for her, "So it's been interesting, you know…to be made aware of something that you didn't think was happening. And then after the fact to go back and to actually think on that." Furthermore, MBT seemed to support all participants to reduce their previous tendency to make assumptions about the motives of others. Sarah cited this as the "big gain" from MBT and described the other group members as her “numbskulls” who helped her to see things from different perspectives and to become “more rational.” John stated that he grew up in a family of "wrong mind readers" who were quick to make judgements about others and this was a pattern that he also acquired. Through attending MBT he learned to give himself space before acting which enabled him to develop a range of explanations outside of his immediate assumptions and thus see the world differently and in a more balanced way.

This ability to look for different perspectives and to see events in a new way seemed to support participants to react more positively to challenging incidents, such as confrontations with others. For example, Laura stated that she learned not to act during disagreements until overwhelming emotions passed as this allowed her to take on board the perspectives of others and thus perceive confrontations in a more balanced way. Not only did mentalising in this way improve Laura's relationships with others but it also facilitated a reduction in suicidal thoughts and self-harm, "It's a solution I can put to a problem…when I've had times of distress…And it does make those times…a lot less stressful…I don't end up…self-harming or…thinking about suicide as much…it just makes it a lot shorter and a lot more bearable." Participants also referred to utilising social interaction within group sessions to see things differently. When Sarah perceived another group member as being critical towards her regarding a situation in her personal life, her automatic reaction was to believe the criticism to be accurate. However, with assistance from one of the therapists during the session, she confronted and explored the criticism with the other group member and began to see it differently. She no longer believed the other group member’s comments to be true and she also learned that this group member had not been intentionally critical of her. Mentalising in the group appeared to support her to view the criticism in a less extreme and polarised way.

Some participants also seemed to view therapy and mental health services differently due to their experiences of MBT. Both Jo and Ruth developed more realistic expectations of therapy following the realisation during MBT that it did not provide a “magic button” (Jo) or "magic cure" that immediately removed difficulties. Engaging in MBT appeared to result in Kevin viewing wider mental health services differently. Kevin previously had some very negative experiences of mental health services where he generally found a lack of understanding and compassion. However, his experience of MBT was much more positive and seemed to give him a different view of mental health services, “…the engagement with the people and the engagement with the staff involved in the mentalisation helps you to recognise that you're not being judged, that people are actually there trying to help you to get over the issues that you've got.”

In addition, participants described learning to see other people in general differently as well as parts of themselves. Kevin’s interactions with group members helped him to see that not everyone was "void, callous and cold". He developed a mistrust of others due to an abusive past but attending MBT seemed to assist him to see that there are people who are caring and supportive. Ruth also described wanting the trust she developed in group members to change her perception of other people outside of the group in a positive way. John seemed to learn to see intense emotions, such as depression, in a different and more accepting way. He previously considered the removal of depression to be essential in order to manage his life but he learned in MBT that he could have a better life even with depression "…now I know that, even it's just like, 30, 40 per cent of a better life…with depression…So I think in the end it's started to change my point of view of it." John also started to view his future prospects differently and more positively due to MBT as it helped him to see "light at the end of the tunnel".

Discussion

This IPA study examined the experiences of individuals who were engaging in an MBT programme in the UK. The findings illustrate that participants found the group component of MBT to be an intense, challenging and sometimes frightening experience. For all participants building trust in both group and individual sessions was an essential part of benefitting from MBT but was much more difficult to achieve in the group component. Overall, participants found that the individual and group components of MBT were an effective combination but individual therapy was viewed as the core and most important element of MBT. All participants learned to see the world differently which resulted in a positive shift in experience.

The Purpose of MBT: Learning to Mentalise

Obtaining an understanding of the suppression of mentalisation model of BPD (Bateman & Fonagy, 2006) is a valuable framework for understanding the purpose of MBT for BPD and participants' experiences of mentalising. A lack of mentalisation capacity is seen to arise as a result of childhood abuse and maltreatment, therefore reducing capacity to be aware of and understand one's own mental states and the mental states of others. The failure to mentalise is specifically associated with close attachment relationships and may arise for a variety of reasons including psychological defences (e.g. an inability to think about the mental states of an abusive attachment figure as it is too frightening) or due to the trauma-related hyper-arousal of the attachment system following the experience of lack of safety with the attachment figure. Such lapses in mentalisation are seen to lead directly to difficulties with attachment relationships but can also result in further complications such as psychic equivalence (i.e. the experience of inner states as absolute representations of outer reality, sometimes resulting in paranoid hostility) and pretend mode (i.e. inner reality and outer reality are completely separate sometimes leading to dissociation). Thus, by specifically focusing on enhancing the ability to be aware of, understand and question one's own mental states and the mental states of others MBT is seen to directly address the root cause of the primary difficulties associated with BPD such as impulsivity, interpersonal difficulties and self-harm.

The understanding of mentalisation that participants held and the impact of this process on them largely aligned with this model. All participants placed a significant emphasis on learning to view the world from different perspectives thus becoming more aware of the mental states of others. For example, John's description of growing up in a family of "wrong mind readers", and acquiring this tendency himself, indicate a tendency towards psychic equivalence. Findings from this study suggest that participants were able to reduce or remove psychic equivalence by seeing things in a more balanced way which in turn appeared to enhance interpersonal relationships. Participants also described becoming more aware of their own mental states. Lisa's ability to reflect on internal processes during personal situations when she had not been mentalising supported her to view these situations in a different and more balanced way . Thus, the process of mentalising represented a positive shift for all participants and appears to have provided support for specific difficulties associated with BPD that may arise from psychic equivalence (e.g. impulsivity, self-harm and interpersonal difficulties).

Potential Contributors to the Failure to Mentalise During MBT

Findings from this study also point towards certain aspects of MBT that may contribute to a failure to mentalise. These relate to concurrent individual and group therapy and to pre-treatment.

Concurrent individual and group therapy

Both individual and group therapy are viewed as complementary and essential parts of the MBT programme (Karterud & Bateman, 2012). Yalom (2005) maintains that significant interpersonal learning occurs through the surfacing of maladaptive behaviours, conflict and hostile expression during group sessions provided that cohesiveness (i.e. "the attractiveness of a group for its members", p. 55) is in place. This fits well with the MBT model as group sessions are viewed as a valuable opportunity to mentalise and to tolerate intense emotional experiences (Bateman & Fonagy, 2006). All participants in this study appeared to struggle with the group component for at least the first few months. Both participants who had been attending MBT for three months found the group component challenging and it appears that they were struggling to mentalise and to tolerate intense feelings triggered in the group. All of the other participants had started to see benefits to the group and the three participants who had been attending for more than ten months were each able to see how conflict and/or unpredictability within the group could be used as valuable opportunities to enhance mentalisation. However, it appears that these participants had found a sense of belonging in the group and highly valued the contributions of the other group members, whereas those who had only been attending for three months had yet to find that cohesiveness. Therefore, it may be that participants in the early stages of the group were unable to benefit through interpersonal learning without that cohesiveness.

This sits well with the views of Haigh (1999) who highlights the need for containment, belonging and safety to be firmly in place before a culture of openness, curiosity, questioning and challenging of others can thrive. Research has also indicated that the lack of a containing environment in group psychotherapy may be a contributing factor to drop-out (Hummelen et al., 2007) and an unpublished qualitative thesis found therapists' lack of authority as an obstacle to encouraging mentalisation during group MBT sessions (Inderhaug, 2013). This would appear to suggest that safety and containment should be prioritised during the early stages of the group component of MBT but that following this, once a cohesive group has been created, boundaries could be gradually loosened in order to encourage a more challenging environment. Karterud and Bateman (2012) liken this to in vivo practice as the individual gradually increases their exposure to intense affect states in an interpersonal environment so that mentalisation capacity is maximised throughout.

Even though all participants appeared to experience the group as unsafe and uncontained during the initial stages each of them viewed individual sessions as a secure place where trust with the individual therapist was built relatively swiftly and easily. Individual sessions were described as a "safety net" where challenges could be discussed in a contained environment and ideally would be available within a day or two of a group session. If this safety net was not available soon after the group it appears that the group became a less safe place. Thus, drawing on attachment theory (Bowlby,1973, 1988) individual sessions could perhaps be viewed as a secure base from which the outside world (including group psychotherapy) is explored and there is a need for the secure base to be readily available to return to. Other structural elements of MBT also appear to impact the experience of safety during group sessions. For example, some participants who had the same therapist in individual and group sessions felt more reassured and supported in the group whilst participants in rolling groups felt anxious, uneasy and untrusting when a new member joined the group.

Preparing for MBT and the Process of Mentalising

Whilst factors such as openness (Haigh, 1999) and interpersonal learning (Yalom, 2005) appear to facilitate change in themselves and also support enhanced mentalisation (Allen, 2013; Karterud & Bateman, 2012), simply attending to and understanding mental states incorporates the core process of mentalising (Allen et al., 2008). It appears that some of the participants were unaware of one of the primary purposes of the group component, i.e. mentalising in an intense and challenging environment (Bateman & Fonagy, 2006). For example, John's discomfort in the midst of conflict in his group, Lisa's frustration with the lack of structure in her group and Ruth's feeling that she wasted a group session when she was unable to contribute could have all been potential opportunities to mentalise but the participants did not seem aware of this.

Therefore, although the unpredictability and lack of safety within the group environment seem to contribute to a failure to mentalise it also appears from the findings that participants may not have been sufficiently prepared for how challenging the group component would be and how intense situations in the group can be important opportunities to enhance mentalisation capacity. Mayerson (1984), drawing on Bandura's social learning theory, discusses a number of factors that maximise clients' ability to benefit from group therapy. These include knowing what to expect from group therapy and being confident of one's ability to accomplish this without excess discomfort. The main recommended focus for pre-treatment seems to centre around psychoeducation in a more structured format (Karterud & Bateman, 2012) and it appears that participants benefitted from it on a more intellectual, cognitive level rather than an experiential level. Thus, when participants did begin group

MBT, which is much less structured than pre-treatment, the contrast appeared to be difficult for them to manage. Contrary to Mayerson's (1984) recommendations, not knowing what to expect seems to have contributed to the discomfort of participants in the initial stages of group therapy and more experiential preparation during pre-treatment may have alleviated some of this discomfort.

Finally, it is important to note that the only participant who attended pre-treatment for more than four weeks (i.e. 12 weeks) found the amount of information presented overwhelming. Again, it appears that the emphasis on more cognitive than experiential learning was of limited value. Furthermore, this participant experienced a gap in between pre-treatment and MBT which he found disruptive. It seems that he managed to build some cohesion and a sense of belonging (Haigh, 1999; Yalom, 2005) in the pre-treatment group but the gap disrupted this sense of belonging which he had to try to attain again when he began the group component of MBT.

Implications for MBT

Therefore, a number of implications are suggested for MBT arising from the points discussed above. Programme facilitators should consider a pre-treatment to MBT that is less structured and less focused on learning through psychoeducation over a lengthy period of time, although maintaining an element of this psychoeducation over a shorter period (e.g. four weeks) would still seem important. Introducing an experiential aspect to pre-treatment where the process of mentalising is exercised in a complex group environment could bridge the contrast between pre-treatment and group MBT. Furthermore, placing an emphasis on adequately preparing service users for the unpredictability of group MBT, and for the opportunities to engage in mentalisation that such unpredictability brings, may enhance service user experiences of this component. There should ideally be no gap between pre-treatment and full programme MBT to enhance cohesion, continuity and a sense of belonging.

A considerable emphasis on enhancing cohesion during the initial stages of the group component, possibly during the first three to six months, may maximise potential benefits of the programme. Facilitators should place a significant emphasis on maintaining safety and containment in group sessions and facilitating trust. This may involve interjection by facilitators in order to achieve this. Having the same therapist in individual and group sessions appears to create a more containing environment for service users. Furthermore, scheduling individual sessions to take place within a few days of group sessions would ensure that participants can return to their "safety net" to explore possible challenges that arise in the group.

The potentially therapeutic role of conflict and discomfort during group sessions should be emphasised once a cohesive group has been created. Rolling MBT groups provide a simultaneous obstacle and opportunity. The arrival of new members can create difficulties in cohesion and trust among existing group members. However, the lack of predictability that these groups bring provide a valuable opportunity to mentalise in trying circumstances. Thus, for services that utilise rolling groups clear communication about their potential challenges and benefits should be emphasised to service users.

Limitations and Future Research

This study contains a number of limitations. As a qualitative study with a small sample the findings cannot be generalised. Furthermore, although the sample was sufficiently homogenous for an IPA study homogeneity was reduced due to a number of factors such as length of time attending therapy and a varying structure among different MBT groups (e.g. rolling groups and non-rolling groups). The validity of the findings was lessened as it was not possible to engage in robust strategies such as triangulation or respondent validation due to time constraints associated with this study (however, as previously stated, an experienced qualitative researcher supervised analysis which somewhat reduced the impact of this on validity).

The research has presented some tentative implications for MBT but much of these findings need to be further explored through future research. Each of the participants in this study was still attending MBT but a qualitative study on the experiences of individuals who have dropped out of MBT would be valuable. Furthermore, qualitative research on the process of change during MBT would be beneficial from the perspective of therapists and also service users who have completed the full programme. Finally, there is a suggestion from this study that cohesiveness may be most likely to develop between the three month and six month stage and is possibly maintained by the 12 month stage. However, this needs to be verified through future research. Quantitative research measuring and comparing cohesiveness in group MBT at three month intervals would provide valuable information regarding this.

Conclusion

Findings from this study suggest that MBT enhances the ability to mentalise which appears to result in an improvement in specific challenges associated with BPD such as impulsivity and interpersonal difficulties. However, certain aspects of MBT appear to disrupt the ability to mentalise at certain stages of the programme. The lack of safety and unpredictability associated with the early stages of the group component present a particular challenge for service users. Furthermore, pre-treatment does not appear to sufficiently prepare service users for this unpredictability or for the opportunities that it presents to enhance mentalisation capacity in an intense environment. Although these findings need to be further explored through future research it would appear that taking measures to develop these aspects of MBT would facilitate further enhancement of mentalisation capacity for service users during the programme.

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Table 1

Demographic Features of Participants

Pseudonym	**Age (in years)**	**Length of time attending MBT (in months)**	**Gender**
Sarah	52	10	Female
Jo	40	13	Female
Kevin	45	14	Male
John	42	3	Male
Ruth	34	5	Female
Laura	26	6	Female
Lisa	40	3	Female

Appendix 2-A

Extract from Initial Transcript

Key for Initial Comments According to Colour

Black: Descriptive Comments

Red: Linguistic Comments (e.g. metaphors)

Blue: Conceptual Comments (e.g. interpretations and questions)

Initial Comments	Transcript	Emergent Themes
Positive that not just one-to-one as have to deal with real life situations in group "Really difficult and scary" - being criticised in the group When being criticised, "my heart was pounding" - physical experience due to being criticised Sarah had automatically assumed she was in the wrong when criticised, but through mentalising was able to see more clearly. Tries to make sense of what happens to her when criticised. Mentalising seems to alleviate her extreme reactions. Seems to need the support of her therapist to do this.	in his past…how he responded to what I was saying. Yeah. Yeah. So that's, I suppose it's good that it's not just one-to-one. Cos the person's there that's…upsetting me…and I'm having trouble dealing with. And that was highlighted. And it was really difficult…and scary. I was really…and when I was saying, 'Yeah, I do feel criticised' I couldn't look at him. My heart was pounding, you know. But, yeah…I'm really glad it's been done. There's still a little bit of me that thinks, 'Is he really okay with that?' You know [laughs]…has he gone home and thought, 'Silly woman. I wasn't criticising her.' Or, 'I was criticising her and she deserved it.' You know, there's still a little bit of me…yeah…but I can talk to Jane about that on Wednesday maybe. Or on Friday…we can think about it. But it might not…it might just go away…and I'm not…you know…it could just go away…I'll never know	The Group: "Difficult and Scary"

with my…with the mind…my mind…what'll happen. It just takes me by surprise.

Wanting a break from the intensity

I: Um…it's interesting that you said you can talk about it during your next session. Um…how do you find having…um…solo sessions and group sessions in the one week? A combination of them in the one week?

Wanting a Break from MBT

Sometimes wants to escape from feeling pressure to talk at MBT sessions. Perhaps a sense of attending out of duty or routine? But not really wanting to participate? Is MBT experienced as a duty here - she has to go but doesn't want to contribute? This results in her withdrawing.

R: Yeah. Yeah. Um…I think it's good…yeah. It's uh…I sometimes…I do sometimes think…'God, I could do with a break from all that.' Cos sometimes you think, 'If I didn't need to talk about all this…maybe I'd feel better'. It's like raking it up all the time…and having to discuss. Sometimes I do think, 'Oh god. I've gotta go to group. And I really don't wanna. I just want to keep it personal and private.' But then you can say that…and that's fine. But sometimes it doesn't actually do…you know – and then it could be brought up at a later date. Cos sometimes when it's very raw…something that's just – and you don't want to talk about it. You don't want to go back there. You're trying to move on. But in your head you don't move on. So…sometimes it is difficult. You think, 'Oh…I really don't want to sit there and have to talk about it.' And that's when…you find yourself…you withdraw. You withdraw from the group in a way. And it is noticed that you're quiet. Sometimes you feel able to just say, 'Well yeah, I'm just having…that's how I feel today. I don't want to really talk.' And other times that can open up the whole…you

"it's drawn out of you" - not wanting to talk but pressure put on to talk? - can be most "rewarding" sessions. A sense here that Sarah needs a push from others to express her feelings and that this can be very rewarding	know, you're quiet today and then…it's sort of…drawn out of you a bit…and then you do – and they're often the most rewarding…sessions. They can be. Yeah. But sometimes it is a bit of a drag…having to…you know, but you can…yeah.	"It's Drawn Out of You": Difficult but Rewarding
	I: Um…how do you find having the MBT every week – on a weekly basis?	
	R: I think…yeah, I think it has to be really. But it can be…yeah…it can be…hard work. Yeah.	
	I: So you think…it has to be every week…but…	
	R: But sometimes I wish I could have a break.	
	I: Okay. Okay. Yeah.	
Wants a break sometimes Is there a sense from Sarah that she must leave her comfort zone in order to engage in mentalisation?. Mentalisation does not come naturally to her. Therefore, she benefits when in situations when it is difficult to disengage, such as individual sessions.	**R:** And you do that in your head. You can't in the solo sessions though. In the group, if you're wanting a break from it, you just tend to want to listen to everybody else this week. And I've done that sometimes. But you can't in the one-to-one. You can't just sit there and not say anything. Well I suppose you could but it would be awkward [laughs]. Yeah. Yeah.	Wanting a Break Leaving Comfort Zone
	I: And when you say you feel like a break sometimes – why is that, do you think?	
Needs a break due to intensity Experiences discomfort when conflict in the group	**R:** Cos it can be so intense. Yeah. I know when there's been a session where there has been conflict it's been like, 'Oh' – you dread the next session. You think, 'Oh no. Is it going to be like last week?' Yeah. They're not very…they're few and far between, those…those kind…	Experiencing Conflict in the Group

Appendix 2-B

Superordinate Theme from Initial Transcript

Superordinate Theme

Group MBT: A “difficult and scary” experience

Emergent Themes

Fear of being judged/Feeling unsafe in the group
Experiencing feelings of loss
Leaving comfort zone
The group as unpredictable
“They’re going to be sick of me”
Feeling afraid in the group
Fear of being judged
Joining the group as anxiety-provoking
Initial desire for individual sessions only
Experiencing conflict in the group
Experiencing criticism
The group: “difficult and scary”
Experiencing criticism in the group
“Is it something I said to upset them?”
Fear of being judged
Group MBT: An uncomfortable experience
Fear of being judged
Worry about offending group member

Summary of Superordinate Theme

Sarah appears to experience the group component of MBT as an unpredictable, difficult and unsafe place. When she initially joined the group she found it anxiety provoking as the other members had already settled in and she was a new addition to the group. At the beginning of MBT she wished to attend individual therapy sessions only due to her feelings of fear and anxiety during group sessions. These feelings largely arise due to her fear of being judged within the group. It took Sarah many months to open up and begin to express herself in the group because of this. She explains that she expected the group members to be "appalled" when she spoke about her relationship with her son, which reveals the depth of her anxiety. Sarah states that she is more comfortable sitting back in group situations and therefore she has to leave her comfort zone to engage in the group. Indeed she wonders at times during group sessions when she is talking if the other group members are "going to be sick of me". Furthermore, she sometimes considers her topics of conversation to be "trivial" in comparison to topics discussed by others.

Sarah reflects on several experiences during group MBT that she found particularly difficult. She describes feeling criticised by another member of the group during a particular session when she spoke about her relationship with her son. She found this deeply upsetting and the experience had a strong physical impact on her also, "I couldn't look at him. My heart was pounding." Experiences such as this contributed to it being a "difficult and scary" place for her. Further uncomfortable experiences include Sarah wondering if she did something to upset group members when they are not present at a session. Sarah also describes a group member leaving the room suddenly when she was in conversation with her and she worried that she had said something to offend her. This difficult relational experiences make the group an uncomfortable place for Sarah. Indeed it is not just Sarah's relationships with the other group members that have an impact her as she explains that conflict between other group members also affects her and leads to uncomfortable feelings. Furthermore, even though Sarah has built positive relationships with other group members she describes feelings of pain and loss when such members have left the group.

Overall, Sarah appears to experience the group as an overwhelming environment. This may be related to the importance that she places on trust and feeling that she can trust several people within a group has been a challenging experience for her. Due to her difficulty predicting the responses and behaviours from the other group members, she is often left feeling unsettled and unsafe during group sessions. Although it seems to have become a less threatening environment for her over time due to her ability to build relationships and trust over time, it is still experienced as an unpredictable place that can lead to uncomfortable and distressing feelings.

Appendix 2-C

Final Superordinate Themes

Final Superordinate Theme	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6	Participant 7
	Sarah: Emergent Themes	*Jo: Emergent Themes*	*Kevin: Emergent Themes*	*John: Emergent Themes*	*Ruth: Emergent Themes*	*Laura: Emergent Themes*	*Lisa: Emergent Themes*
Experiencing group MBT as unpredictable and challenging	**Theme 1** *Fear of being judged/Feeling unsafe in the group* *Experiencing feelings of loss* *Leaving comfort zone* *The group as unpredictable* *"They're going to be sick of me"* *Feeling afraid in the group* *Fear of being*	**Theme 1** *MBT group: feeling "adrift"* *Group MBT: an uncomfortable experience* *Beginning the group: determined and anxious* *Worrying about group members* *Commitment and courage*	**Theme 1** *MBT sessions as invasive* *Beginning the group: an uncomfortable experience* *Challenges with group MBT*	**Theme 1** *The role of gender: struggling in the group* *Group MBT: "a battle of words"* *Group MBT: the importance of interaction* *Group MBT: struggling to contribute* *Group MBT: struggling to concentrate* *Disrupting the*	**Theme 1** *Group MBT: a challenging beginning* *Comparing own problems to others in the group* *Group MBT: struggling to contribute* *The group as a struggle* *Group MBT: needing support from facilitators*	**Theme 2** *Group MBT: coping with a challenging group member* *Group MBT: a challenging beginning* *Joining the group: "thinking and acting confidently"*	**Theme 1** *Feeling lost in the group* *Group MBT: a challenging beginning* *Starting the group: feeling abandoned*

	judged *Joining the group as anxiety-provoking* *Initial desire for individual sessions only* *The group: “difficult and scary”* *“Is it something I said to upset them?”* *Fear of being judged* *Group MBT: an uncomfortable experience* *Fear of being judged* *Worry about offending group member*			*group* *Group as challenging and “overpowering”* *Group MBT: contrasting atmosphere* *Pre-group anxiety*	*Comparing oneself to other group members* *Group MBT as “hard hitting”* *Beginning the group with support* *Group MBT: receiving support from facilitators* *Feeling uncomfortable around others* *“Invading” the group: a challenging experience*		

	Experiencing conflict in the group *Experiencing criticism* *Experiencing criticism in the group*						
Building trust: a gradual and important process during MBT	**Theme 2** *Individual therapist as ally in the group* *Individual therapist's presence in group as helpful* *Support from therapist* *Feeling challenged by individual therapist* *Feeling understood by individual therapist*	**Theme 1** *Group MBT as uncomfortable but necessary* *Rolling MBT group: mixed feelings* *Unusual relationship with group members* *Group MBT as "extra difficult" but useful* *Group MBT: taking risks*	**Theme 1** *Growing into the group over time* *Taking time to engage* *Feeling a "duty of care" to group members* *Trust as essential in group MBT* *Trust facilitating openness* *Learning to confront*	**Theme 1** *Group MBT: learning through listening* *Group MBT: hopes for the future* *Group MBT: positive future prospects* *MBT: learning to understand group members* *Group MBT: feeling understood*	**Theme 1** *New people joining the group: a difficult experience* **Theme 2** *The group as a learning process* *Relating to experiences of other group members* *Group MBT: feeling understood* *Gradually*	**Theme 2** *Group MBT: taking time to build trust* *Group MBT: the importance of trust* *Group MBT: the importance of having a common goal* *Identifying with MBT group members* *Identifying with group members* *Group MBT:*	**Theme 1** *Struggling with the social aspect of the group* *Learning to tolerate the group* *Group MBT: becoming more comfortable* *Group MBT as triggering a social difficulty* *Group MBT: anxiety about new members joining*

	Gradually building trust with individual therapist *Trust takes time/Learning to trust* *Therapist as source of support* *Therapist as source of support in group* *Learning to understand individual therapist* *Feeling cared about* *Feeling supported in the group* *Feeling supported*	*Previous experiences of group therapy as influence on approach to MBT* *Rolling group: learning from other group members* *Identifying with other group members* **Theme 2** *Valuing the individual therapist* *Effective therapists* *Individual sessions as safe and predictable* *Individual therapy as predictable versus group*	*difficulties* *Trust as essential in the group* *Group MBT: negative impact of new members* *New members as disruptive to the group* *Opening up in the group: intimidating but essential* **Theme 2** *Individual sessions as a support during difficult personal times*	*Group MBT: feeling understood* *Identifying with group members* **Theme 2** *MBT: Providing an opportunity to talk to others* *The importance of talking, listening & understanding*	*feeling part of the group* *Building trust: the group as a representation of outside world* *Building a “close knit” group through sharing difficult experiences* *Talking in the group as beneficial* *Building trust with the group* *Group MBT: challenging but important* **Theme 3** *Individual MBT: learning to talk to and trust others*	*respectful and supportive*	

	Trust takes time *Group as supportive* *Support from group* *Group as support for life situations* *Building trust in the group* *Group as a support in difficult times* *Identifying with other group members* *Disrupting the group: new person joining* *New person joining: unsafe and unpredictable*	*therapy as unpredictable* *MBT therapists as effective facilitators* *Individual therapy: providing support through a difficult time* *Same therapist in group and individual: "mostly it's good"* *Feeling cared for by the MBT programme*			*Individual as easier than group sessions*		

	Theme 3 *The group: a difficult but powerful learning experience* *The group: confronting real life situations* *Feeling empowered in relationships* *“It’s drawn out of you”: difficult but rewarding* *Experiencing a breakthrough with help from therapist*						
Putting the Pieces Together: Making Sense of the Overall MBT Structure	**Theme 3** *Appreciating MBT* *Regular MBT: Experiencing consistency* *MBT: an intense*	**Theme 1** *A frustrating and “cold” experience* **Theme 2** *Using individual sessions to*	**Theme 3** *MBT: providing routine* **Theme 2** *Gap between individual and group sessions*	**Theme 2** *Individual therapy: No interruptions* *Individual MBT: Space to talk & learn new*	**Theme 3** *Individual MBT: the “most rewarding” sessions* **Theme 4** *MBT: finding a*	**Theme 3** *Individual therapy: the importance of having a designated slot* *MBT light: an appropriate*	**Theme 2** *Questioning group therapy* *Questioning the purpose of the group* *Group MBT: A*

	experience *Experiencing MBT as a secret* *Individual versus group sessions: differences regarding pressure to talk* *Wanting a break from MBT* *Wanting a break* *Individual sessions as catalyst for opening up in group sessions* *Individual sessions as link to group sessions*	*understand behaviour in group sessions* *Having two therapists in group as beneficial* *Individual therapy as essential component of MBT* *MBT: knowing “what to expect”* **Theme 3** *A “tough type of therapy”* *A tough therapy* *A big commitment* *Struggling to manage MBT*	*as too long* *Individual sessions: “that is where it all comes together”* *Individual sessions as productive* *Individual sessions as a support for group sessions* *Individual and group MBT: gap too wide* *Individual sessions: confronting difficulties* *Gap between individual and group sessions as too long* **Theme 4**	*perspectives* *Individual therapy: no interruptions* **Theme 4** *MBT as a “let-down”* *Difficult transition from introductory group to full programme* *Introductory group: feeling uncertainty* *Disrupted transition from introductory group to full programme*	*“middle ground”* *Individual therapy: reflecting on the group* *Expectations about MBT: finding a middle ground* *MBT: struggling to find “steady feelings”* *Integrating MBT into weekly routine* *Group and individual sessions providing separate and complementary functions* *Individual and group MBT: a*	*introduction* *Reflecting on the group in individual MBT* *Group MBT: a valuable “stepping stone”* *Individual and group MBT: an effective combination* *Experiencing MBT therapists as an integrated team* *Valuing support in group MBT* *Group MBT: a safe place to interact with others* *Individual MBT: a*	*frustrating experience* *Group MBT: lack of space* *Group MBT: feeling frustrated* *MBT: failing to meet expectations* *Group MBT: a frustrating experience* *Group MBT: looking for equal time and structure* *Group MBT: lack of structure* *Tuning out during group MBT* *Group MBT:*

		Struggling to manage MBT	*Lack of support outside of MBT* *Feeling judged outside of MBT* *Feeling dismissed & judged by other mental health services* *MBT: feeling understood* *MBT vs other services: lack of cohesion* *MBT: different to previous care* *MBT as something different to & better than other services* *Expectations of MBT influenced by past*		*good balance* *A smooth transition into full programme MBT*	*positive experience* *MBT: a worthwhile commitment* *Mentalisation: exploring the past and present* *Having space to talk to a professional as supportive* *MBT: being “ready to talk”*	*lack of structure* *Group MBT: finding a therapeutic value* *Group MBT: A disruptive experience* *Failing to meet expectations in the group* *Group MBT: a shift in perspective* **Theme 3** *An excessive gap between group and individual sessions* *Individual and group sessions: an excessive gap*

			experiences *Frustration prior to MBT* *Time wasted prior to MBT* *Disconnection between MBT & other professionals* *Lack of cohesion between MBT & other services* *Feeling judged in other services* *Feeling judged before MBT* *Lack of understanding outside of MBT* *Negative experiences*				*MBT light: a lack of transition* *Group MBT: lack of openness* *Individual sessions as a platform for containing frustration* *Individual therapy: a positive experience* *Individual MBT: learning to mentalise* *MBT light versus group MBT* *Lack of integration between individual and group sessions*

			outside of MBT				*Individual MBT as "proper therapy"*
Seeing the World Differently due to MBT: A Positive Shift in Experience	**Theme 3** *Experiencing curiosity* *Experiencing different perspectives* *Mentalising: examining the facts* *"Name and shaming" behaviours* *Making sense of mentalising* *"Getting other perspectives"* *Mentalising: waiting to calm down* **Theme 4**	**Theme 3** *Progress in MBT: "up and down"* *Learning mentalisation techniques* *Struggling due to personal situation* *A battle between logic and what seems manageable* *No magic button: a scary reality* *Comparing MBT to other therapies* *Struggling to*	**Theme 1** *New insight into difficulties through different perspectives* *The group: gaining other perspectives* **Theme 3** *Mentalisation: becoming calmer* *Recognising negative patterns* *Gradual Change* *Mentalisation: increasing awareness*	**Theme 3** *MBT: "light at the end of the tunnel"* *MBT: thinking & reflecting* *Making sense of mentalisation* *Mentalising reducing challenging behaviours*	**Theme 3** *Individual therapy: becoming more self-aware* *Mentalisation: Seeing things differently and "broadening my mind"* *Sharing & confronting difficulties as important* *Individual therapy as a catalyst for seeing different perspectives* *Increasing awareness through MBT*	**Theme 1** *Learning to take responsibility* *MBT as an effective therapy* *Finding solutions through mentalisation* *MBT facilitating positive change* *Struggling to contain emotions* *MBT: Struggling to contain emotions*	**Theme 4** *Becoming stronger and more aware* *Improving due to individual therapy* *Making sense of mentalisation* *Individual sessions: becoming more self-aware* *Individual therapy as a platform for enhancing relationships* *Becoming more self-aware*

	Learning to accept feelings *Feelings: “overwhelming” and “normal”* *Counteracting “collateral damage”* *Gaining clarity* *Learning to “take more care of meself”* *Learning to be aware* *Feeling empowered in relationships* *The group: confronting real-life situations* *Increasing self-awareness*	*mentalise during difficult time* *Making sense of MBT techniques*	*Looking from the outside “on a fence”* *MBT increasing awareness* *Accessing mentalisation tools* *Learning to “open up”* *Before and after MBT* *Seeing things differently through mentalising* *Mentalisation: recognition and changing perceptions* *Relating to people outside the group*		*Learning mentalisation techniques*	*MBT: Increasing self-awareness* *Seeing things differently: a powerful shift* *Enhancing relationships with mentalisation* *Becoming self-aware through group MBT* *Feeling better due to MBT* *Replacing destructive coping strategies with mentalisation* *Gaining control through mentalisation* *Containing emotions*	

	Gradual positive change *Adverse life circumstances as opportunity for growth* *MBT facilitating change of "mindset"* *Confronting difficulties* *Becoming more rational* *Experiencing a breakthrough with help from therapist* *The group: a difficult but powerful learning experience* *MBT versus previous therapies:*		*Relationships: opening up but feeling vulnerable* *Mentalisation: increasing understanding of others* *MBT more productive than CBT*			*through mentalisation* *Making sense of overwhelming emotions through psycho-education*	

	tougher but more helpful						

Appendix 2-D: Instructions for Authors for Journal of Mental Health

Instructions for Authors

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form.

Submissions

All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at http://mc.manuscriptcentral.com/cjmh . New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

Keywords

Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice.

Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association , and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:
a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. Magnetic Resonance Imaging, 18 , 351–355.
b) For books:

Powell, T.J. & Enright, S.J. (1990) Anxiety and Stress management . London: Routledge
c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry & F. Watts (Eds.), A Handbook of Skills and Methods in Mental Health Research (pp. 75–89). London:Lawrence Erlbaum.

Illustrations should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

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Section Three:

Critical Appraisal of the Paper 'Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives'

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Introduction

This critical appraisal begins with an overview of the main findings from my research paper, followed by an account of how I chose the topic. I explore the suitability of IPA as the methodological approach utilised in this study and key learning points that I acquired during the study are discussed. These relate to specific experiences that I had during recruitment, data collection and analysis.

Research Paper: Overview of Results

I conducted a research paper on how service users experience attending mentalisation-based treatment (MBT) as a therapy for difficulties associated with borderline personality disorder (BPD). MBT is an 18-month programme that consists of concurrent weekly individual and group therapy. The aim is to stimulate and enhance mentalisation capacity, which involves increasing understanding and awareness of one's own mental states and the mental states of others. All participants experienced the group component of MBT as challenging and sometimes frightening, particularly in the early stages of the programme. The unpredictability of the group was difficult for the service users who sometimes perceived other group members as threatening or critical. Furthermore, building trust during individual and group therapy, with both therapists and other group members, was highlighted as a priority. This was achieved without much difficulty during individual therapy but was more of a challenge during group therapy which was a less secure and safe place for participants. However, all but two participants could also see considerable benefits to this component. Interestingly, the two participants who placed limited value on the group had been attending MBT for a shorter time-period than each of the other participants.

Most participants found that individual therapy and group therapy complemented each other well during the programme, but the former was identified as the core and most important component. This was where everything came together and the benefits of the group were often dependent on reflections on group interactions during individual sessions. The majority of participants experienced pre-treatment as a useful lead-in to full programme MBT, although with limited benefit. One participant however, who had a much longer pre-treatment than all the other participants, struggled with a gap between pre-treatment and full programme and felt that he was overloaded with information. The primary benefit that participants achieved while attending MBT was learning to see the world differently through mentalising. This not only applied to external events and interactions with others, but also to therapy, mental health services and internal processes such as emotions. Implications for MBT were discussed which included sufficiently preparing service users for the unpredictability of the group component during pre-treatment and prioritising security and safety for service users during the initial stages of therapy.

Choosing a Topic and Methodological Approach

I became aware of MBT through my interest in BPD. From my experience on placements I had developed a keen interest in the potential link between childhood experiences and enduring mental health difficulties during adulthood. Furthermore, the link between difficult early experiences and attachment theory (Bowlby, 1973) is a topic that I am very interested in and in some of my placements I had come to understand difficulties associated with BPD through an attachment framework. Moreover, stigma and prejudice associated with BPD is well documented in the literature (e.g. Nehls, 2000) and this is something that I had witnessed on placements and also during a previous role as an assistant psychologist before I began the doctorate in clinical psychology. I felt that stigma and assumptions relating to BPD arose due to a lack of understanding amongst many staff working with individuals with this diagnosis. The most common example that I had seen was the assertion that service users were being intentionally challenging in order to receive attention. This was an assumption that I was eager to challenge when the opportunity arose but I was also keen to understand more about the origins of such assumptions relating to BPD.

Therefore, I decided that I would like to conduct some research in an area related to BPD and I began to search for potential gaps in the literature. I also liaised with the personality disorder lead in an NHS Trust who put me in touch with my field supervisor who was interested in supervising research on BPD. My field supervisor is a clinical psychologist and a MBT therapist and we discussed the possibility of conducting some research on MBT. As a trainee clinical psychologist I have a particular interest in intervention and believe that having a range of options for service users is important as individual preferences and needs should be taken into account. In fact, National Institute for Health and Care Excellence (2009) guidelines recommend taking into account service user preferences regarding psychological therapy for BPD emphasising that a choice should be provided where possible. From my experience dialectical behaviour therapy (DBT) is a commonly utilised intervention for BPD and I felt that exploring another intervention relevant to BPD would be worthwhile and timely.

Following a review of the literature on MBT I discovered that there was a robust quantitative evidence base for the therapy as a treatment for BPD but I was unable to discover any published qualitative research on this. This in itself was a significant gap as service user views of the treatment were not represented in the literature and I was eager to address this. Thus, whilst quantitative research found that MBT resulted in an improvement in difficulties associated with BPD, such as self-harm behaviour and interpersonal functioning, it was not possible to determine how well these quantitative measures matched with the experiences, desires and goals of service users. I considered a variety of research questions, such as how the process of change occurs in MBT. However, although quantitative studies indicate that change does occur during MBT I felt that it would be more appropriate to allow for all experiences due to the absence of service user perspectives to date. Therefore, following discussion with my field and academic supervisors I finally decided to simply explore how individuals experience an MBT programme for difficulties associated with BPD. My hope was that this would provide information about what service users find beneficial but also potential challenges in MBT that could result in suggestions for enhancing the therapy. I considered recruiting individuals who had completed a MBT course as they would be in a position to give a full account of MBT over an 18 month period. However, I felt that capturing the 'here and now' experience of attending MBT would be important in order to identify potential challenges in MBT that could be somewhat lost during recollection after the programme. Therefore, I decided to recruit individuals who were still attending the programme and I developed the following research question: How do adults with difficulties associated with BPD experience intensive out-patient MBT?

Selecting an Appropriate Qualitative Method

When I decided that I would be interested in learning about the experiences of individuals who were still in the process of attending a MBT programme for BPD I began to consider the design of the research and the most appropriate qualitative method for analysing data. I examined a few potential options for this. For example, I felt that thematic analysis would potentially be suitable as it examines and describes patterns and similarities across a set of transcripts and collates these patterns into themes (Braun & Clark, 2006). I also considered grounded theory which is used to collect, synthesise and analyse qualitative data in order to create a model or theory that provides an explanation of specific social processes (Charmaz, 2008; Starks & Trinidad, 2007). Whilst grounded theory would have been feasible, a more defined and specific research question would perhaps have been more suitable for this approach (e.g. developing a theory or model relating to the process of change during MBT). However, I felt that IPA was the qualitative method best suited to this research question. I will now provide some background information on IPA so that I can place my reasons for prioritising the method at this point in context.

Background information on IPA.

IPA is a qualitative approach that examines "how people make sense of their major life experiences" (Smith et al., 2009, p. 1). It draws on and combines teachings from three separate traditions: phenomenology, hermeneutics and idiography (Smith, 2004). Phenomenological philosophy focuses on the lived experiences of individuals and the meanings that they discern from them. Furthermore, individuals are considered to exist in relation to a world of relationships, language, culture and other external objects; their experiences, meanings and perspectives are thus considered in this context. Hermeneutics, however, examines interpretation and ponders the extent to which an original source can be understood by a third party. Finally, idiography emphasises the relevance of the particular or the individual in itself rather than merely considering the whole. This is in contrast to many psychological research approaches where participant data is examined at group level (Smith et al., 2009).

Thus, IPA holds a defined epistemological position. There is an understanding that although it focuses on the lived experiences and meanings of participants these phenomena can never be fully seen. This is where the concept of a double hermeneutic arises from as the researcher attempts to understand and interpret the meaning that the participant makes of their world. Therefore, the phenomenological and hermeneutic traditions are combined (Smith, 2004). As Smith et al. (2009) reveal, “Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen” (p. 37). Although IPA focuses on major life experiences of relatively small, homogenous samples it is also concerned with the particular or the individual within the sample due to the influence of the idiography tradition (Smith et al., 2009; Smith & Osborn, 2008).

Deciding on IPA.

There are a number of reasons why I deemed IPA to be a suitable approach for this study. This approach prioritises major life experiences and I felt that committing to an 18 month intensive programme in an attempt to find support for significant and often enduring interpersonal and/or emotional difficulties was a good example of this. The significant focus that IPA places on trying to understand rich, lived experiences relating to major life events seemed very relevant when thinking about what it is like for individuals to attend a MBT programme. Moreover, I felt that the strong emphasis on a double hermeneutic and interpretation could enhance and enrich these experiences and perhaps assist in the discovery of more meaningful findings than less interpretative approaches. A further element to IPA that I felt would be particularly useful is the idiographic component of the method to ensure that individual experiences would not be lost amongst the commonalities discerned from the data. This fits with my beliefs about the importance of being mindful of the individual's needs during therapy rather than assuming that encouraging results regarding therapy from generalised data will necessarily be beneficial to everyone. Furthermore, I felt that being able to explore and understand individual experiences as well as similarities would be particularly useful in helping to discover more about what it is like for service users to engage in MBT.

However, during the design stage of the project I attended a MBT interest group with professionals from a variety of NHS Trusts who were involved in running and facilitating MBT programmes. This presented me with an opportunity to provide information about the research and also to learn more about MBT. Some of the therapists who were present wondered if the potential sample for the study would be sufficiently homogenous for an IPA study as they had found that service user experiences differed greatly at different stages of the programme. This prompted me to reflect more on the role of homogeneity in IPA. Smith et al. (2009) outline the importance of having a relatively homogenous sample in an IPA study for whom the research question is meaningful. However, they emphasise that the parameters of homogeneity will vary from study to study and variance can sometimes be decided by the practicality of the available recruitment pool. I felt that this was relevant to this study as I considered the recruitment pool available to me to be somewhat restricted and that successfully recruiting a sample that had been attending for the same length of time would be challenging. Therefore, while a certain degree of homogeneity is necessary there is a distinct flexibility surrounding this element of IPA. This is highlighted by Smith et al. who emphasise that homogeneity can be adapted and that the parameters can change during the design stage for pragmatic reasons, "…if it is difficult to recruit participants from a particular group one may need to expand one's inclusion criteria or to change path and approach a different group" (p. 50). Following this review of IPA literature, in addition to discussion during supervision, I was content that interviewing a group of individuals who have each experienced difficulties associated with BPD and who each committed to an 18 month MBT programme involving two sessions per week would be sufficiently homogenous for an IPA study.

The Process of Conducting an IPA Study

The process of conducting an IPA study involved several different stages. I found that the process of recruitment, collecting data and using interpretation during analysis facilitated some interesting points of learning and reflection.

Recruiting Participants

In order to begin recruitment it was important for me to be in a position to inform individuals attending a MBT programme for BPD about the research. My field supervisor was in a position to provide a link with two MBT groups in the trust in which she worked. Furthermore, one of the benefits of attending the MBT interest day referred to above was that it provided me with an opportunity to inform MBT therapists from other Trusts about the research. As a result of this MBT therapists from two other Trusts agreed to pass on the information to individuals attending their respective MBT programmes. Therapists from a third Trust did not pass the information on to attendees at their MBT programme as there appeared to be some sensitivity within the Trust about somebody from outside collecting what could be viewed as performance or outcome data. Therefore, I initially had four MBT groups to recruit from within the region I was based. I decided that I would begin to recruit from these groups and depending on sample size I would then make a decision as to whether I would recruit from outside this region.

Gaining permission to pass information about the research on to certain MBT groups but not to others prompted me to consider the process of gaining access to potential participants for research and to reflect on gatekeeping. Gatekeeping in health research involves “the process of permitting or denying access to a selected research site” (Lee, 2005, p. 36). It is an important part of health research for a number of reasons, not least due to the potential vulnerability of service users (Lee, 2005; Mander, 1992). This is, of course, necessary as the interests of service users during health research should be paramount at all times and it is essential that participants are in a position to provide informed consent before participating in research (Wiles et al., 2007). Gallo et al. (2012) acknowledge the necessary role that gatekeepers should have in protecting vulnerable potential participants when there is a legitimate reason but they question their authority to do so otherwise and argue that their role should be limited. This is a particularly important point as restriction of participants in research due to gatekeeping can limit and narrowly define its parameters (Broadhead & Rist, 1976). However, Gallo et al. continue their argument by arguing that gatekeepers should have the authority to protect organisations' interests adding that individual interests and organisation interests are often connected.

This appears to have been the reason that I was unable to approach potential participants within the Trust referred to above. It raises a complex question as to how to balance the needs of the service user and the needs of the organisation with the importance of not restricting research. Ultimately in this situation the Trust had the power to make the final decision whereas perhaps a more balanced distribution of power, such as involving service users in the decision, would be more equitable. Furthermore, I believe that the ethical standards (e.g. confidentiality and anonymity) applied to research within the NHS would have protected the Trust from information becoming public regarding the performance of the MBT programme, whether negative or positive. Thus, whilst I believe that management and therapists in the Trust had genuine concerns it is also my view that it is important to reflect that service users in the Trust missed an opportunity to find out about research that they may have wished to participate in.

Collecting Data

Data was collected for this study through semi-structured interviews. This is the recommended form of data collection for IPA as it allows a flexibility that encourages participants to relate their experiences with depth and detail (Smith et al., 2009; Smith & Osborn, 2008). I reflected on each interview afterwards using a reflective diary, considering elements such as how I thought the interview progressed, how well I thought the interview flowed, how well the questions worked and how relevant the data was to the research question. The interview with the first participant progressed and flowed well and I felt that we developed a positive rapport throughout. However, there were also elements that I felt could be improved (see Appendix A for reflective diary following this interview) and I discussed the interview with my supervisor, who also listened to a recording of the interview. My supervisor felt that the final question on the topic guide (i.e. what does full programme MBT mean to you?) confused the interviewee. I concurred with this and decided to exclude this question from the schedule in future interviews. Furthermore, we agreed that although the interview went well in many respects and generated very relevant data, I sometimes asked questions from the topic guide that had been answered already through natural discussion. We agreed that although this was not problematic for this interviewee it could potentially be experienced as disruptive for another participant. I listened back to the interview and identified occasions when I did this. I reflected on feeling nervous during my initial interview and that I was perhaps overly keen to ensure that I could elicit as much relevant data as possible from the interview. However, on hindsight this information was already being generated through natural discussion and therefore sticking rigidly to the topic guide was not necessary.

Arthur et al. (2014) emphasise that when a topic guide is used too rigidly it can impose the researcher on the interview in a way that can interfere with a naturally flowing interview, which is most likely to produce in-depth and rich data. As its purpose is merely to guide topics, questions can be asked very differently depending on the participant. Thus, during the interviews that followed I endeavoured to only use the topic guide if I felt a relevant area had not been covered or if the flow of the conversation became somewhat stilted. Consequently, I ticked questions off the topic guide list as they were naturally covered during the interview to ensure that I would not unknowingly repeat questions at a later stage in the interview. During the initial interview I had probed for more information where relevant and returned to phrases or comments that the interviewee made if I felt they required further exploration - I continued this during subsequent interviews. I also continued to reflect on interviews after they took place. I felt that the next three interviews flowed very well and that relevant information was frequently generated without rigidly adhering to the topic guide. I also noted that a few topics started to naturally arise that were not on the original topic guide, e.g. the meaning attributed to mentalisation by participants and the impact of MBT on relationships outside of the MBT programme. Therefore, I added the following questions to the topic guide: 'What is your experience of mentalisation?' and 'Has attending the MBT programme had any impact on your relationships outside of the group?' I continued the interview style that I had been using for the remaining interviews with these extra questions added to the topic guide and felt that very relevant, in-depth data was generated from all seven interviews.

IPA Analysis and the Role of Interpretation

I am not an experienced IPA researcher and one of the challenges that I faced during analysis concerned the role of interpretation. Although I had included interpretation in initial comments in each of my transcripts, that interpretative element had not come across strongly in the first draft of my findings. Smith et al. (2009) describe different levels of interpretation that involve varying degrees of depth, adding that inexperienced IPA researchers can be too cautious. I believe that this initially applied to me as it felt like a risk to move beyond description. However, Smith et al also state that there is a limit to interpretation in IPA and that it should only be used in close alignment to the content of the transcript. Therefore, I endeavoured to increase my use of interpretation, albeit at different levels of depth, while also attempting to ensure that when adopted it did not move beyond the text or was not forced.

For example, John’s description of growing up in a family of “wrong mind readers” struck me as a rich and powerful metaphor to emphasise the absence of understanding (and mentalisation) in his childhood family environment. John did not actually state this so interpretation was required, although it did not seem like a significantly big leap to make. A deeper level of interpretation perhaps involved Laura's present description of group therapy as respectful and supportive whilst stating that the other group members are "not wanting to…hurt each other" as a way to emphasise this. I interpreted her use of the word "hurt" to imply an anxiety about the group becoming less safe and less predictable in the future even though she felt supported at that time. This was not explicitly stated by Laura but was my way of using the double hermeneutic to try to make sense of Laura's attempts to understand her experiences of group MBT.

Conclusion

In conclusion, this paper focused on my reflections of conducting an IPA study on MBT. I recalled how my interest in BPD and psychological intervention prompted me to choose a topic in this area. I described that after considering other methodological approaches I felt that IPA was particularly suited to the study's research question which simply asked how individuals with difficulties associated with BPD experience MBT. Conducting this study resulted in several learning points including personal reflections on gatekeeping in research and the use of topic guides in semi-structured interviews. Considering the role of interpretation in IPA analysis was a further key learning point.

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Appendix 3-A: Excerpt from Reflective Diary

Reflective Diary: Interview One

Overall, I felt that the interview with Sarah went well. Sarah and I were able to build rapport quite well and I felt that Sarah freely expressed herself. Although we mostly engaged in a free-flowing conversation I possibly stuck a bit too rigidly to the topic guide towards the end of the interview which I think restricted the interview a little as it seemed a bit more stop-start. It may also have been that I was probing for information when Sarah had no more information to give so in future interviews it would be better to keep the interview as natural as possible.

Although I was expecting the group component of MBT to be more challenging than the individual component, I was not expecting the depth of emotion expressed by Sarah in relation to the group component. On reflection, I went into the interview with some assumptions about group therapy (e.g. as a safe, contained version of the outside world where interpersonal skills can be built; as a place where service users can identify with and meet others with similar difficulties). Whilst some of these assumptions applied to Sarah to an extent the group did not seem safe or secure for Sarah on occasion and seemed quite frightening for her at times. Therefore, during analysis and during future interviews it will be important for me to bracket these assumptions about group MBT as much as possible.

Section Four: Ethics Documents

Ethics Documents for the Paper 'Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives'

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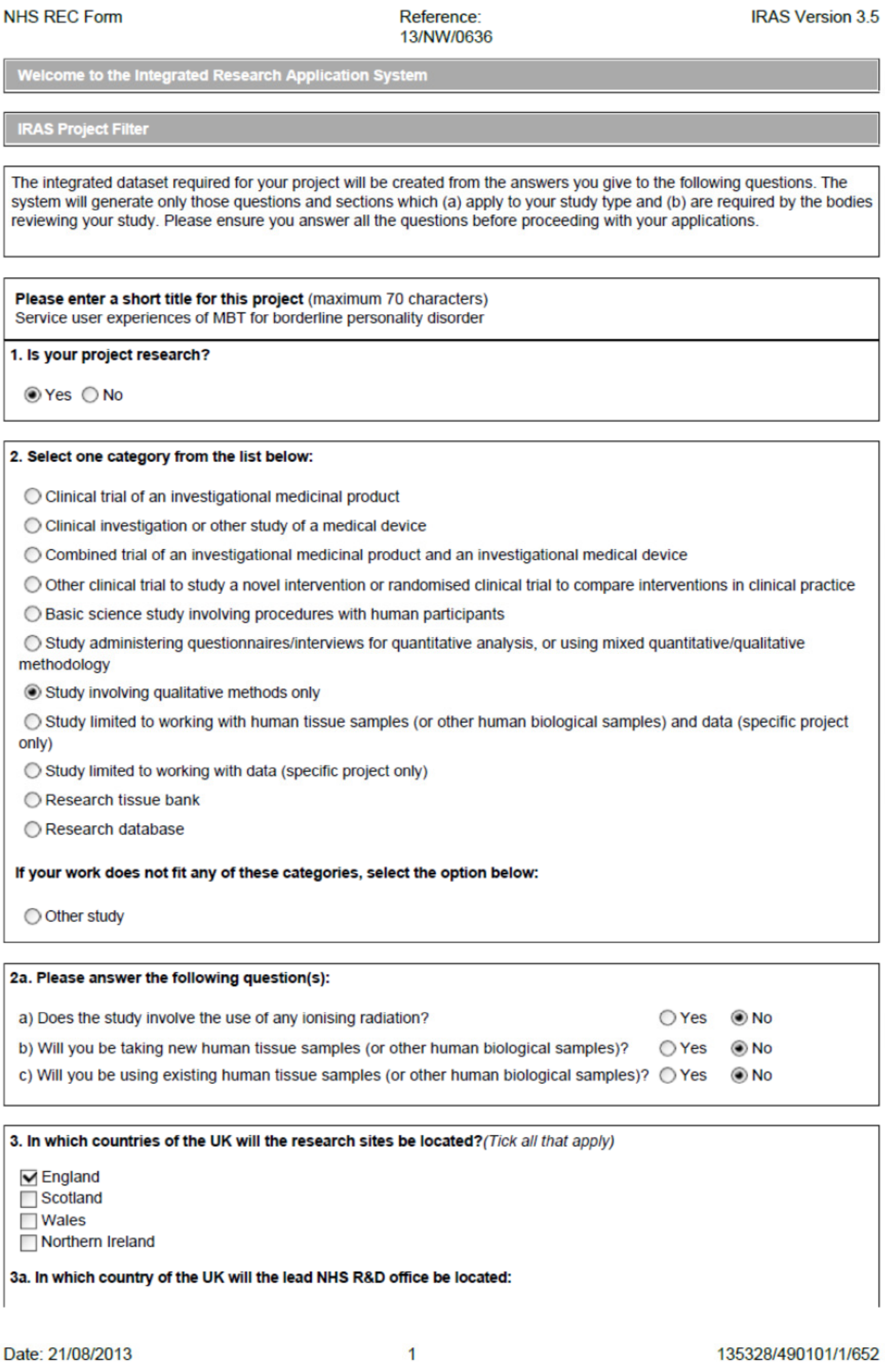
NHS IRAS Ethics Application

The following pages contain the NHS IRAS ethics application for the current study.



NHS REC Form | Reference: 13/NW/0636 | IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Service user experiences of MBT for borderline personality disorder

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
● Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

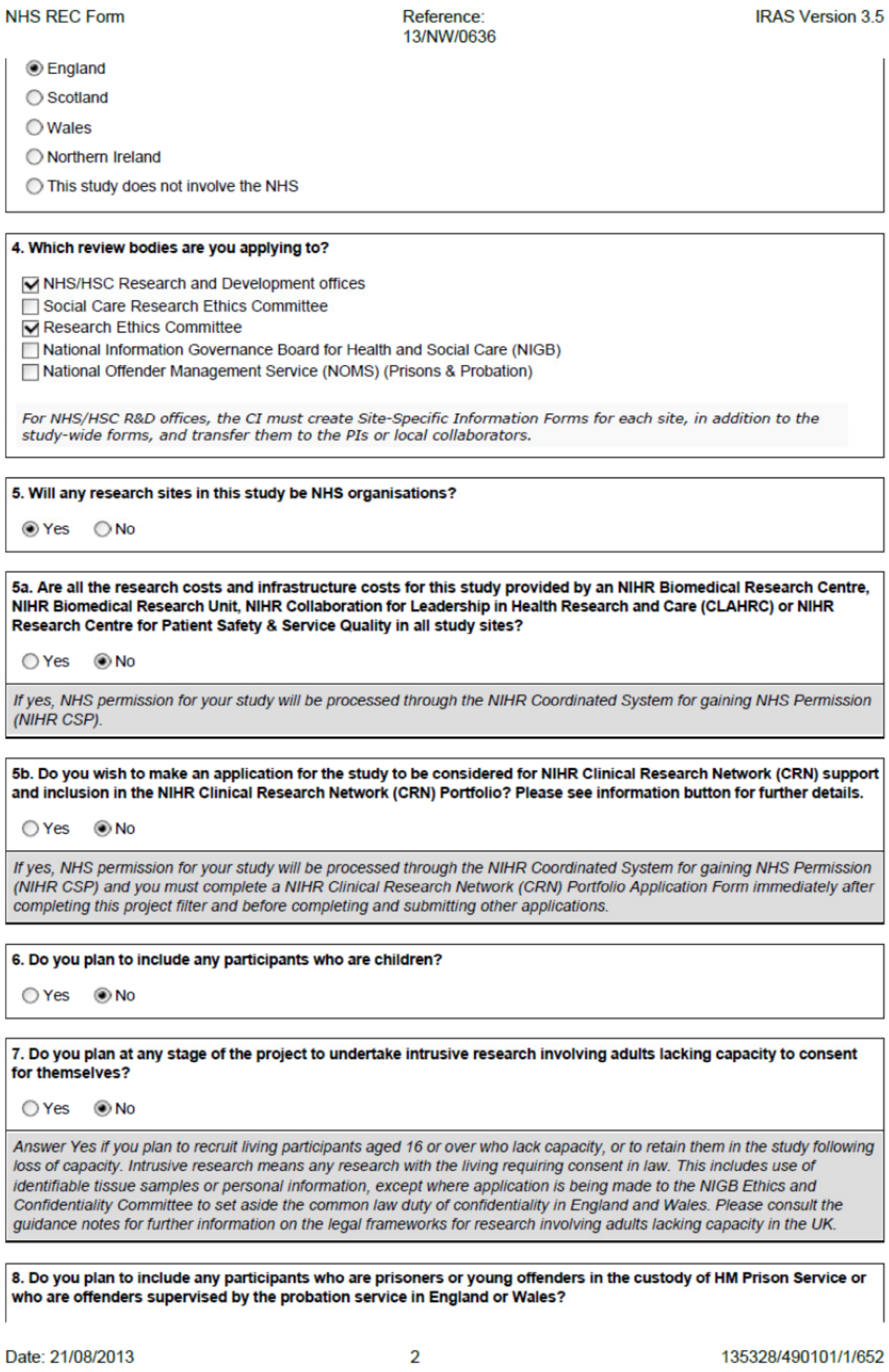
2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

3. In which countries of the UK will the research sites be located?*(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:



● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which review bodies are you applying to?

☑ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☑ Research Ethics Committee
☐ National Information Governance Board for Health and Social Care (NIGB)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

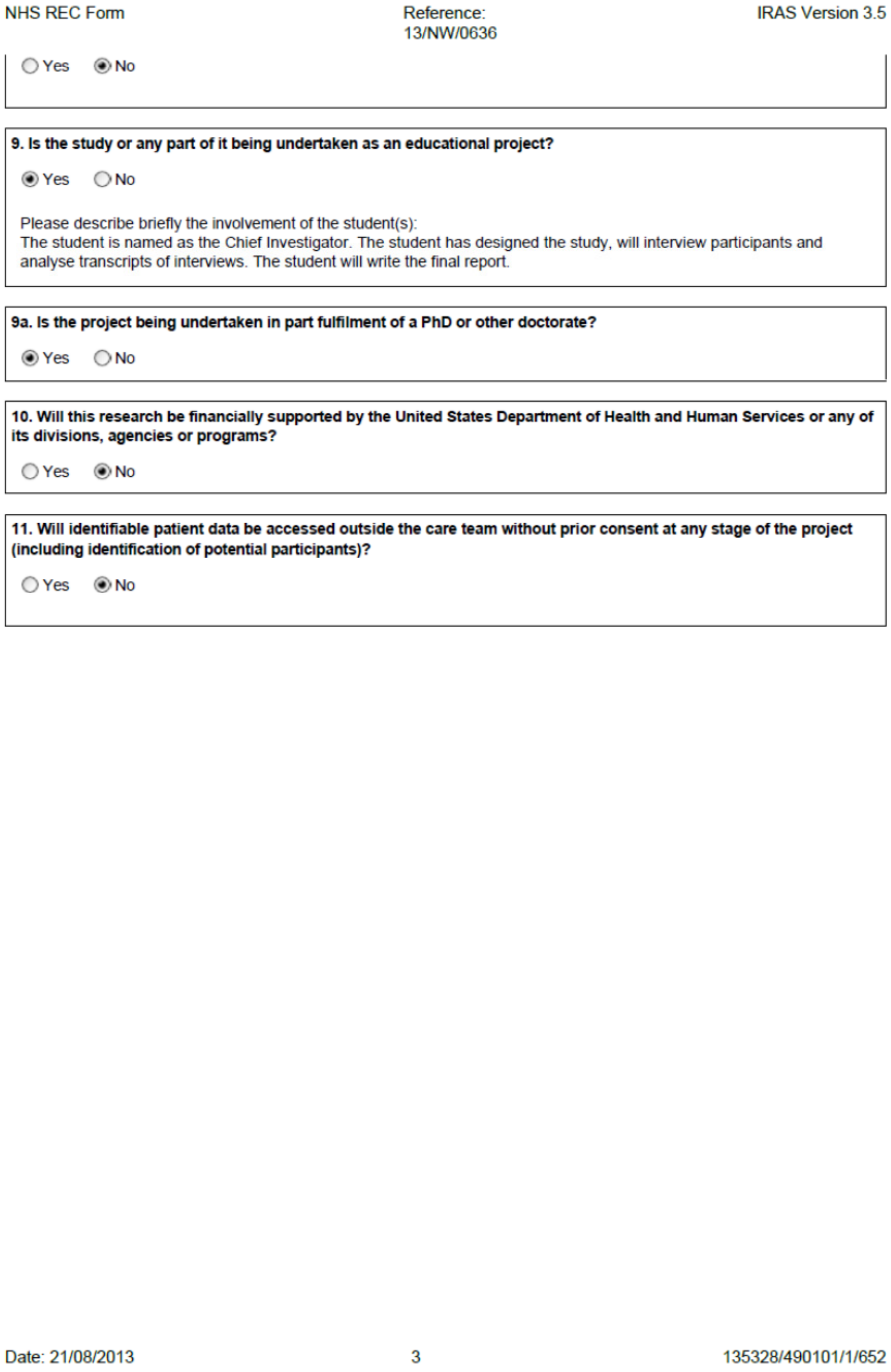
○ Yes ● No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?



○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
The student is named as the Chief Investigator. The student has designed the study, will interview participants and analyse transcripts of interviews. The student will write the final report.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

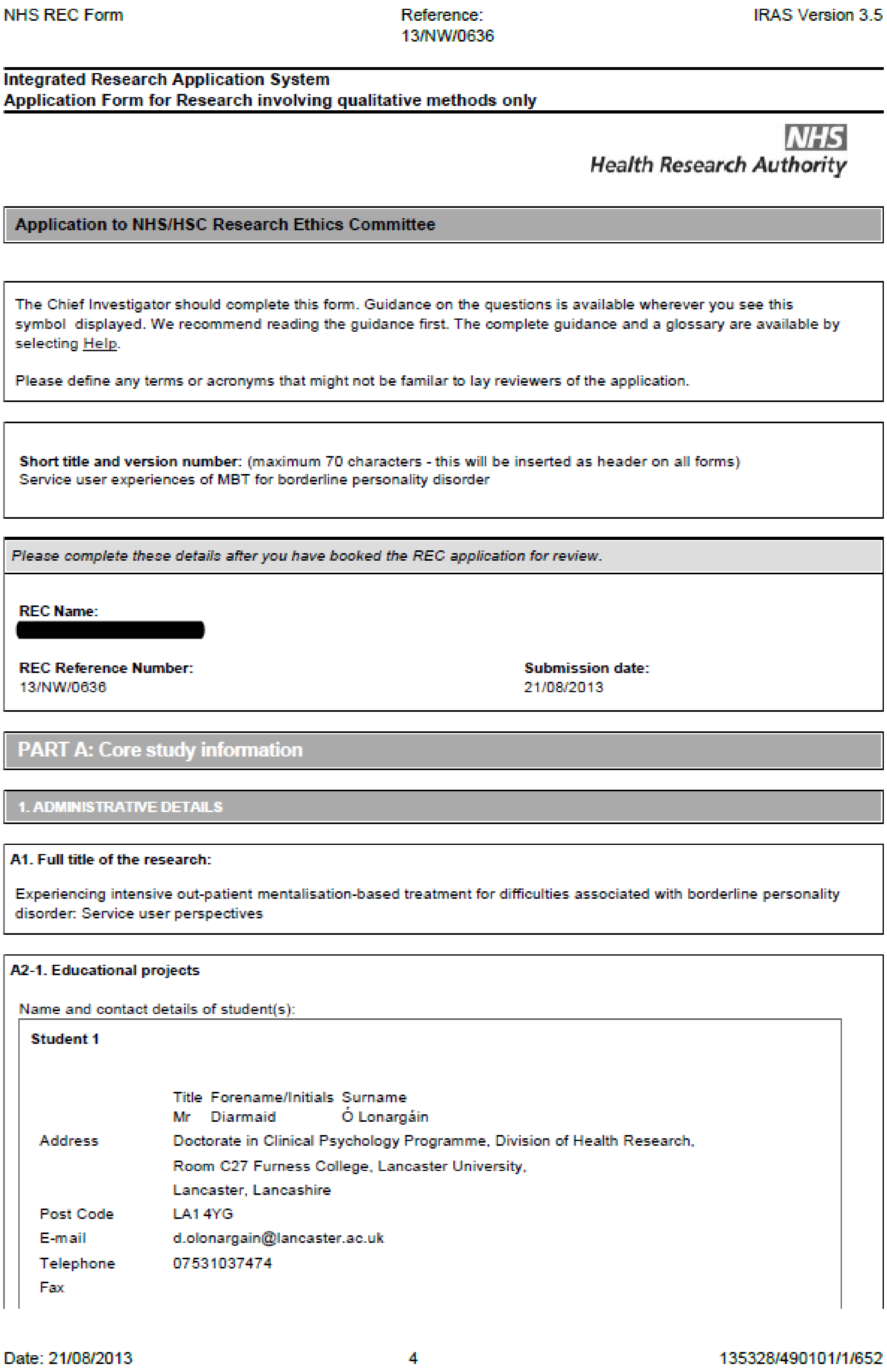
● Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No



Integrated Research Application System
Application Form for Research involving qualitative methods only

NHS
Health Research Authority

Application to NHS/HSC Research Ethics Committee

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Service user experiences of MBT for borderline personality disorder

Please complete these details after you have booked the REC application for review.

REC Name:
[redacted]

REC Reference Number: 13/NW/0636	**Submission date:** 21/08/2013

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives

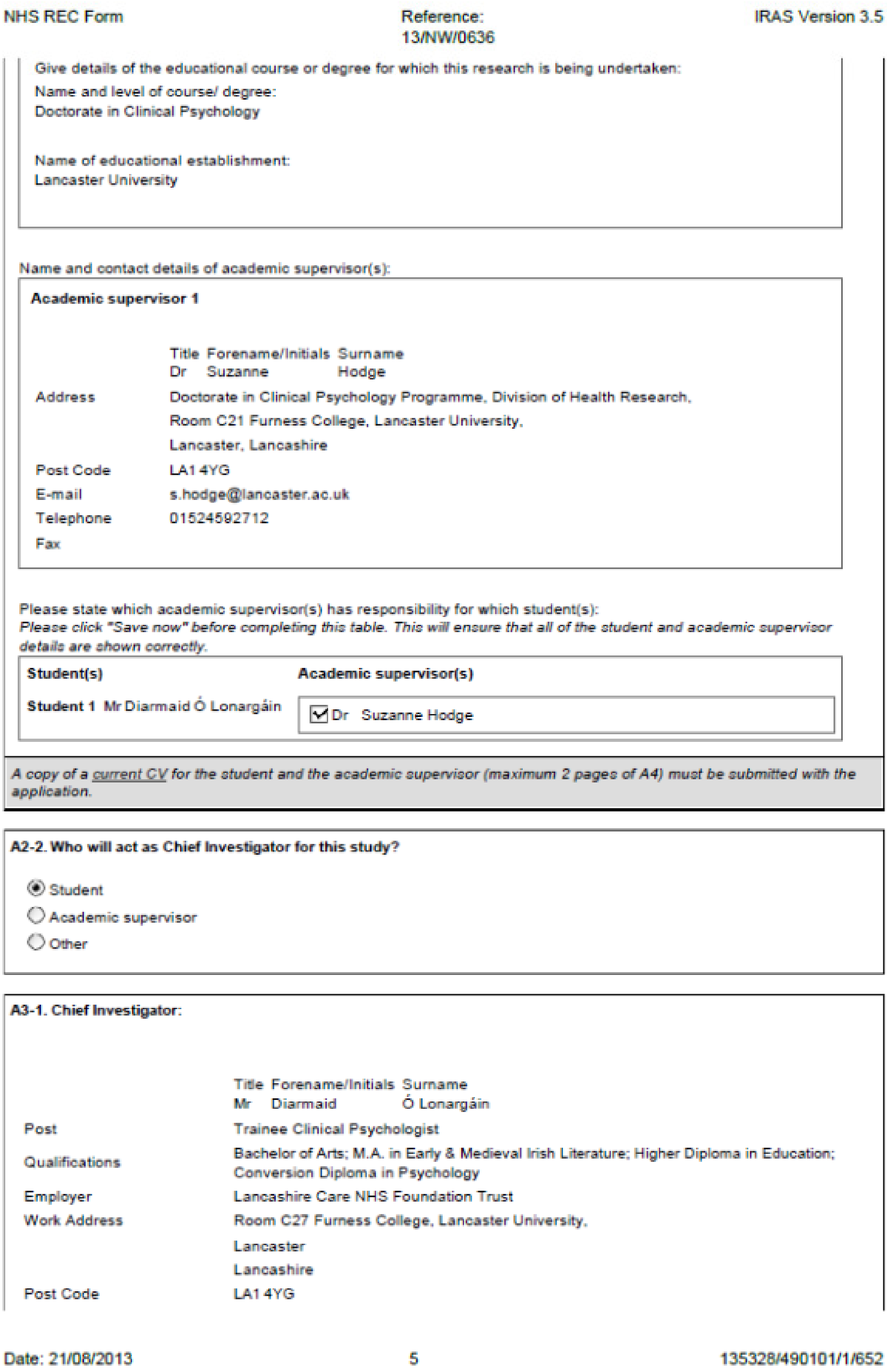
A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Mr	Diarmaid	Ó Lonargáin

Address: Doctorate in Clinical Psychology Programme, Division of Health Research,
Room C27 Furness College, Lancaster University,
Lancaster, Lancashire
Post Code: LA1 4YG
E-mail: d.olonargain@lancaster.ac.uk
Telephone: 07531037474
Fax:



Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Suzanne	Hodge
Address	Doctorate in Clinical Psychology Programme, Division of Health Research, Room C21 Furness College, Lancaster University, Lancaster, Lancashire		
Post Code	LA1 4YG		
E-mail	s.hodge@lancaster.ac.uk		
Telephone	01524592712		
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	**Academic supervisor(s)**
Student 1 Mr Diarmaid Ó Lonargáin	☑ Dr Suzanne Hodge

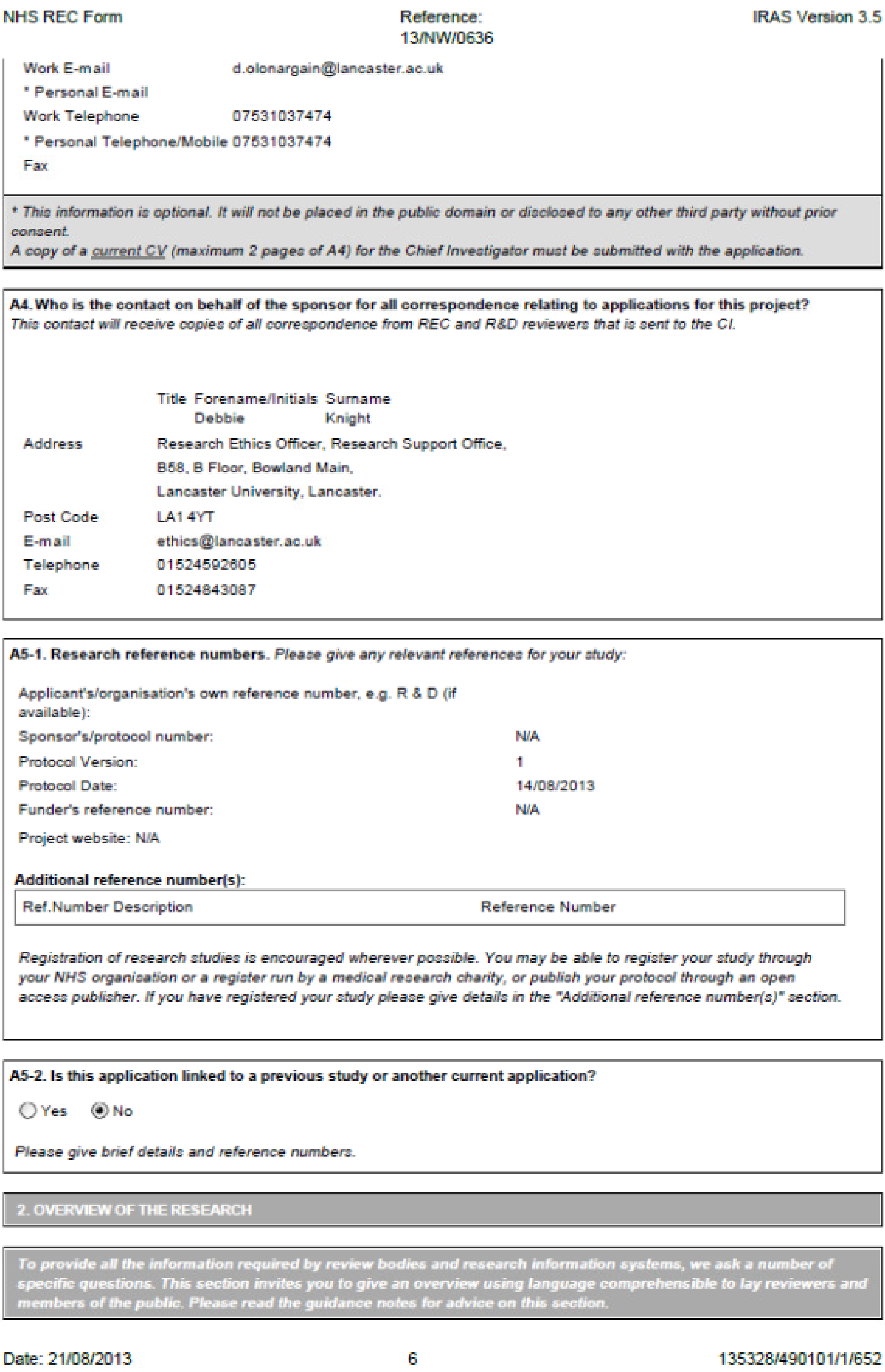
A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

● Student
○ Academic supervisor
○ Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Mr	Diarmaid	Ó Lonargáin
Post	Trainee Clinical Psychologist		
Qualifications	Bachelor of Arts; M.A. in Early & Medieval Irish Literature; Higher Diploma in Education; Conversion Diploma in Psychology		
Employer	Lancashire Care NHS Foundation Trust		
Work Address	Room C27 Furness College, Lancaster University, Lancaster Lancashire		
Post Code	LA1 4YG		



Work E-mail	d.olonargain@lancaster.ac.uk
* Personal E-mail	
Work Telephone	07531037474
* Personal Telephone/Mobile	07531037474
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

Title	Forename/Initials	Surname
	Debbie	Knight

Address Research Ethics Officer, Research Support Office,
B58, B Floor, Bowland Main,
Lancaster University, Lancaster.
Post Code LA1 4YT
E-mail ethics@lancaster.ac.uk
Telephone 01524592605
Fax 01524843087

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	
Sponsor's/protocol number:	N/A
Protocol Version:	1
Protocol Date:	14/08/2013
Funder's reference number:	N/A

Project website: N/A

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

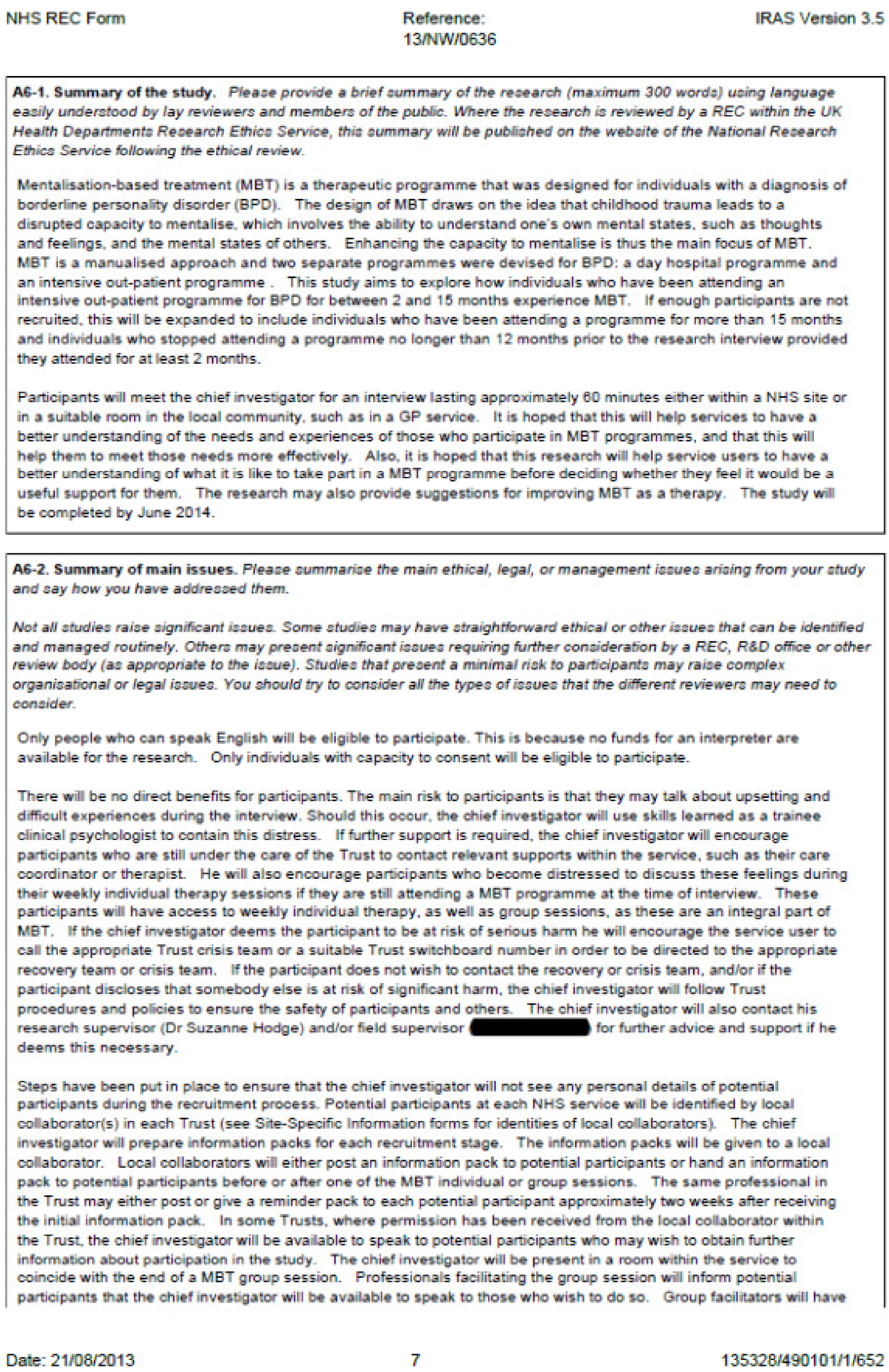
A5-2. Is this application linked to a previous study or another current application?

○ Yes ● No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.



A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.*

Mentalisation-based treatment (MBT) is a therapeutic programme that was designed for individuals with a diagnosis of borderline personality disorder (BPD). The design of MBT draws on the idea that childhood trauma leads to a disrupted capacity to mentalise, which involves the ability to understand one's own mental states, such as thoughts and feelings, and the mental states of others. Enhancing the capacity to mentalise is thus the main focus of MBT. MBT is a manualised approach and two separate programmes were devised for BPD: a day hospital programme and an intensive out-patient programme . This study aims to explore how individuals who have been attending an intensive out-patient programme for BPD for between 2 and 15 months experience MBT. If enough participants are not recruited, this will be expanded to include individuals who have been attending a programme for more than 15 months and individuals who stopped attending a programme no longer than 12 months prior to the research interview provided they attended for at least 2 months.

Participants will meet the chief investigator for an interview lasting approximately 60 minutes either within a NHS site or in a suitable room in the local community, such as in a GP service. It is hoped that this will help services to have a better understanding of the needs and experiences of those who participate in MBT programmes, and that this will help them to meet those needs more effectively. Also, it is hoped that this research will help service users to have a better understanding of what it is like to take part in a MBT programme before deciding whether they feel it would be a useful support for them. The research may also provide suggestions for improving MBT as a therapy. The study will be completed by June 2014.

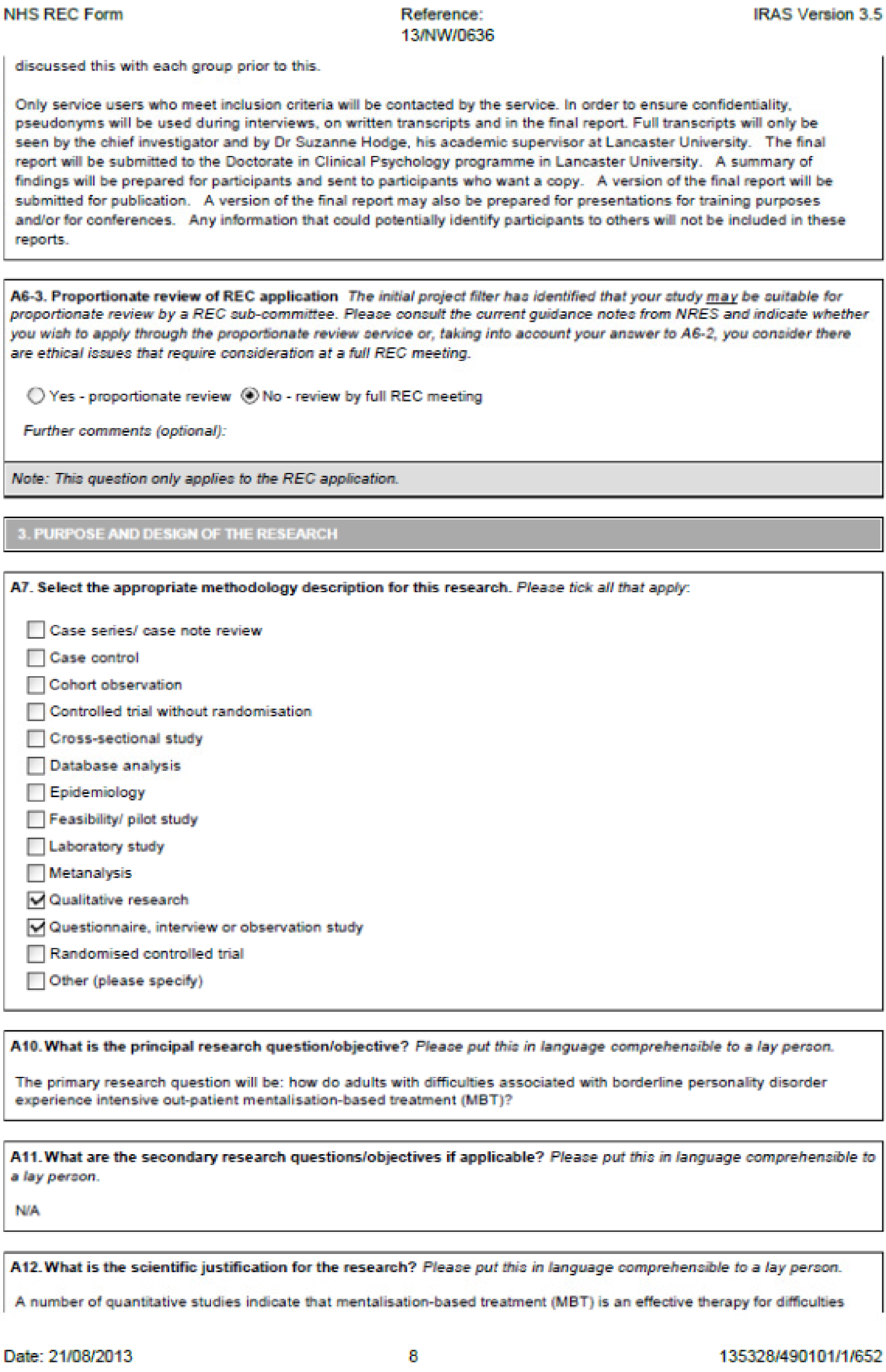
A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Only people who can speak English will be eligible to participate. This is because no funds for an interpreter are available for the research. Only individuals with capacity to consent will be eligible to participate.

There will be no direct benefits for participants. The main risk to participants is that they may talk about upsetting and difficult experiences during the interview. Should this occur, the chief investigator will use skills learned as a trainee clinical psychologist to contain this distress. If further support is required, the chief investigator will encourage participants who are still under the care of the Trust to contact relevant supports within the service, such as their care coordinator or therapist. He will also encourage participants who become distressed to discuss these feelings during their weekly individual therapy sessions if they are still attending a MBT programme at the time of interview. These participants will have access to weekly individual therapy, as well as group sessions, as these are an integral part of MBT. If the chief investigator deems the participant to be at risk of serious harm he will encourage the service user to call the appropriate Trust crisis team or a suitable Trust switchboard number in order to be directed to the appropriate recovery team or crisis team. If the participant does not wish to contact the recovery or crisis team, and/or if the participant discloses that somebody else is at risk of significant harm, the chief investigator will follow Trust procedures and policies to ensure the safety of participants and others. The chief investigator will also contact his research supervisor (Dr Suzanne Hodge) and/or field supervisor [redacted] for further advice and support if he deems this necessary.

Steps have been put in place to ensure that the chief investigator will not see any personal details of potential participants during the recruitment process. Potential participants at each NHS service will be identified by local collaborator(s) in each Trust (see Site-Specific Information forms for identities of local collaborators). The chief investigator will prepare information packs for each recruitment stage. The information packs will be given to a local collaborator. Local collaborators will either post an information pack to potential participants or hand an information pack to potential participants before or after one of the MBT individual or group sessions. The same professional in the Trust may either post or give a reminder pack to each potential participant approximately two weeks after receiving the initial information pack. In some Trusts, where permission has been received from the local collaborator within the Trust, the chief investigator will be available to speak to potential participants who may wish to obtain further information about participation in the study. The chief investigator will be present in a room within the service to coincide with the end of a MBT group session. Professionals facilitating the group session will inform potential participants that the chief investigator will be available to speak to those who wish to do so. Group facilitators will have



discussed this with each group prior to this.

Only service users who meet inclusion criteria will be contacted by the service. In order to ensure confidentiality, pseudonyms will be used during interviews, on written transcripts and in the final report. Full transcripts will only be seen by the chief investigator and by Dr Suzanne Hodge, his academic supervisor at Lancaster University. The final report will be submitted to the Doctorate in Clinical Psychology programme in Lancaster University. A summary of findings will be prepared for participants and sent to participants who want a copy. A version of the final report will be submitted for publication. A version of the final report may also be prepared for presentations for training purposes and/or for conferences. Any information that could potentially identify participants to others will not be included in these reports.

A6-3. Proportionate review of REC application *The initial project filter has identified that your study may be suitable for proportionate review by a REC sub-committee. Please consult the current guidance notes from NRES and indicate whether you wish to apply through the proportionate review service or, taking into account your answer to A6-2, you consider there are ethical issues that require consideration at a full REC meeting.*

○ Yes - proportionate review ● No - review by full REC meeting

Further comments (optional):

Note: This question only applies to the REC application.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

☐ Case series/ case note review
☐ Case control
☐ Cohort observation
☐ Controlled trial without randomisation
☐ Cross-sectional study
☐ Database analysis
☐ Epidemiology
☐ Feasibility/ pilot study
☐ Laboratory study
☐ Metanalysis
☑ Qualitative research
☑ Questionnaire, interview or observation study
☐ Randomised controlled trial
☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

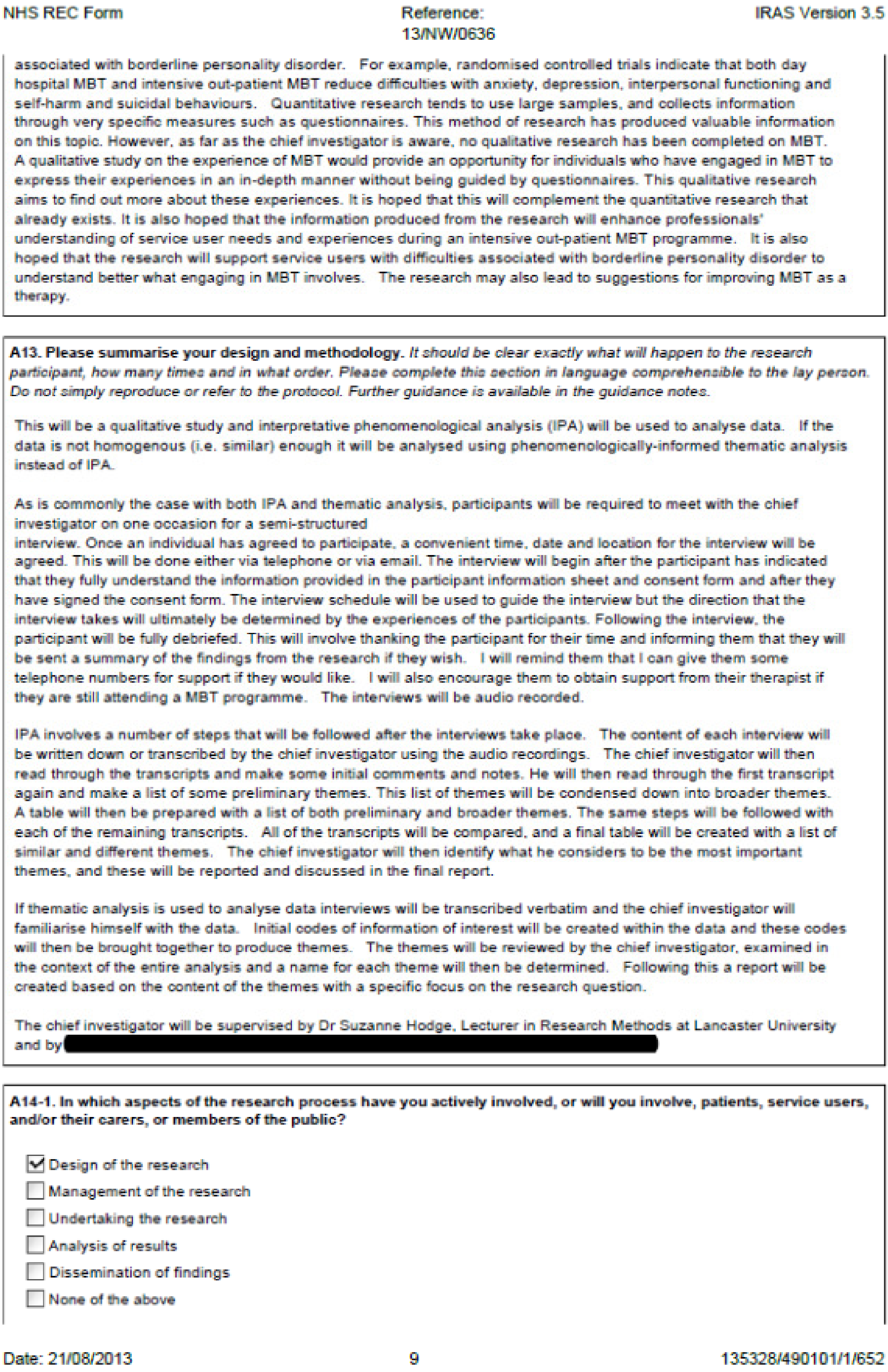
The primary research question will be: how do adults with difficulties associated with borderline personality disorder experience intensive out-patient mentalisation-based treatment (MBT)?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

N/A

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

A number of quantitative studies indicate that mentalisation-based treatment (MBT) is an effective therapy for difficulties



associated with borderline personality disorder. For example, randomised controlled trials indicate that both day hospital MBT and intensive out-patient MBT reduce difficulties with anxiety, depression, interpersonal functioning and self-harm and suicidal behaviours. Quantitative research tends to use large samples, and collects information through very specific measures such as questionnaires. This method of research has produced valuable information on this topic. However, as far as the chief investigator is aware, no qualitative research has been completed on MBT. A qualitative study on the experience of MBT would provide an opportunity for individuals who have engaged in MBT to express their experiences in an in-depth manner without being guided by questionnaires. This qualitative research aims to find out more about these experiences. It is hoped that this will complement the quantitative research that already exists. It is also hoped that the information produced from the research will enhance professionals' understanding of service user needs and experiences during an intensive out-patient MBT programme. It is also hoped that the research will support service users with difficulties associated with borderline personality disorder to understand better what engaging in MBT involves. The research may also lead to suggestions for improving MBT as a therapy.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

This will be a qualitative study and interpretative phenomenological analysis (IPA) will be used to analyse data. If the data is not homogenous (i.e. similar) enough it will be analysed using phenomenologically-informed thematic analysis instead of IPA.

As is commonly the case with both IPA and thematic analysis, participants will be required to meet with the chief investigator on one occasion for a semi-structured interview. Once an individual has agreed to participate, a convenient time, date and location for the interview will be agreed. This will be done either via telephone or via email. The interview will begin after the participant has indicated that they fully understand the information provided in the participant information sheet and consent form and after they have signed the consent form. The interview schedule will be used to guide the interview but the direction that the interview takes will ultimately be determined by the experiences of the participants. Following the interview, the participant will be fully debriefed. This will involve thanking the participant for their time and informing them that they will be sent a summary of the findings from the research if they wish. I will remind them that I can give them some telephone numbers for support if they would like. I will also encourage them to obtain support from their therapist if they are still attending a MBT programme. The interviews will be audio recorded.

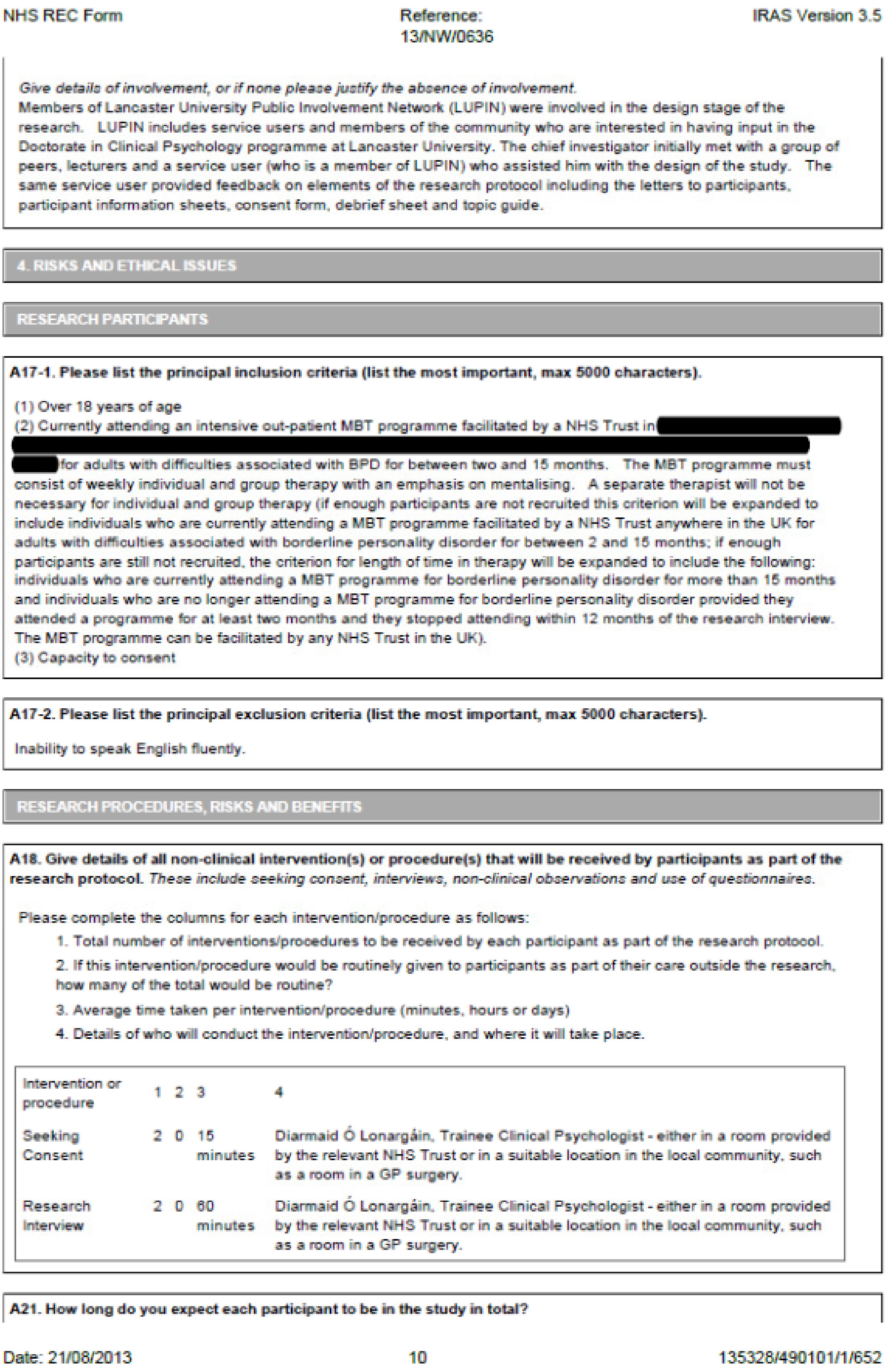
IPA involves a number of steps that will be followed after the interviews take place. The content of each interview will be written down or transcribed by the chief investigator using the audio recordings. The chief investigator will then read through the transcripts and make some initial comments and notes. He will then read through the first transcript again and make a list of some preliminary themes. This list of themes will be condensed down into broader themes. A table will then be prepared with a list of both preliminary and broader themes. The same steps will be followed with each of the remaining transcripts. All of the transcripts will be compared, and a final table will be created with a list of similar and different themes. The chief investigator will then identify what he considers to be the most important themes, and these will be reported and discussed in the final report.

If thematic analysis is used to analyse data interviews will be transcribed verbatim and the chief investigator will familiarise himself with the data. Initial codes of information of interest will be created within the data and these codes will then be brought together to produce themes. The themes will be reviewed by the chief investigator, examined in the context of the entire analysis and a name for each theme will then be determined. Following this a report will be created based on the content of the themes with a specific focus on the research question.

The chief investigator will be supervised by Dr Suzanne Hodge, Lecturer in Research Methods at Lancaster University and by [redacted]

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☑ Design of the research
☐ Management of the research
☐ Undertaking the research
☐ Analysis of results
☐ Dissemination of findings
☐ None of the above



Give details of involvement, or if none please justify the absence of involvement.
Members of Lancaster University Public Involvement Network (LUPIN) were involved in the design stage of the research. LUPIN includes service users and members of the community who are interested in having input in the Doctorate in Clinical Psychology programme at Lancaster University. The chief investigator initially met with a group of peers, lecturers and a service user (who is a member of LUPIN) who assisted him with the design of the study. The same service user provided feedback on elements of the research protocol including the letters to participants, participant information sheets, consent form, debrief sheet and topic guide.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

(1) Over 18 years of age
(2) Currently attending an intensive out-patient MBT programme facilitated by a NHS Trust in [redacted] for adults with difficulties associated with BPD for between two and 15 months. The MBT programme must consist of weekly individual and group therapy with an emphasis on mentalising. A separate therapist will not be necessary for individual and group therapy (if enough participants are not recruited this criterion will be expanded to include individuals who are currently attending a MBT programme facilitated by a NHS Trust anywhere in the UK for adults with difficulties associated with borderline personality disorder for between 2 and 15 months; if enough participants are still not recruited, the criterion for length of time in therapy will be expanded to include the following: individuals who are currently attending a MBT programme for borderline personality disorder for more than 15 months and individuals who are no longer attending a MBT programme for borderline personality disorder provided they attended a programme for at least two months and they stopped attending within 12 months of the research interview. The MBT programme can be facilitated by any NHS Trust in the UK).
(3) Capacity to consent

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Inability to speak English fluently.

RESEARCH PROCEDURES, RISKS AND BENEFITS

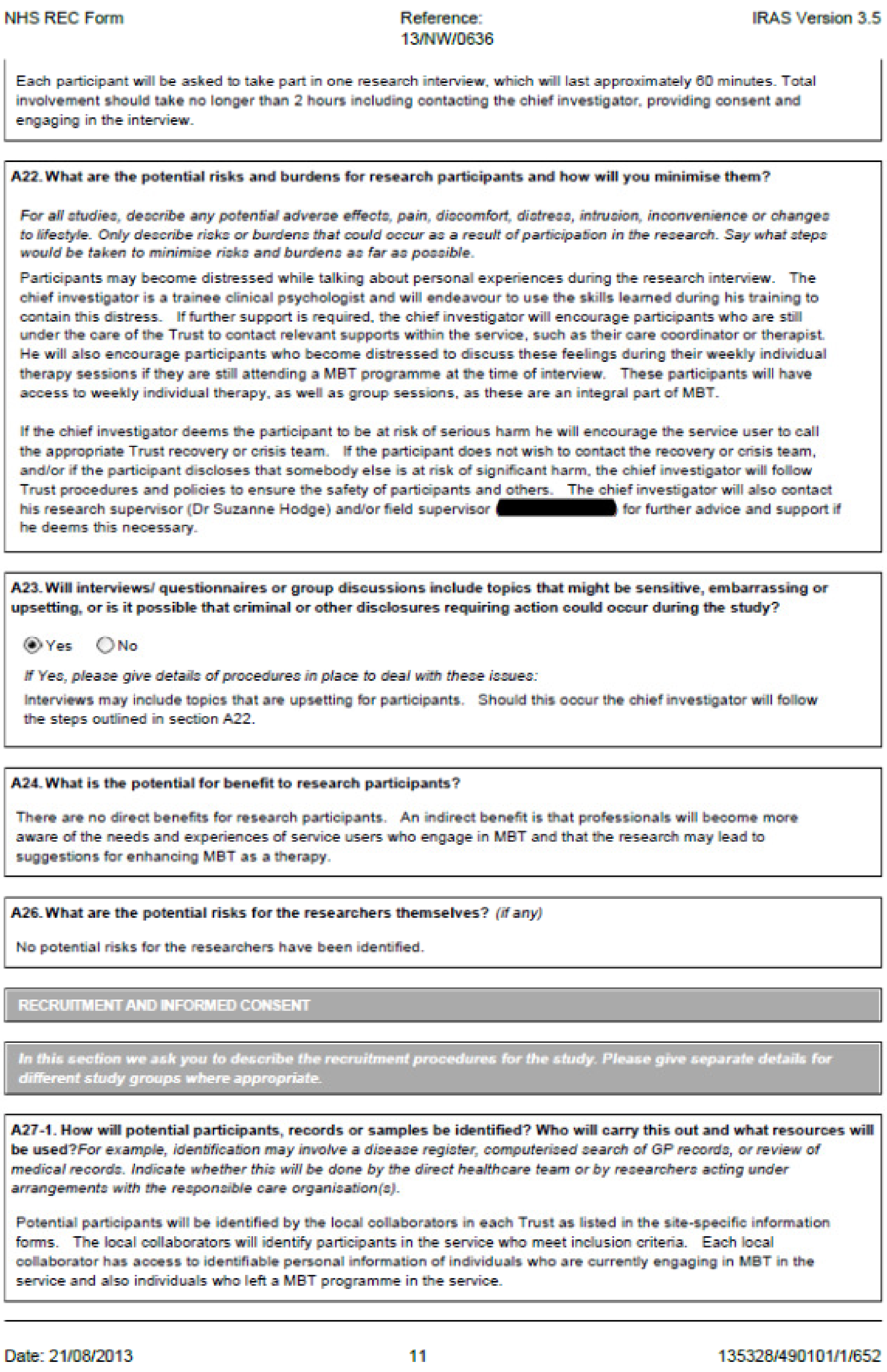
A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Seeking Consent	2	0	15 minutes	Diarmaid Ó Lonargáin, Trainee Clinical Psychologist - either in a room provided by the relevant NHS Trust or in a suitable location in the local community, such as a room in a GP surgery.
Research Interview	2	0	60 minutes	Diarmaid Ó Lonargáin, Trainee Clinical Psychologist - either in a room provided by the relevant NHS Trust or in a suitable location in the local community, such as a room in a GP surgery.

A21. How long do you expect each participant to be in the study in total?



Each participant will be asked to take part in one research interview, which will last approximately 60 minutes. Total involvement should take no longer than 2 hours including contacting the chief investigator, providing consent and engaging in the interview.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Participants may become distressed while talking about personal experiences during the research interview. The chief investigator is a trainee clinical psychologist and will endeavour to use the skills learned during his training to contain this distress. If further support is required, the chief investigator will encourage participants who are still under the care of the Trust to contact relevant supports within the service, such as their care coordinator or therapist. He will also encourage participants who become distressed to discuss these feelings during their weekly individual therapy sessions if they are still attending a MBT programme at the time of interview. These participants will have access to weekly individual therapy, as well as group sessions, as these are an integral part of MBT.

If the chief investigator deems the participant to be at risk of serious harm he will encourage the service user to call the appropriate Trust recovery or crisis team. If the participant does not wish to contact the recovery or crisis team, and/or if the participant discloses that somebody else is at risk of significant harm, the chief investigator will follow Trust procedures and policies to ensure the safety of participants and others. The chief investigator will also contact his research supervisor (Dr Suzanne Hodge) and/or field supervisor ([redacted]) for further advice and support if he deems this necessary.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

● Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

Interviews may include topics that are upsetting for participants. Should this occur the chief investigator will follow the steps outlined in section A22.

A24. What is the potential for benefit to research participants?

There are no direct benefits for research participants. An indirect benefit is that professionals will become more aware of the needs and experiences of service users who engage in MBT and that the research may lead to suggestions for enhancing MBT as a therapy.

A26. What are the potential risks for the researchers themselves? *(if any)*

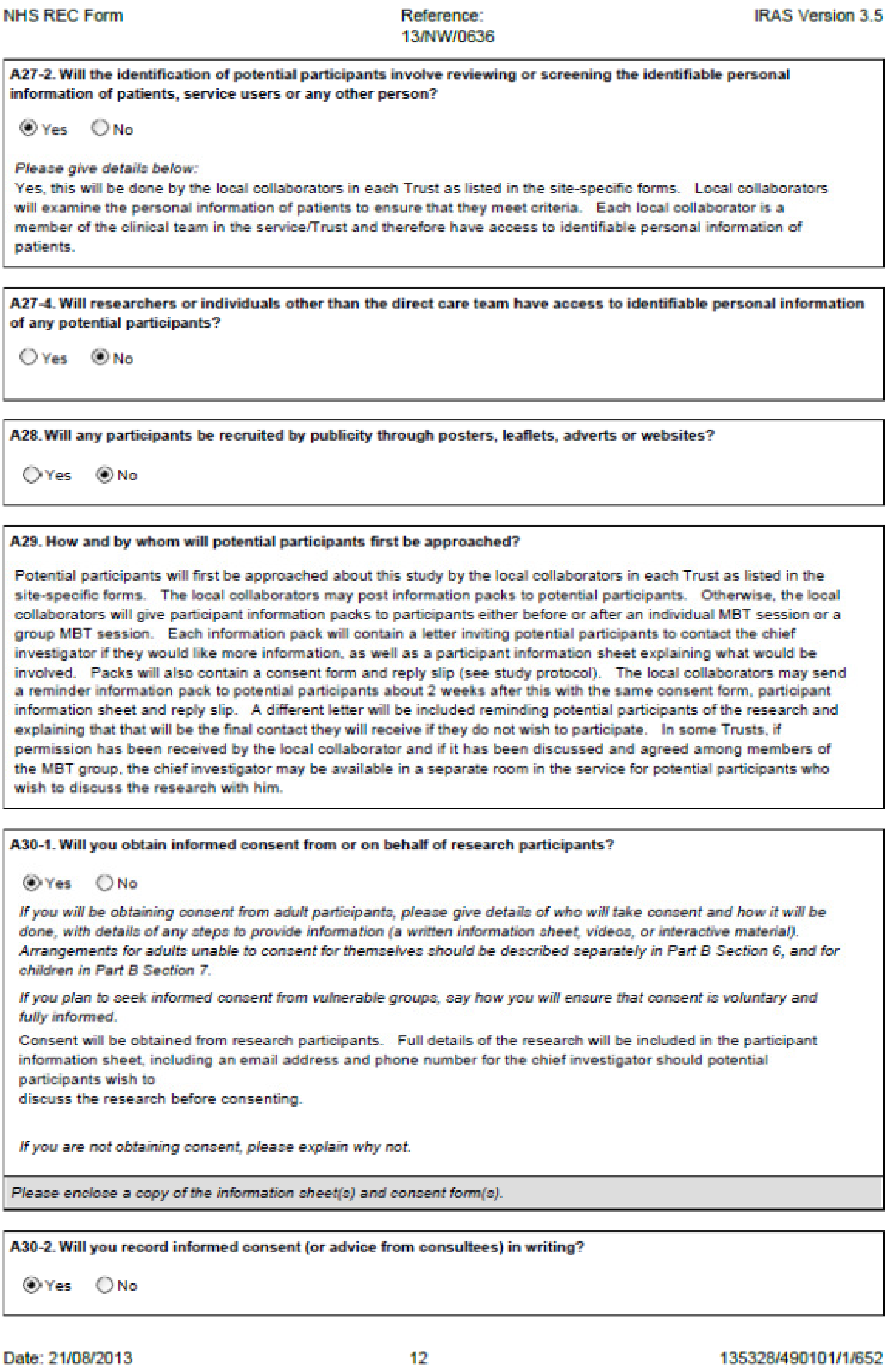
No potential risks for the researchers have been identified.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Potential participants will be identified by the local collaborators in each Trust as listed in the site-specific information forms. The local collaborators will identify participants in the service who meet inclusion criteria. Each local collaborator has access to identifiable personal information of individuals who are currently engaging in MBT in the service and also individuals who left a MBT programme in the service.



A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

● Yes ○ No

Please give details below:
Yes, this will be done by the local collaborators in each Trust as listed in the site-specific forms. Local collaborators will examine the personal information of patients to ensure that they meet criteria. Each local collaborator is a member of the clinical team in the service/Trust and therefore have access to identifiable personal information of patients.

A27-4. Will researchers or individuals other than the direct care team have access to identifiable personal information of any potential participants?

○ Yes ● No

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

○ Yes ● No

A29. How and by whom will potential participants first be approached?

Potential participants will first be approached about this study by the local collaborators in each Trust as listed in the site-specific forms. The local collaborators may post information packs to potential participants. Otherwise, the local collaborators will give participant information packs to participants either before or after an individual MBT session or a group MBT session. Each information pack will contain a letter inviting potential participants to contact the chief investigator if they would like more information, as well as a participant information sheet explaining what would be involved. Packs will also contain a consent form and reply slip (see study protocol). The local collaborators may send a reminder information pack to potential participants about 2 weeks after this with the same consent form, participant information sheet and reply slip. A different letter will be included reminding potential participants of the research and explaining that that will be the final contact they will receive if they do not wish to participate. In some Trusts, if permission has been received by the local collaborator and if it has been discussed and agreed among members of the MBT group, the chief investigator may be available in a separate room in the service for potential participants who wish to discuss the research with him.

A30-1. Will you obtain informed consent from or on behalf of research participants?

● Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

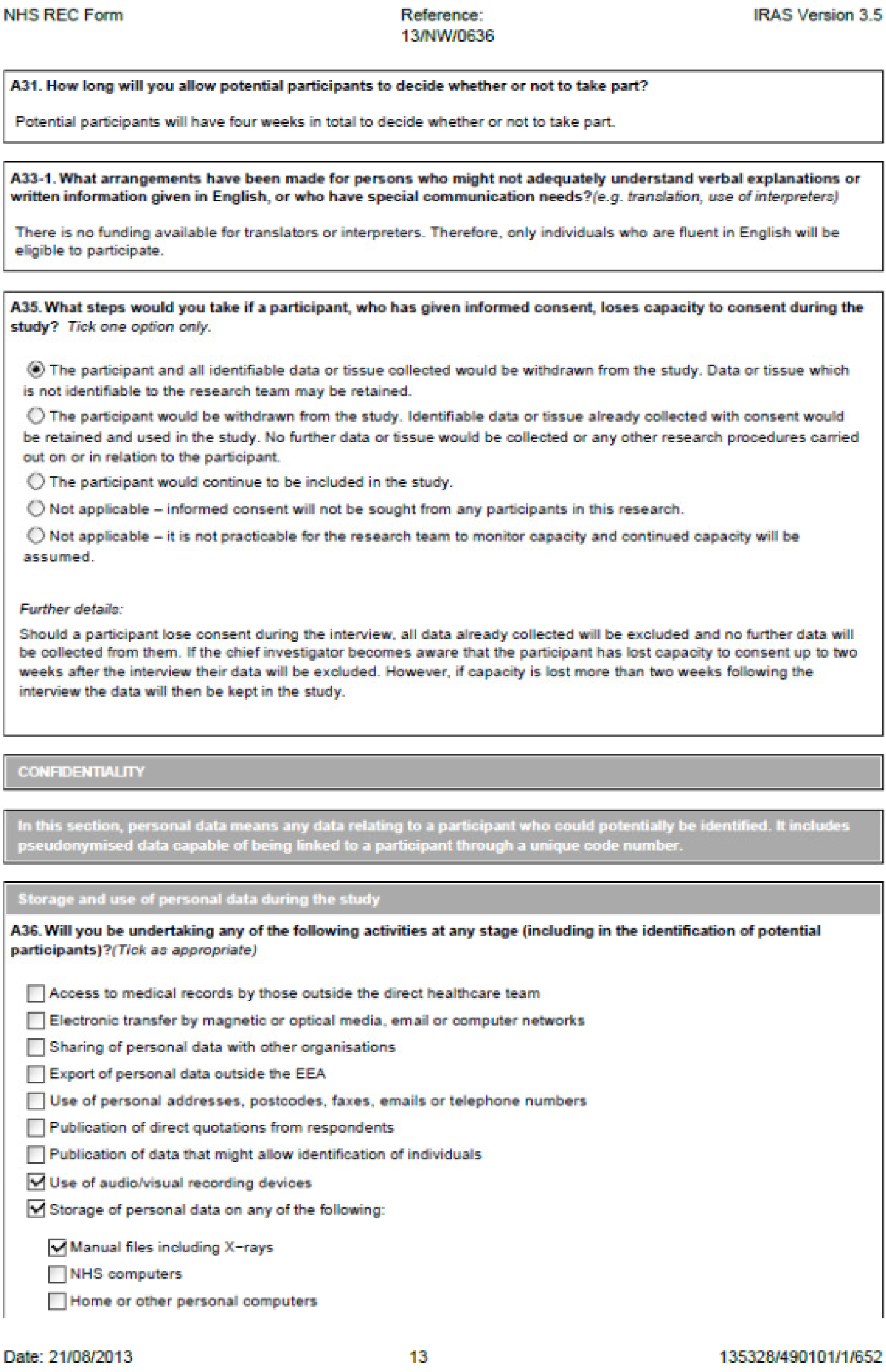
Consent will be obtained from research participants. Full details of the research will be included in the participant information sheet, including an email address and phone number for the chief investigator should potential participants wish to
discuss the research before consenting.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

● Yes ○ No



A31. How long will you allow potential participants to decide whether or not to take part?

Potential participants will have four weeks in total to decide whether or not to take part.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

There is no funding available for translators or interpreters. Therefore, only individuals who are fluent in English will be eligible to participate.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

● The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

Should a participant lose consent during the interview, all data already collected will be excluded and no further data will be collected from them. If the chief investigator becomes aware that the participant has lost capacity to consent up to two weeks after the interview their data will be excluded. However, if capacity is lost more than two weeks following the interview the data will then be kept in the study.

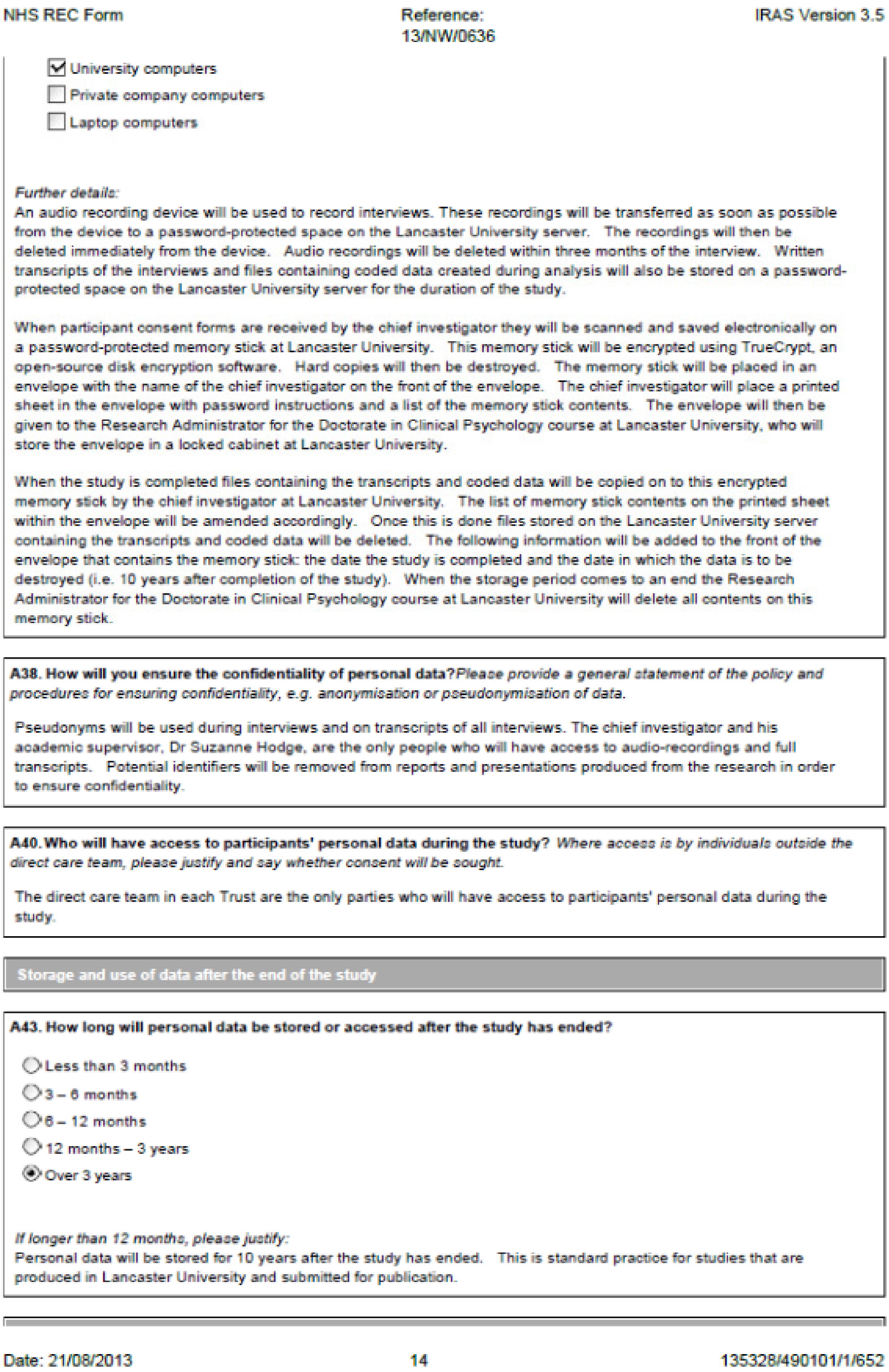
CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☐ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☑ Manual files including X-rays
  - ☐ NHS computers
  - ☐ Home or other personal computers



☑ University computers
☐ Private company computers
☐ Laptop computers

Further details:
An audio recording device will be used to record interviews. These recordings will be transferred as soon as possible from the device to a password-protected space on the Lancaster University server. The recordings will then be deleted immediately from the device. Audio recordings will be deleted within three months of the interview. Written transcripts of the interviews and files containing coded data created during analysis will also be stored on a password-protected space on the Lancaster University server for the duration of the study.

When participant consent forms are received by the chief investigator they will be scanned and saved electronically on a password-protected memory stick at Lancaster University. This memory stick will be encrypted using TrueCrypt, an open-source disk encryption software. Hard copies will then be destroyed. The memory stick will be placed in an envelope with the name of the chief investigator on the front of the envelope. The chief investigator will place a printed sheet in the envelope with password instructions and a list of the memory stick contents. The envelope will then be given to the Research Administrator for the Doctorate in Clinical Psychology course at Lancaster University, who will store the envelope in a locked cabinet at Lancaster University.

When the study is completed files containing the transcripts and coded data will be copied on to this encrypted memory stick by the chief investigator at Lancaster University. The list of memory stick contents on the printed sheet within the envelope will be amended accordingly. Once this is done files stored on the Lancaster University server containing the transcripts and coded data will be deleted. The following information will be added to the front of the envelope that contains the memory stick: the date the study is completed and the date in which the data is to be destroyed (i.e. 10 years after completion of the study). When the storage period comes to an end the Research Administrator for the Doctorate in Clinical Psychology course at Lancaster University will delete all contents on this memory stick.

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Pseudonyms will be used during interviews and on transcripts of all interviews. The chief investigator and his academic supervisor, Dr Suzanne Hodge, are the only people who will have access to audio-recordings and full transcripts. Potential identifiers will be removed from reports and presentations produced from the research in order to ensure confidentiality.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

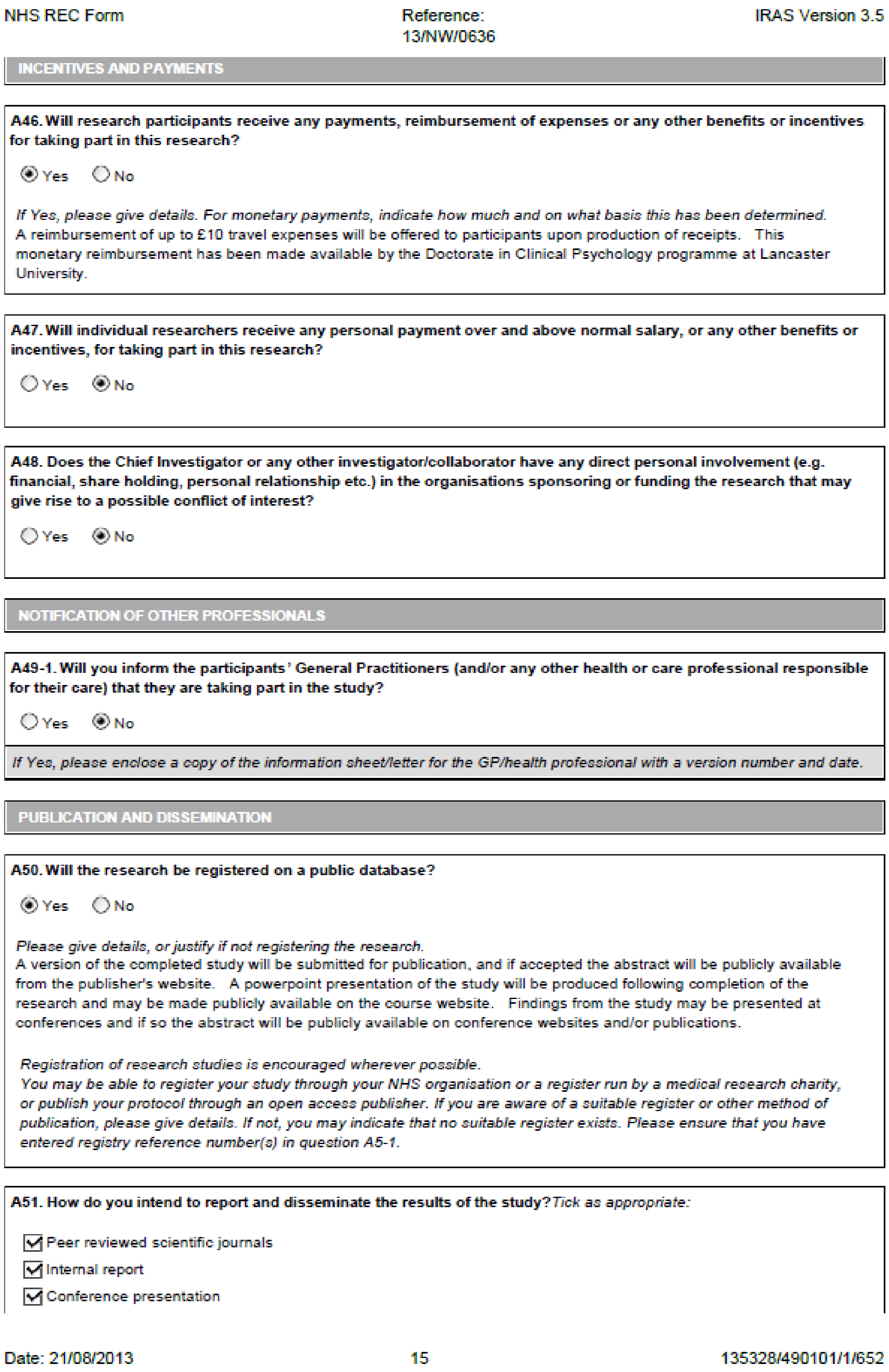
The direct care team in each Trust are the only parties who will have access to participants' personal data during the study.

Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

○ Less than 3 months
○ 3 – 6 months
○ 6 – 12 months
○ 12 months – 3 years
● Over 3 years

If longer than 12 months, please justify:
Personal data will be stored for 10 years after the study has ended. This is standard practice for studies that are produced in Lancaster University and submitted for publication.



INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

● Yes ○ No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
A reimbursement of up to £10 travel expenses will be offered to participants upon production of receipts. This monetary reimbursement has been made available by the Doctorate in Clinical Psychology programme at Lancaster University.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ● No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ● No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

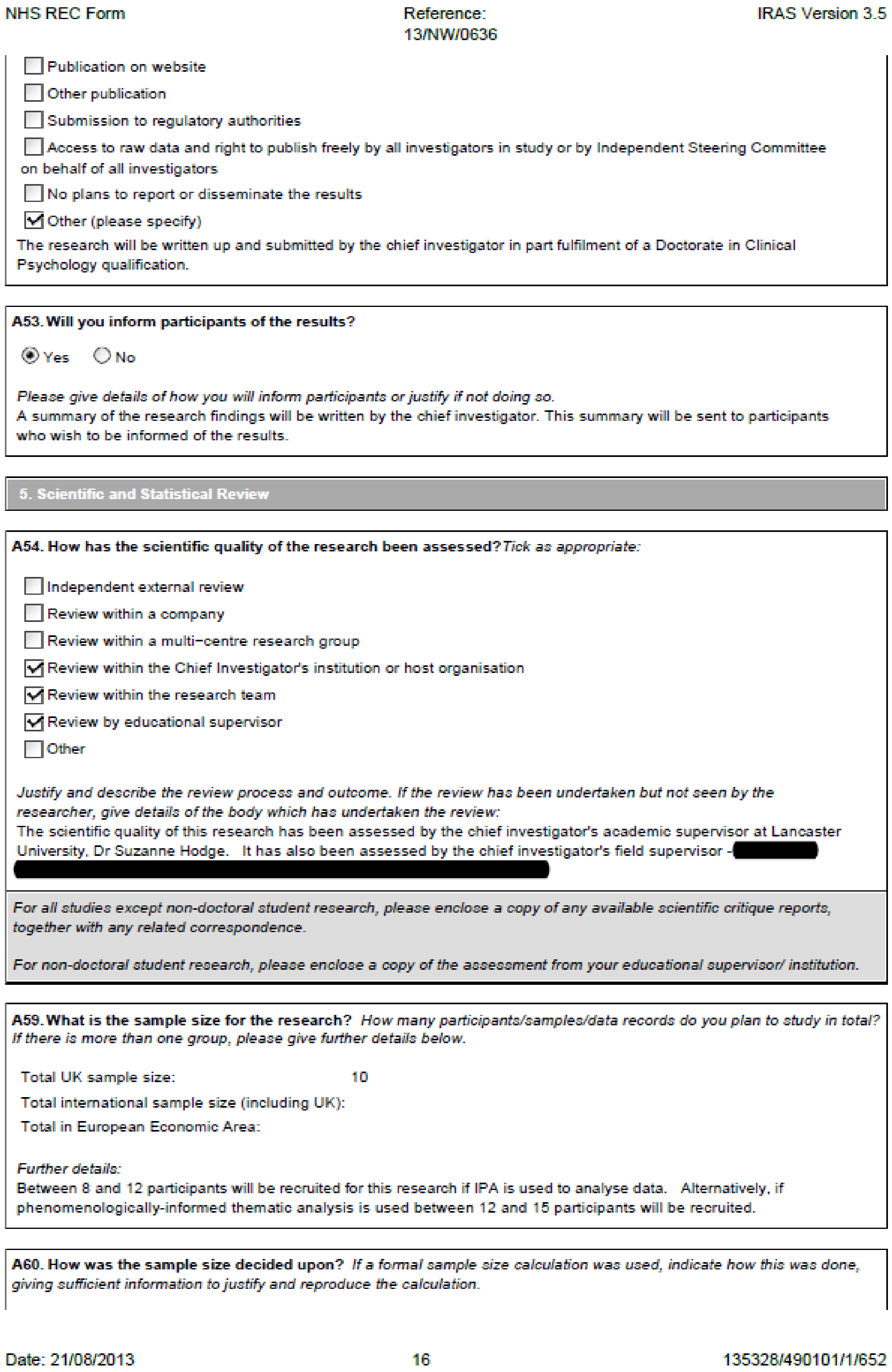
● Yes ○ No

Please give details, or justify if not registering the research.
A version of the completed study will be submitted for publication, and if accepted the abstract will be publicly available from the publisher's website. A powerpoint presentation of the study will be produced following completion of the research and may be made publicly available on the course website. Findings from the study may be presented at conferences and if so the abstract will be publicly available on conference websites and/or publications.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

☑ Peer reviewed scientific journals
☑ Internal report
☑ Conference presentation



☐ Publication on website
☐ Other publication
☐ Submission to regulatory authorities
☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
☐ No plans to report or disseminate the results
☑ Other (please specify)

The research will be written up and submitted by the chief investigator in part fulfilment of a Doctorate in Clinical Psychology qualification.

A53. Will you inform participants of the results?

● Yes ○ No

Please give details of how you will inform participants or justify if not doing so.
A summary of the research findings will be written by the chief investigator. This summary will be sent to participants who wish to be informed of the results.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

☐ Independent external review
☐ Review within a company
☐ Review within a multi−centre research group
☑ Review within the Chief Investigator's institution or host organisation
☑ Review within the research team
☑ Review by educational supervisor
☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The scientific quality of this research has been assessed by the chief investigator's academic supervisor at Lancaster University, Dr Suzanne Hodge. It has also been assessed by the chief investigator's field supervisor -[redacted]

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 10
Total international sample size (including UK):
Total in European Economic Area:

Further details:
Between 8 and 12 participants will be recruited for this research if IPA is used to analyse data. Alternatively, if phenomenologically-informed thematic analysis is used between 12 and 15 participants will be recruited.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

The above sample sizes are consistent with numbers typically used for interpretative phenomenological analysis studies and thematic analysis studies.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The probable qualitative method of analysis that will be used to evaluate data is 'interpretative phenomenological analysis' (IPA). Using this method, the data will be written down or transcribed by the chief investigator. The chief investigator will then become familiar with written transcripts and some initial comments will be made based on this. Following this, the first transcript will be examined and initial themes will be identified. These initial themes will then be brought together to create broader themes. A table will be formed with all of the broad themes, and initial themes within each broad theme. Each transcript will then be analysed in the same way. Following this, a table will be created identifying themes that participants have in common, as well as themes that are different. 'Interpretative phenomenological analysis' acknowledges that the researcher cannot fully understand the experiences of participants, but can only interpret their experiences. Therefore, the most important themes according to the researcher will be included in the final report.

If participant transcripts are not homogenous or similar enough (homogeneity is an important characteristic for IPA studies), phenomenologically-informed thematic analysis will be used to analyse data. If thematic analysis is used to analyse data a number of steps will be followed. Interviews will be transcribed verbatim and the chief investigator will familiarise himself with the data. Initial codes of information of interest will be created within the data and these codes will then be brought together to produce themes. The themes will be reviewed by the chief investigator, examined in the context of the entire analysis and a name for each theme will then determined. Following this a report will be created based on the content of the themes with a specific focus on the research question.

The chief investigator's academic supervisor, Dr Suzanne Hodge, will listen to some of the audio recordings and will review a subset of the transcripts prepared by the chief investigator. She will provide input on the overall analysis conducted by
the chief investigator. The chief investigator's field supervisor, [redacted] will provide feedback on the themes created from the analysis.

6. MANAGEMENT OF THE RESEARCH

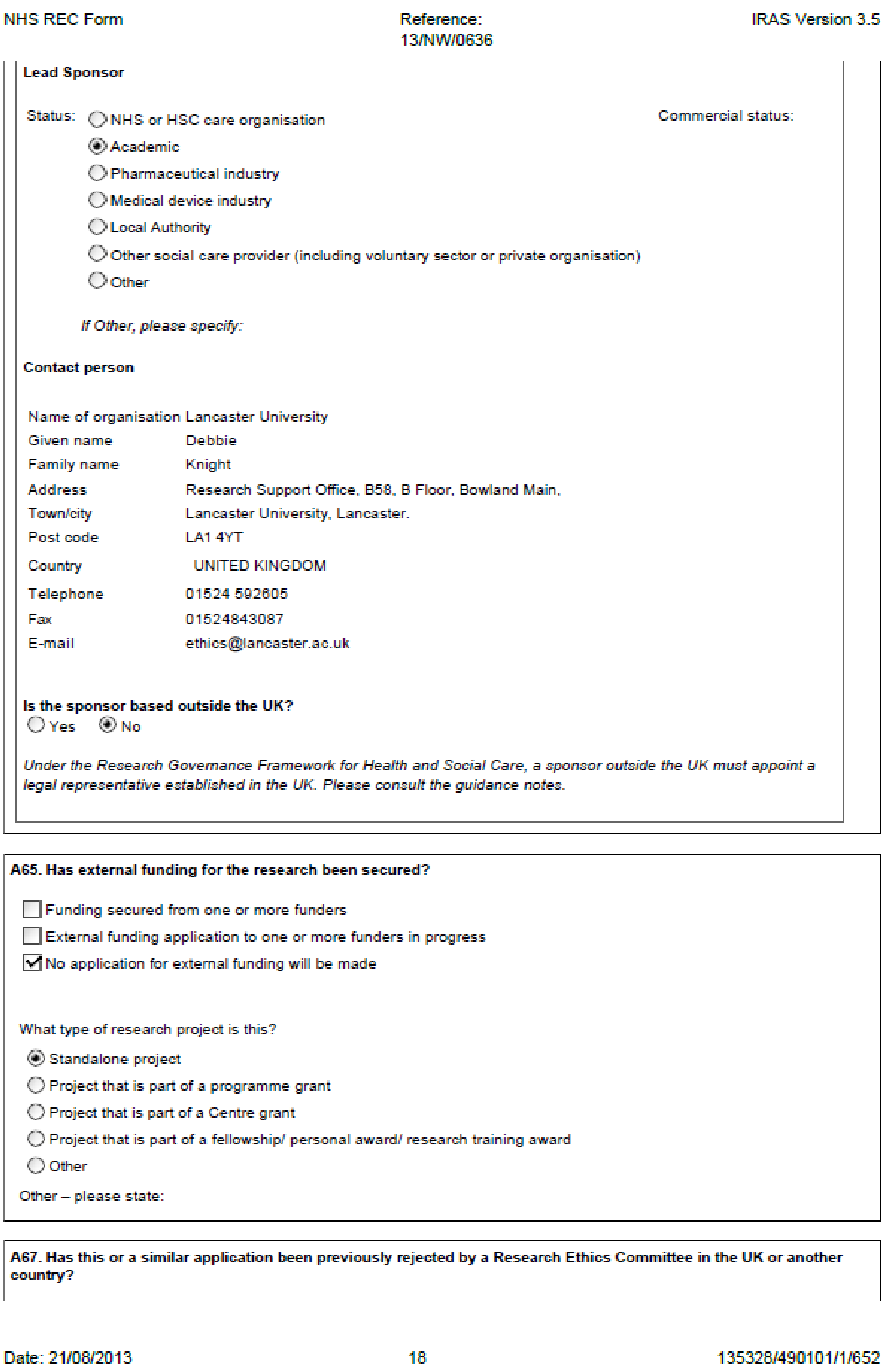
A63. Other key investigators/collaborators. *Please include all grant co–applicants, protocol co–authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	[redacted]	[redacted]	[redacted]

Post	Clinical Psychologist
Qualifications	Doctorate in Clinical Psychology
Employer	[redacted]
Work Address	[redacted]
Post Code	[redacted]
Telephone	[redacted]
Fax	
Mobile	
Work Email	[redacted]

A64. Details of research sponsor(s)

A64-1. Sponsor



Lead Sponsor

Status:
○ NHS or HSC care organisation
● Academic
○ Pharmaceutical industry
○ Medical device industry
○ Local Authority
○ Other social care provider (including voluntary sector or private organisation)
○ Other

Commercial status:

If Other, please specify:

Contact person

Name of organisation	Lancaster University
Given name	Debbie
Family name	Knight
Address	Research Support Office, B58, B Floor, Bowland Main,
Town/city	Lancaster University, Lancaster.
Post code	LA1 4YT
Country	UNITED KINGDOM
Telephone	01524 592605
Fax	01524843087
E-mail	ethics@lancaster.ac.uk

Is the sponsor based outside the UK?
○ Yes ● No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

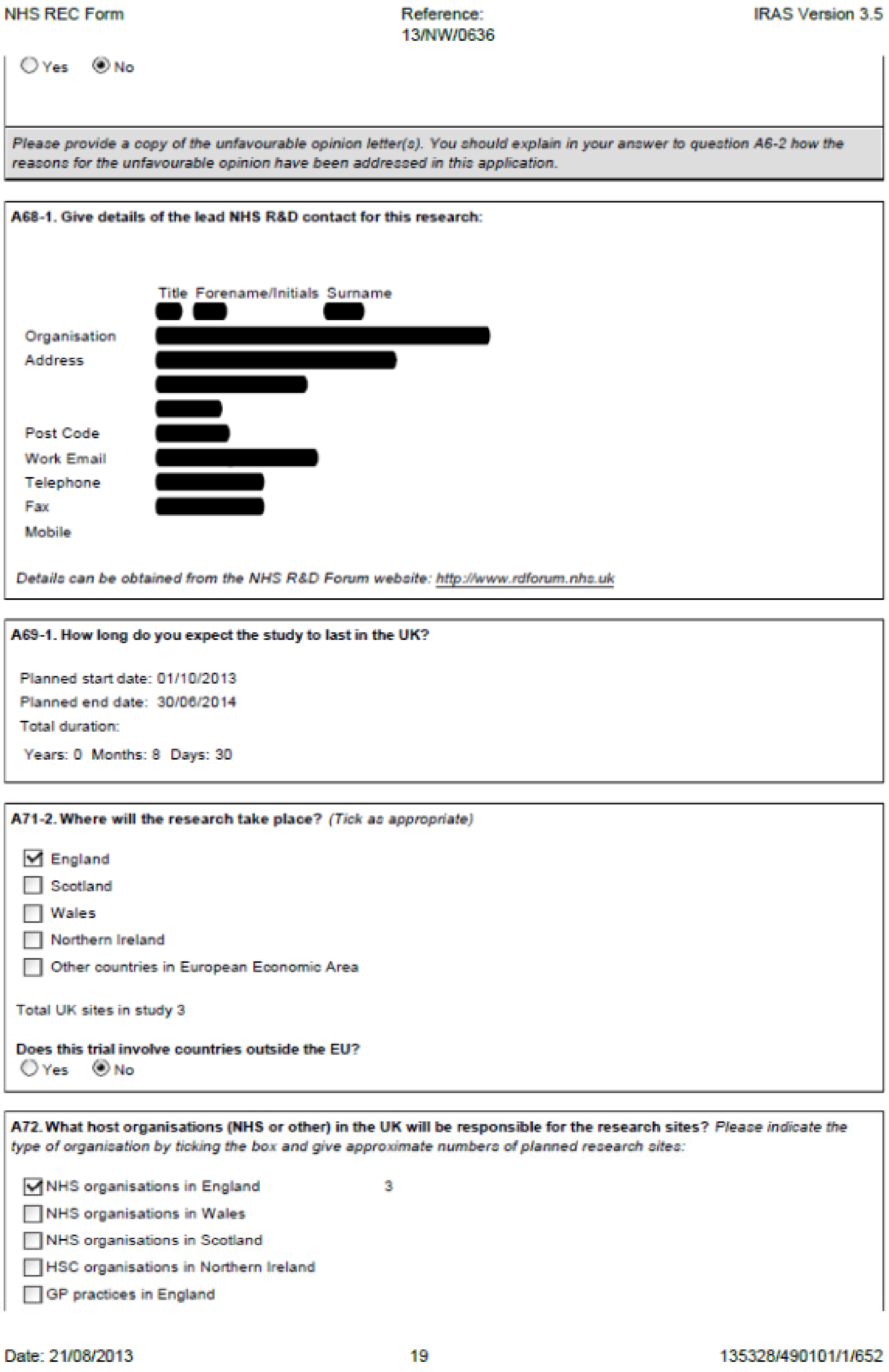
☐ Funding secured from one or more funders
☐ External funding application to one or more funders in progress
☑ No application for external funding will be made

What type of research project is this?

● Standalone project
○ Project that is part of a programme grant
○ Project that is part of a Centre grant
○ Project that is part of a fellowship/ personal award/ research training award
○ Other

Other – please state:

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?



NHS REC Form Reference: 13/NW/0636 IRAS Version 3.5

○ Yes ● No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title	Forename/Initials	Surname
	[redacted]	[redacted]	[redacted]

Organisation [redacted]
Address [redacted]
[redacted]
[redacted]
Post Code [redacted]
Work Email [redacted]
Telephone [redacted]
Fax [redacted]
Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/10/2013
Planned end date: 30/06/2014
Total duration:
Years: 0 Months: 8 Days: 30

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 3

Does this trial involve countries outside the EU?
○ Yes ● No

A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? *Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:*

☑ NHS organisations in England	3
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	

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☐ GP practices in Wales
☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Social care organisations
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas
☐ Independent hospitals
☐ Educational establishments
☐ Independent research units
☐ Other (give details)

Total UK sites in study: 3

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:** in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

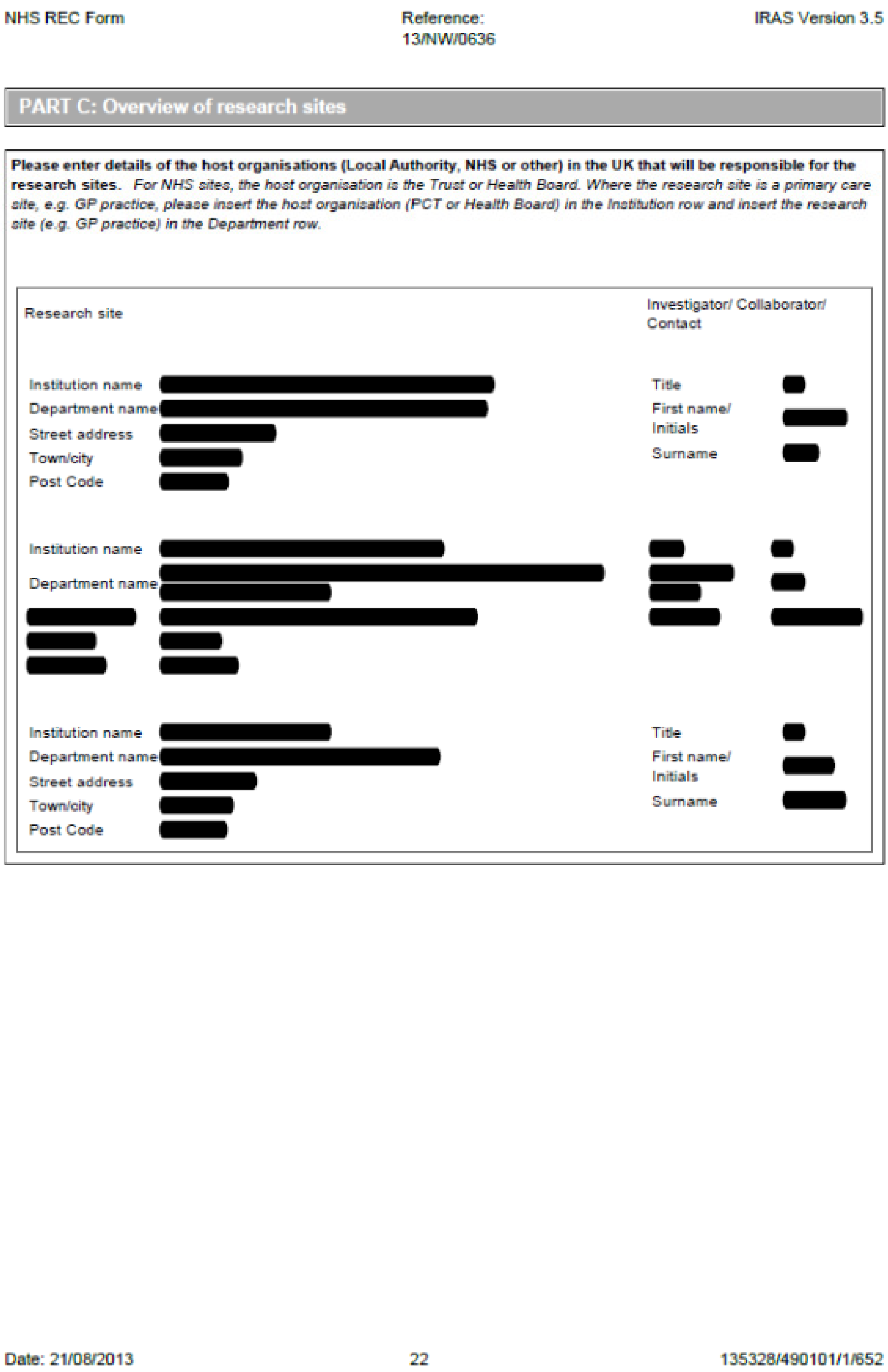
Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☐ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.



NHS REC Form | Reference: 13/NW/0636 | IRAS Version 3.5

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.*

Research site		Investigator/ Collaborator/ Contact	
Institution name	[redacted]	Title	[redacted]
Department name	[redacted]	First name/ Initials	[redacted]
Street address	[redacted]	Surname	[redacted]
Town/city	[redacted]		
Post Code	[redacted]		
Institution name	[redacted]	[redacted]	[redacted]
Department name	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		
[redacted]	[redacted]		
Institution name	[redacted]	Title	[redacted]
Department name	[redacted]	First name/ Initials	[redacted]
Street address	[redacted]	Surname	[redacted]
Town/city	[redacted]		
Post Code	[redacted]		

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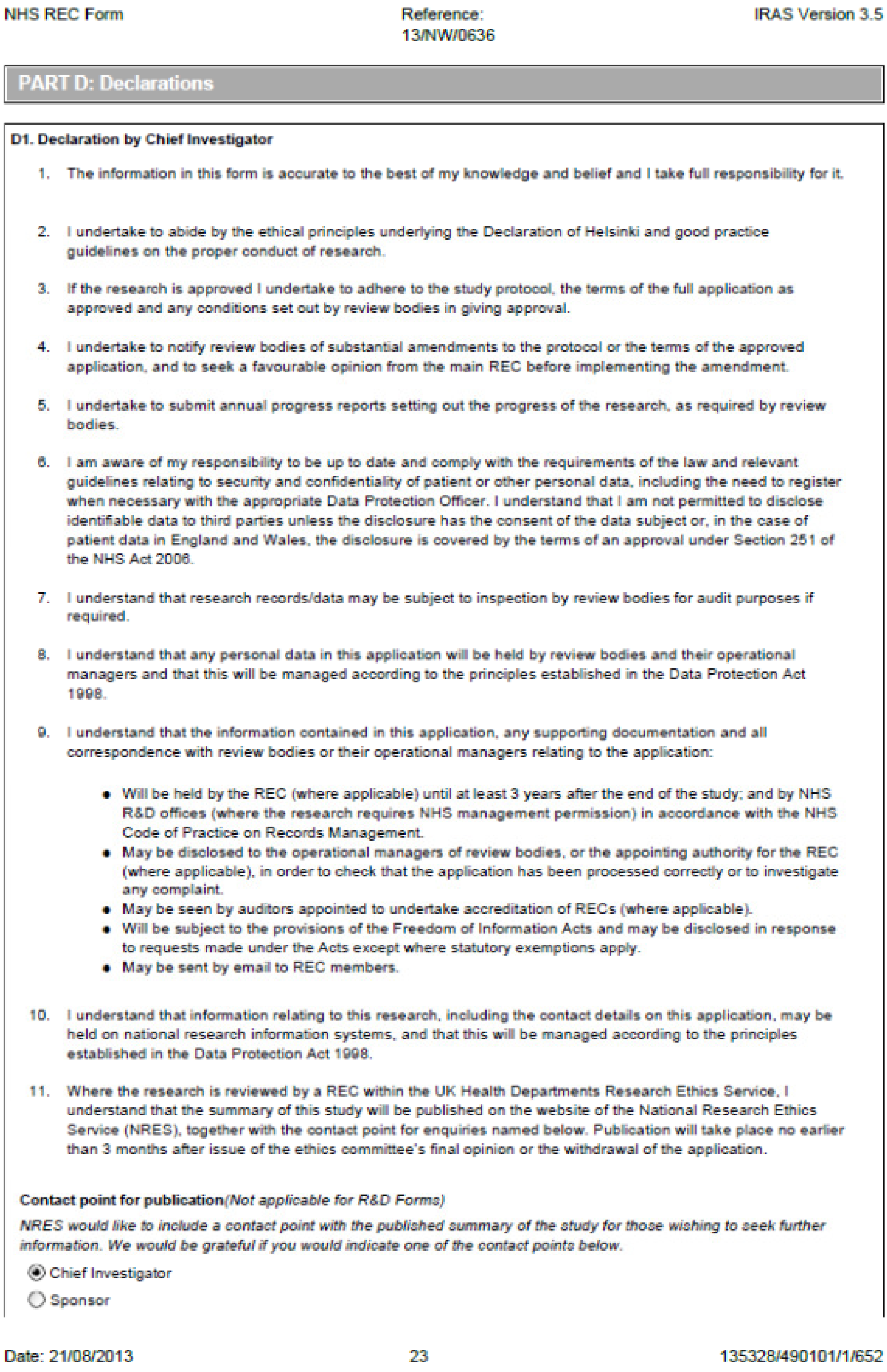


NHS REC Form | Reference: 13/NW/0636 | IRAS Version 3.5

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.
10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

● Chief Investigator
○ Sponsor

Date: 21/08/2013 | 23 | 135328/490101/1/652

○ Study co-ordinator
○ Student
○ Other – please give details
○ None

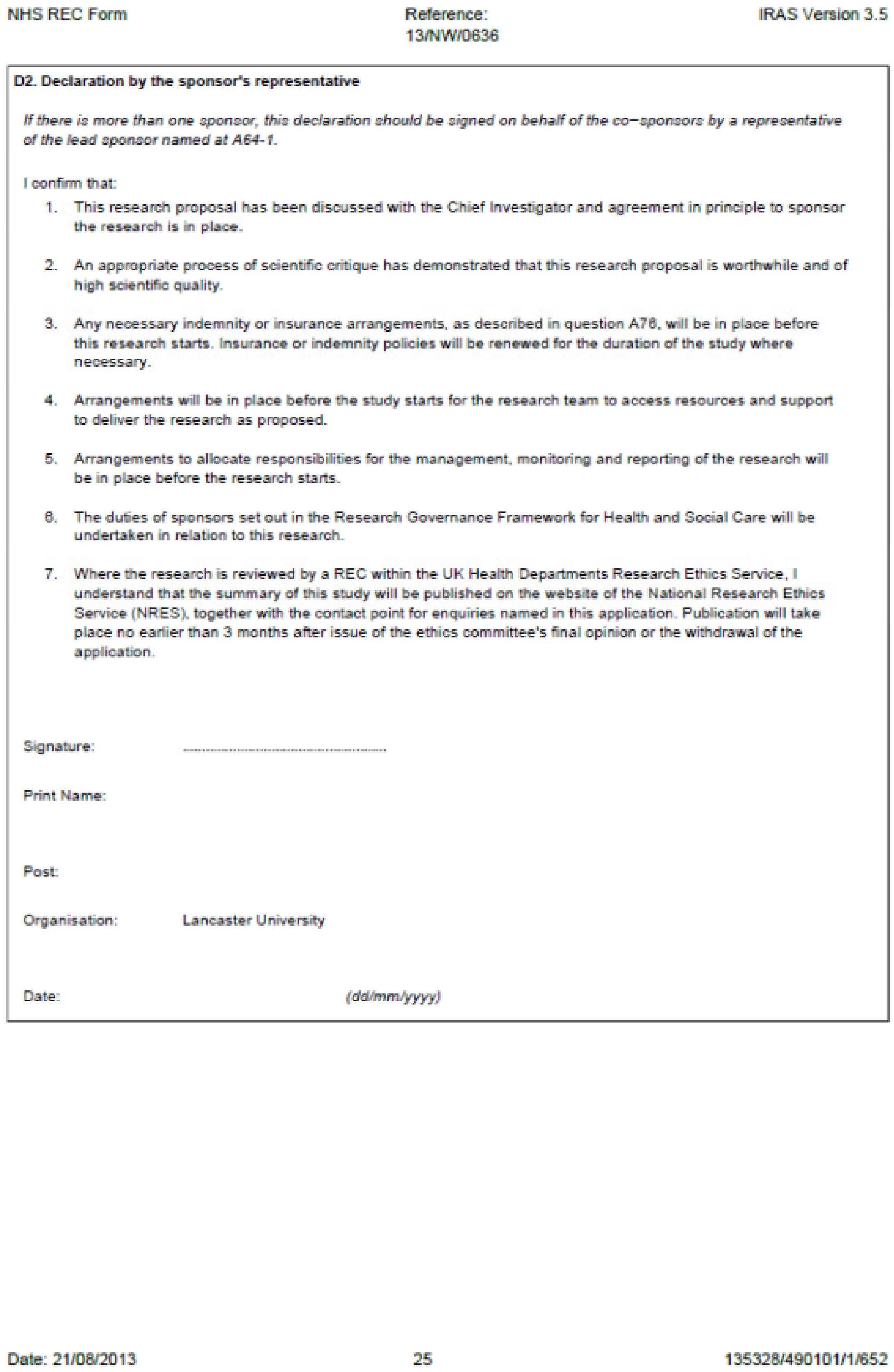
Access to application for training purposes *(Not applicable for R&D Forms)*
Optional – please tick as appropriate:

☑ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature: ....

Print Name: Diarmaid Ó Lonargáin

Date: *(dd/mm/yyyy)*



D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co−sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

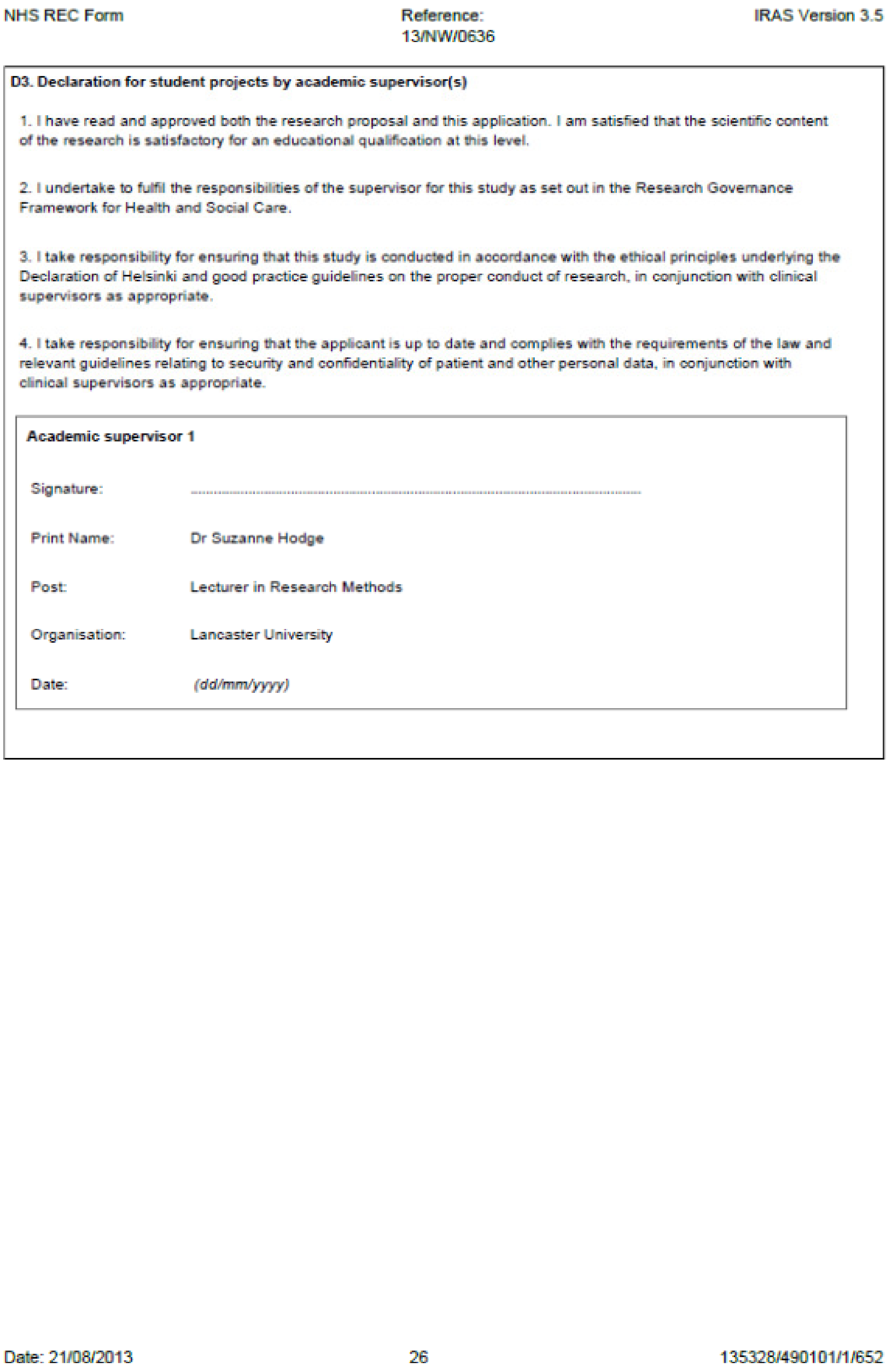
Signature: ....

Print Name:

Post:

Organisation: Lancaster University

Date: *(dd/mm/yyyy)*



D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

Signature: ....

Print Name: Dr Suzanne Hodge

Post: Lecturer in Research Methods

Organisation: Lancaster University

Date: *(dd/mm/yyyy)*

Research Protocol

Research Project:	Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives
Chief Investigator:	Diarmaid Ó Lonargáin
Version:	2
Date:	26th September 2013

Introduction

Mentalisation-based treatment (MBT) is a therapeutic programme that was designed for individuals with a diagnosis of borderline personality disorder (BPD) by Anthony Bateman and Peter Fonagy (Bateman & Fonagy, 2006). BPD is associated with persistent suicidal behaviour or threats, volatile interpersonal relationships, an unstable sense of identity and intense emotional experiences. A history of childhood trauma, such as sexual, physical and emotional abuse and neglect, is commonly found in individuals with a BPD diagnosis (e.g. Sansone & Sansone, 2007; Huang, Yang & Wu, 2010). The design of MBT draws on the idea that childhood trauma disrupts an individual's capacity to mentalise (Bateman & Fonagy, 1999), which essentially involves the ability to understand one's own mental states, such as thoughts and feelings, and the mental states of others (Allen, Fonagy & Bateman, 2008). This disruption continues into adult life. Enhancing the capacity to mentalise is thus the central component of MBT, which sets it apart from other therapies that also utilise mentalisation albeit not as their primary focus (Fonagy & Bateman, 2007).

MBT is a manualised approach and two separate programmes were devised for BPD: a day hospital programme and an intensive out-patient programme (Bateman & Fonagy, 2006). In the day hospital programme a combination of individual and group therapy is utilised, service users attend for five days per week initially and the treatment continues for 18-24 months. The out-patient treatment consists of one individual and one group therapy session per week for 18 months. Both MBT programmes involve separate therapists for individual and group therapy.

Bateman and Fonagy (1999; 2009) conducted two randomised controlled trials (RCTs) that suggest that MBT is an effective treatment for difficulties associated with BPD, such as incidents of self-harm, suicidal behaviours and low mood. Subsequent RCTs have continued to demonstrate the effectiveness of MBT for individuals with a diagnosis of BPD (Bales et al., 2012; Rossouw & Fonagy, 2012). The most recent National Institute of Health and Care Excellence (NICE) guideline for the treatment and management of BPD (NICE, 2009) was published prior to the publication of each of the above RCTs, apart from the Bateman and Fonagy (1999) study. It recommends MBT as a possible cost-effective treatment for BPD, while simultaneously highlighting the small evidence-base. However, the considerable additions to the evidence since 2009 would appear to address this limitation.

All of the studies described above utilised RCTS, which are generally considered to be the *gold standard* in quantitative methodology (Salmond, 2008). Although this research has provided valuable information regarding the impact of MBT on a number of behaviours and difficulties associated with BPD, there are limitations that should be considered. The restrictive nature of the scales and questionnaires used in these studies left little room for participants to provide detailed accounts of their experiences of MBT as a therapy. Learning about such experiences could be a relevant factor in developing the therapy further and understanding if there are elements of the therapy that could be enhanced to optimally meet the needs of service users. It may also open up insight into elements of the therapy that would benefit from further exploration. Furthermore, it would provide a useful information base for service users considering engaging in MBT. A qualitative approach would be best suited to facilitate learning about these experiences. As far as the chief investigator is aware, no qualitative research has been published to date exploring service user experiences of MBT; thus, a qualitative method will be employed in this study. The study will examine service user experiences of intensive out-patient MBT only. Due to the differences between the structure of the day hospital programme and the intensive out-patient programme it was deemed necessary not to combine both programmes in this research. The primary research question will be: how do adults with difficulties associated with BPD experience intensive out-patient MBT?

Method

Design

Interpretative phenomenological analysis (IPA) will be used to analyse data. This will be changed to phenomenologically-informed thematic analysis if IPA proves to be unsuitable because of lack of homogeneity among participants.

IPA is considered to be an appropriate form of qualitative analysis for this research for a number of reasons. It focuses on the personal lived experiences of participants (Smith & Osborn, 2008) and is used to scrutinise “how people make sense of their major life experiences” (Smith, Flowers, & Larkin, 2009, p. 1). Attempting to complete an 18 month MBT programme is considered to be an important life experience for the purpose of this research as it involves recognition of significant difficulties associated with borderline personality disorder such as self-harm and suicidal behaviour. It also suggests a desire to resolve such difficulties.

IPA studies usually involve small sample sizes to allow for the data to be analysed in detail. They also seek to analyse data from a homogenous sample to enable the researcher to analyse similarities and differences across participants in depth (Smith, Flowers, & Larkin, 2009). IPA places an emphasis on collecting in-depth, rich data from participants and endeavours to obtain considerable detail in relation to participant experiences (Smith & Osborn, 2008). It is hoped that this will enhance our understanding of how MBT is experienced by service users.

Thematic analysis is a qualitative method that involves “identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). It can also be used to interpret elements of research. Thematic analysis can be flexible in its theoretical approach unlike other qualitative methods such as IPA, narrative analysis and grounded theory which hold definite epistemological positions. For example, it can be used to focus directly on experiences and meanings or it can take a more constructionist approach which emphasises how individuals’ realities are created by discourses within society. Alternatively, it can adopt a combination of both epistemologies (Braun & Clarke, 2006). If thematic analysis is used in this study, a phenomenologically-informed approach will be adopted with a focus on the experiences and meanings of participants.

Participants

IPA studies usually involve small sample sizes to allow for the data to be analysed in detail. Therefore, between eight and 12 participants will be recruited for this research if IPA is used to analyse data. Alternatively, if phenomenologically-informed thematic analysis is used between 12 and 15 participants will be recruited. Adults who have attended a MBT programme with a focus on difficulties associated with BPD for at least two months, and no longer than 15 months, at the time of the research interview will be eligible to participate. It takes time to adjust to any new therapy and the research team for this study considered two months to be a suitable time-frame to be able to discuss experiences of MBT. Furthermore, the potential adverse impact of therapeutic endings on individuals who engage in MBT was identified by experienced MBT therapists at a MBT north-west interest group study day that the chief investigator attended in April 2013. Additionally, Luyten, Fonagy, Lowyck and Vermote (2012) outline how the ability to mentalise is disrupted within relationships that are less secure. This suggests that mentalisation capacity is likely to be disrupted at the beginning and at the end of therapy as the therapeutic relationship is less stable at these times. Therefore, individuals who are merely settling into a MBT programme and also those who are close to the end of a MBT programme will not be eligible to participate, thus enhancing homogeneity among participants.

The MBT programme must be in an out-patient setting and involve weekly individual and group therapy with a focus on mentalising. However, a separate therapist for individual and group therapy will not be necessary as this varies among MBT programmes in the UK. A diagnosis of BPD will not be necessary in order to participate as some UK MBT groups do not have this as a requirement. Participants will initially be recruited from three NHS Trusts in the north-west of England [redacted] If enough participants have not been recruited this will be expanded to any NHS Trust in the UK that facilitates an intensive out-patient MBT programme for individuals with difficulties associated with BPD. If enough participants are still not recruited, adults who are currently attending a MBT programme for more than 15 months will be eligible to participate. Individuals who are no longer attending the programme will also be eligible to participate, provided they attended the programme for at least 2 months and they stopped attending within 12 months of the research interview.

Therefore, the recruitment strategy will involve three potential stages (see inclusion criteria 1a, 1b and 1c for details of these stages). Inclusion criteria are as follows:

1.a) Currently attending an intensive out-patient MBT programme facilitated by a NHS Trust in the north-west of England [redacted] for adults with difficulties associated with BPD for between two and 15 months. The MBT programme must consist of weekly individual and group therapy with an emphasis on mentalising. A separate therapist will not be necessary for individual and group therapy.

1.b) If enough participants are not recruited from 1.a, this criterion will be expanded to include individuals who are currently attending a MBT programme facilitated by a NHS Trust anywhere in the UK for adults with difficulties associated with BPD for between two and 15 months. Similar to criterion 1.a, the MBT programme must consist of weekly individual and group therapy with an emphasis on mentalising and a separate therapist will not be necessary for individual and group therapy.

1.c.) If enough participants are still not recruited, the criterion for length of time in therapy will be expanded to include the following: individuals who are currently attending a MBT programme for BPD for more than 15 months and individuals who are no longer attending a MBT programme for BPD provided they attended a programme for at least two months and they stopped attending within twelve months of the research interview. The MBT programme can be facilitated by any NHS Trust in the UK. Similar to criteria 1.a and 1.b, the MBT programme must consist of weekly individual and group therapy with an emphasis on mentalising and a separate therapist will not be necessary for individual and group therapy.

2) Over 18 years of age

3) Capacity to consent

The exclusion criterion is as follows:

1) Inability to speak English fluently

Procedure

As stated above, participants will be recruited from a number of NHS Trusts within the UK. Local collaborators employed by each Trust who has access to service user details will identify service users who meet criteria for the study (see Site-Specific Information forms for names of local collaborators within each Trust).

Criteria 1.a, 2 and 3 from the inclusion criteria (as well as the exclusion criterion) will apply to the first recruitment stage. For this stage, the chief investigator will prepare information packs. These information packs will include a covering letter from the chief investigator (appendix A), the participant information sheet for the first recruitment stage (appendix B), the consent form (appendix C), a reply slip (appendix D) and a stamped envelope addressed to the chief investigator. The information packs will be given to the local collaborator within each relevant Trust. Each local collaborator will either post an information pack to potential participants or hand an information pack to potential participants before or after one of the MBT individual or group sessions.

For the second recruitment stage, criteria 1.b, 2 and 3 from the inclusion criteria (as well as the exclusion criterion) will apply. For this recruitment stage the exact same procedure as the first recruitment stage will be followed and information packs will contain the same documents (see appendices A, B, C and D) and a stamped envelope addressed to the chief investigator. For the third recruitment stage, criteria 1.c, 2 and 3 from the inclusion criteria (as well as the exclusion criterion) will apply. The same procedure as the first and second recruitment stages will be followed. The information packs will include the same covering letter and consent form as the first and second recruitment stages, but a different participant information sheet will be used (see appendix E). They will also contain a stamped envelope addressed to the chief investigator

The same local collaborator in the Trust may either post or give a reminder pack to each potential participant approximately two weeks after receiving the initial information pack. Reminder packs will contain the same participant information sheet and consent form that were originally sent, and a different covering letter (see appendix F). A contact mobile number (this will be a phone and number provided by Lancaster University for the purpose of the research) and email address for the chief investigator will be provided on the participant information sheet. Participants will be invited to contact the chief investigator by telephone or by email via the participant information sheet if they require further information. If they are interested in participating they will be invited to do so via the participant information sheet either by telephone, by email or by returning the reply slip to the chief investigator using the stamped addressed envelope enclosed in the information pack.

In some Trusts, where permission has been received from the local collaborator within the Trust, the chief investigator will be available to speak to potential participants who may wish to obtain further information about participation in the study. The chief investigator will be present in a room within the service to coincide with the end of a MBT group session. Professionals facilitating the group session will inform potential participants that the chief investigator will be available to speak to those who wish to do so. Group facilitators will have discussed this with each group prior to this.

Interested parties will contact the chief investigator who will book a room for the research interview (see *Practical Issues* section below). The interview will proceed after the chief investigator has been provided with a signed consent form. Each interview will be conducted by the chief investigator, will be audio recorded and will last approximately one hour. Participants will be fully debriefed following the interview (see appendix G). The interviews will be transcribed verbatim by the chief investigator, findings will be analysed and a full report will be completed. This process will be supervised by the chief investigator's academic supervisor, Dr Suzanne Hodge (Lecturer in Research Methods, Lancaster University) and field supervisor, [redacted]

Proposed Analysis

The recommended form of collecting data in IPA is the semi-structured interview as this provides greater flexibility and autonomy for the participant to express their experiences, and it often produces richer data (Smith & Osborn, 2008). The researcher then transcribes the content of the interviews verbatim and specific steps are followed when analysing transcripts. After the researcher becomes familiar with the transcripts and makes some initial comments, he or she then identifies preliminary themes from the first transcript. Superordinate, or broader, themes are then created from these themes. A systematic table of themes is created consisting of superordinate and subordinate themes from the transcript. This process is repeated with each transcript individually following this, and a final table is created identifying similar and different themes. The most pertinent themes, according to the researcher's interpretations, will be displayed and discussed in the final report (Howitt, 2010). Analysis will take place under the supervision of Dr Suzanne Hodge, Lecturer in Research Methods, Lancaster University.

If thematic analysis is used to analyse data Braun and Clarke (2006) outline a number of steps that are required in this process. Interviews are transcribed verbatim and the researcher familiarises himself or herself with the data. Initial codes of information of interest are created within the data and these codes are then brought together to produce themes. The themes are reviewed by the researcher, examined in the context of the entire analysis and a name for each theme is then determined. Following this a report is created based on the content of the themes with a specific focus on the research question.

Materials

In addition to the materials listed in the *Procedure* section above, a copy of the proposed topic guide for the interviews is included in appendix H. Due to the use of semi-structured interviews these questions will be used as guidelines only and may vary depending on the nature of each individual interview. The chief investigator will also have a list of phone numbers with him at each interview. The phone numbers for the following will be on this list: the Samaritans and either a direct number for the appropriate Trust crisis team or a switchboard number for the Trust from which the participant is receiving care (see appendix I). The switchboard number will be used to direct calls to the relevant recovery team or crisis team for each participant if this is deemed necessary.

Practical Issues

Administrative costs will be covered by the Doctorate in Clinical Psychology course at Lancaster University. A reimbursement of up to £10 travel expenses will be offered to participants upon production of receipts. Depending on room availability and the preference of the participant, the research interview will take place either in a room provided by the Trust or in an appropriate service in the community, such as a GP service.

Ethical Concerns

To protect participant confidentiality, pseudonyms will be used during research interviews and on all transcripts. Audio recordings and transcripts will only be accessed by the chief investigator and his academic supervisor, Dr Suzanne Hodge. Audio recordings will be transferred as soon as possible from the recording device to a password-protected space on the Lancaster University server; once this is done they will be deleted immediately from the recording device. Audio recordings will be deleted from the Lancaster University server within three months of the interview. Written transcripts of the interviews and files containing coded data created during analysis will also be stored on a password-protected space on the Lancaster University server for the duration of the study.

When participant consent forms are received by the chief investigator they will be scanned and saved electronically on a password-protected memory stick at Lancaster University. This memory stick will be encrypted using TrueCrypt, an open-source disk encryption software. Hard copies will then be destroyed. The memory stick will be placed in an envelope with the name of the chief investigator on the front of the envelope. The chief investigator will place a printed sheet in the envelope with password instructions and a list of the memory stick contents. The envelope will then be given to the Research Administrator for the Doctorate in Clinical Psychology course at Lancaster University, who will store the envelope in a locked cabinet at Lancaster University.

When the study is completed files containing the transcripts and coded data will be copied on to this encrypted memory stick by the chief investigator at Lancaster University. The list of memory stick contents on the printed sheet within the envelope will be amended accordingly. Once this is done files stored on the Lancaster University server containing the transcripts and coded data will be deleted. The following information will be added to the front of the envelope that contains the memory stick: the date the study is completed and the date in which the data is to be destroyed (i.e. 10 years after completion of the study). When the storage period comes to an end the Research Administrator for the Doctorate in Clinical Psychology course at Lancaster University will delete all contents on this memory stick.

Participants may become distressed while talking about personal experiences during the research interview. The chief investigator is a trainee clinical psychologist and will endeavour to use the skills learned during his training to contain this distress. If further support is required, the chief investigator will encourage participants who are still under the care of the Trust to contact relevant supports within the service, such as their care coordinator or therapist. He will also encourage participants who become distressed to discuss these feelings during their weekly individual therapy sessions if they are still attending a MBT programme at the time of interview. These participants will have access to weekly individual therapy, as well as group sessions, as these are an integral part of MBT (see introduction).

If the chief investigator deems the participant to be at risk of serious harm he will encourage the service user to call the appropriate Trust recovery or crisis team or a suitable Trust switchboard number in order to be directed to the appropriate recovery team or crisis team (see appendix I). If the participant does not wish to contact the recovery or crisis team, and/or if the participant discloses that somebody else is at risk of significant harm, the chief investigator will follow Trust procedures and policies to ensure the safety of participants and others. The chief investigator will also contact his research supervisor (Dr Suzanne Hodge) and/or field supervisor [redacted] for further advice and support if he deems this necessary.

Timescale

Information packs will be posted or handed to service users who meet criteria following ethical approval for the study. It is expected that this will take place between August and November 2013 and that interviews will be completed and transcribed by the end of December 2013. Transcripts will be analysed in January and February 2014 and the final report will be completed by June 2014.

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Appendix 4-A: Initial Covering Letter to Potential Participants

LANCASTER
UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

To whom it may concern,

I am a student at Lancaster University and am currently in the process of completing a doctorate in clinical psychology. I am writing to invite you to take part in a study I am doing as part of this course about the experience of engaging in intensive out-patient (full programme) mentalisation-based treatment (MBT) as a therapy for difficulties associated with borderline personality disorder. I have enclosed a participant information sheet that explains more about the research and what participating in it would involve. I have also enclosed a consent form that outlines the main areas that you should be aware of before agreeing to take part.

Please be assured that this covering letter and enclosed information sheet and consent form have been sent to you by staff employed by the service in which you are currently attending. I have not seen any of your personal details and will only become aware of your name if you do participate in the research. If you think that you may be interested in taking part I would be delighted to hear from you. You can contact me by telephone or by email (see the participant information sheet for my details) or, if you would prefer, you can fill in and return the reply slip to me using the enclosed stamped addressed envelope.

A reminder pack may be sent to you in about two weeks, which would be the last contact you would receive regarding the research unless you decide that you would like to participate. Even if you have been in touch with me regarding the research you may still receive the reminder pack. This is to protect your anonymity and to ensure that staff working in the service will not know whether or not you are getting involved. If you do not receive a reminder pack this letter will be the last contact you will receive from me unless you decide that you would like to participate.

Yours faithfully,

____

Diarmaid Ó Lonargáin

Trainee Clinical Psychologist

Lancaster University

Appendix 4-B: Participant Information Sheet (1)

LANCASTER
UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Participant Information Sheet

WOULD YOU LIKE TO TAKE PART IN THIS RESEARCH?

Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives

My name is Diarmaid Ó Lonargáin and I am a trainee clinical psychologist at Lancaster University. I would like to invite you to take part in a study that I am doing as part of my training.

What is the study about?

The aim of this study is to learn about how people experience intensive out-patient (full programme) mentalisation-based treatment (MBT) that focuses on difficulties associated with borderline personality disorder. Experiences could possibly include what you may have found helpful in the programme or what may have been challenging for you. They could also include how you have felt being a part of this programme.

Why am I being asked to take part?

You are being asked to take part in this research because you have attended an intensive out-patient MBT programme for between two and 15 months and you are still attending this programme. Hearing your experiences about what this is like for you would be a really helpful contribution to this research.

How can I get involved in the research?

If you would like to take part, or if you would like more information, you can contact me by email or by telephone. My contact details are included at the end of this information sheet. Or, if you prefer, you can fill in the enclosed reply slip and return it to me using the enclosed stamped addressed envelope. Depending on how many people would like to get involved, it may not be possible for everybody who expresses an interest in the research to participate. If you decide that you would like to participate, I will do my very best to let you know as soon as possible.

What would I have to do?

If you do participate in the research I will arrange a meeting with you at a convenient date and time either in a room provided by the NHS Trust that you are involved with or in a room provided by a service in the community, such as a GP service. We will need to arrange the meeting on a date during which you are still attending the MBT programme and have been attending for at least two months but no longer than 15 months. The meeting will consist of an interview lasting approximately 60 minutes during which I will ask you a number of questions about your experiences of being involved in a MBT programme. The interview will be audio recorded so that it can later be written down on paper, or transcribed.

Do I have to take part or can I change my mind?

No, you do not have to take part. Your participation in this research is entirely voluntary. If you decide not to take part your care with the NHS Trust that you are involved with will not be affected in any way. You are also free to stop the interview without giving any reason. Also, if you do participate in the research you can withdraw your information from the study at any time without giving a reason. Please be aware that when the content of your interview has been anonymised and created into themes it might not be possible for it to be withdrawn, although I will do my very best to remove your information up until the research becomes published if this is the case.

What about confidentiality?

All of the information collected during the interview will be kept confidential. The audio recording of the interview will be stored in a password-protected computer in Lancaster University following the interview and will be destroyed within 3 months of the interview. An anonymised written transcript of your interview will be stored in a password-protected computer in Lancaster University during the research. When the research is completed it will be stored in a locked cabinet in Lancaster University for 10 years. It will then be destroyed. My research supervisor (Dr Suzanne Hodge) and I are the only people who will have access to the audio recording and to the transcript. Some of the information that you give during the interview may be included in the final report; but any information that may identify you to others, such as your name or date of birth, will be excluded.

There are a few exceptions to confidentiality but I will explain these exceptions to you before the interview begins. For example, if you report information that suggests that you or somebody else is at risk of serious harm I may need to discuss this information with my research supervisor. I will also need to follow Trust procedures to maintain your safety and the safety of others which may involve discussing the information with other professionals. If I do need to contact others about some of the information that you give me I will talk to you about this first.

What are the benefits of taking part?

There are no immediate, direct benefits of taking part. However, it is my hope that this research will help services to have a better understanding of the needs and experiences of those who participate in MBT programmes, and that this will help them to meet those needs more effectively. Also, it is my hope that this research will help other service users to have a better understanding of what it is like to take part in a MBT programme before deciding whether they feel it would be a useful support for them. The research may also provide suggestions for improving MBT as a therapy.

What are the risks of taking part?

A possible risk of taking part may include talking about difficult or upsetting experiences. Should this happen during the interview, you will be able to stop the interview if you wish to do so. I am aware that you attend individual therapy on a weekly basis as part of your MBT programme and you may wish to use these sessions for support. In addition to this, I will be able to put you in touch with appropriate supports within the Trust if you feel that you need this. I will also have the number for the Samaritans if you feel that you would like to contact them.

Ethical Approval

This study has been reviewed and approved by **(INSERT NAME)** Ethics Committee. It has also been approved by **(INSERT NAME)** Research and Development committee.

What will happen to the results of the research?

The results of the research will be summarised and submitted to Lancaster University as a report. They may also be submitted for publication in an academic or professional journal, presented at conferences and/or presented at training events.

Where can I obtain further information if I need it?

This research is conducted by Diarmaid Ó Lonargáin, Trainee Clinical Psychologist, Doctorate in Clinical Psychology, C27 Furness College, Lancaster University, Lancaster, Lancashire, LA1 4YG; email: d.olonargain@lancaster.ac.uk; Tel. **(INSERT NUMBER)**.

How do I make a complaint or representation?

If you wish to make a complaint or representation about any aspect of this study and do not want to speak to the researcher, you can contact Dr Craig Murray, Senior Lecturer in Research Methods, Doctorate in Clinical Psychology, Lancaster University; email: c.murray@lancaster.ac.uk; Tel. 01524 592730.

If you wish to speak to somebody outside of the Doctorate in Clinical Psychology programme you can contact Professor Susan Cartwright, Faculty of Health and Medicine, Head of Division of Health Research, Lancaster University; email: s.cartwright@lancaster.ac.uk; Tel. 01524 592430.

Thank you for taking the time to read this information sheet

Appendix 4-C: Consent Form

LANCASTER
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Doctorate In Clinical Psychology

Consent Form

Study Title: Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the chief investigator, Diarmaid Ó Lonargáin.

Please initial box after each statement

1. I have read the participant information sheet and understand what my participation involves. I have had the opportunity to ask questions and have them answered. ☐
2. I consent to my interview being audio recorded and turned into a typed transcript. I understand that the audio recording will be destroyed after 3 months and the transcript destroyed 10 years after completion of the study. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my medical care or legal rights being affected. ☐
4. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, although every attempt will be made to extract my data, up to the point of publication. ☐
5. I consent to anonymised information and quotations from my interview being used in reports, conferences and training events. ☐
6. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the chief investigator may need to share this information with his research supervisor and/or other professionals. ☐
7. I consent to take part in the above study. ☐

Name of Participant____

Signature____________________________________ **Date** ___________

Name of Researcher____

Signature____________________________________ **Date** ___________

Appendix 4-D: Reply Slip

Reply Slip

Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives

I would like to express an interest in taking part in this study and I give consent for the chief investigator to contact me to discuss the research.

My Name: ………………………………………………………………………………

Contact telephone number: ………………………………

Email address: ………………………………………………………

(Please complete this slip and return to the chief investigator in the enclosed envelope)

Appendix 4-E: Participant Information Sheet (2)

DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Participant Information Sheet

WOULD YOU LIKE TO TAKE PART IN THIS RESEARCH?

Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives

My name is Diarmaid Ó Lonargáin and I am a trainee clinical psychologist at Lancaster University. I would like to invite you to take part in a study that I am doing as part of my training.

What is the study about?

The aim of this study is to learn about how people experience intensive out-patient (full programme) mentalisation-based treatment (MBT) that focuses on difficulties associated with borderline personality disorder. Experiences could possibly include what you may have found helpful in the programme or what may have been challenging for you. They could also include how you have felt being a part of this programme.

Why am I being asked to take part?

You are being asked to take part in this research because you have attended an intensive out-patient MBT programme for at least two months. In addition, you are either still attending this programme or you stopped attending no longer than twelve months ago. Hearing your experiences about what this is like for you would be a really helpful contribution to this research.

How can I get involved in the research?

If you would like to take part, or if you would like more information, you can contact me by email or by telephone. My contact details are included at the end of this information sheet. Or, if you prefer, you can fill in the enclosed reply slip and return it to me using the enclosed stamped addressed envelope. Depending on how many people would like to get involved, it may not be possible for everybody who expresses an interest in the research to participate. If you decide that you would like to participate, I will do my very best to let you know as soon as possible.

What would I have to do?

If you do participate in the research I will arrange a meeting with you at a convenient date and time either in a room provided by the NHS Trust that you are involved with or in a room provided by a service in the community, such as a GP service. We will need to arrange the meeting on a date during which you are either still attending the MBT programme or no longer than 12 months after you finished the programme. The meeting will consist of an interview lasting approximately 60 minutes during which I will ask you a number of questions about your experiences of being involved in a MBT programme. The interview will be audio recorded so that it can later be written down on paper, or transcribed.

Do I have to take part or can I change my mind?

No, you do not have to take part. Your participation in this research is entirely voluntary. If you decide not to take part your care with the NHS Trust that you are involved with will not be affected in any way. You are also free to stop the interview without giving any reason. Also, if you do participate in the research you can withdraw your information from the study at any time without giving a reason. Please be aware that when the content of your interview has been anonymised and created into themes it might not be possible for it to be withdrawn, although I will do my very best to remove your information up until the research becomes published if this is the case.

What about confidentiality?

All of the information collected during the interview will be kept confidential. The audio recording of the interview will be stored in a password-protected computer in Lancaster University following the interview and will be destroyed within 3 months of the interview. An anonymised written transcript of your interview will be stored in a password-protected computer in Lancaster University during the research. When the research is completed it will be stored in a locked cabinet in

Lancaster University for 10 years. It will then be destroyed. My research supervisor (Dr Suzanne Hodge) and I are the only people who will have access to the audio recording and to the transcript. Some of the information that you give during the interview may be included in the final report; but any information that may identify you to others, such as your name or date of birth, will be excluded.

There are a few exceptions to confidentiality but I will explain these exceptions to you before the interview begins. For example, if you report information that suggests that you or somebody else is at risk of serious harm I may need to discuss this information with my research supervisor. I will also need to follow Trust procedures to maintain your safety and the safety of others which may involve discussing the information with other professionals. If I do need to contact others about some of the information that you give me I will talk to you about this first.

What are the benefits of taking part?

There are no immediate, direct benefits of taking part. However, it is my hope that this research will help services to have a better understanding of the needs and experiences of those who participate in MBT programmes, and that this will help them to meet those needs more effectively. Also, it is my hope that this research will help other service users to have a better understanding of what it is like to take part in a MBT programme before deciding whether they feel it would be a useful support for them. The research may also provide suggestions for improving MBT as a therapy.

What are the risks of taking part?

A possible risk of taking part may include talking about difficult or upsetting experiences. Should this happen during the interview, you will be able to stop the interview if you wish to do so. I will be able to put you in touch with appropriate supports within the Trust if you feel that you need this. I will also have the number for the Samaritans if you feel that you would like to contact them.

Ethical Approval

This study has been reviewed and approved by **(INSERT NAME)** Ethics Committee. It has also been approved by **(INSERT NAME)** Research and Development committee.

What will happen to the results of the research?

The results of the research will be summarised and submitted to Lancaster University as a report. They may also be submitted for publication in an academic or professional journal, presented at conferences and/or presented at training events.

Where can I obtain further information if I need it?

This research is conducted by Diarmaid Ó Lonargáin, Trainee Clinical Psychologist, Doctorate in Clinical Psychology, C27 Furness College, Lancaster University, Lancaster, Lancashire, LA1 4YG; email: d.olonargain@lancaster.ac.uk; Tel. **(INSERT NUMBER)**.

How do I make a complaint or representation?

If you wish to make a complaint or representation about any aspect of this study and do not want to speak to the researcher, you can contact Dr Craig Murray, Senior Lecturer in Research Methods, Doctorate in Clinical Psychology, Lancaster University; email: c.murray@lancaster.ac.uk; Tel. 01524 592730.

If you wish to speak to somebody outside of the Doctorate in Clinical Psychology programme you can contact Professor Susan Cartwright, Faculty of Health and Medicine, Head of Division of Health Research, Lancaster University; email: s.cartwright@lancaster.ac.uk; Tel. 01524 592430.

Thank you for taking the time to read this information sheet

Appendix 4-F: Reminder Covering Letter to Potential Participants

DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

To whom it may concern,

You recently received an information pack from me inviting you to participate in a study that I am doing as part of my doctorate in clinical psychology. Please find enclosed the same participant information sheet and consent form that were previously sent to you as a reminder about this research. If you have already been in touch with me about the research you have received this reminder pack because staff working in the service do not know whether or not you plan to participate in the research. This is to make sure that your anonymity is protected.

If you think that you may be interested in taking part I would be delighted to hear from you. You can contact me by telephone or by email (see the participant information sheet for my details) or, if you would prefer, you can fill in and return the reply slip to me using the enclosed stamped addressed envelope. However, this will be the last contact you will receive from me regarding the research if you would prefer not to participate.

Yours faithfully,

____

Diarmaid Ó Lonargáin

Trainee Clinical Psychologist

Lancaster University

Appendix 4-G: Debrief Sheet

Thank you for participating in this research. Before we finish, I'd like to let you know about a few options that you have at this point. If you feel in any way upset or distressed after talking about your personal experiences during the interview I have a list of telephone numbers with me that you may wish to call for support. Also, you may wish to discuss some of these experiences with your MBT therapist if you are currently attending a MBT programme.

I will be preparing a summary of the findings from this research for those of you who have participated. Would you like me to send you a copy of this summary after the research has been completed? If you are not certain now, you can contact me at any time if you decide that you would like a copy of the summary. My email address is d.olonargain@lancaster.ac.uk.

Appendix 4-H: Semi-Structured Topic Guide

General perceptions of attending MBT

1. Could you tell me a bit about your experience of attending a full MBT programme?
2. How did you find the transition from the MBT introduction group to full programme MBT?
3. How have things been for you since you started attending the full MBT programme?
4. How do you find attending a mixture of group therapy and individual therapy every week?
5. How does your experience of full programme MBT fit with the expectations you had before you started?

Impact on the life of the participant

6. What impact has attending full programme MBT had on your life generally?
7. What emotional impact has it had on you?
8. How do you manage this emotional impact?
9. Are there any other ways that attending full programme MBT has affected you?
10. How does MBT fit in with the rest of your life?

Interacting with Others

11. How have you found interacting with others during full programme MBT?
12. What has your experience been of individual therapy during MBT?
13. What has your experience been of group therapy during MBT?

Coping

14. How do you find attending full programme MBT on a weekly basis?
15. What does full programme MBT mean to you?

Appendix 4-I: Telephone Numbers

The Samaritans: 08457 90 90 90

[redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]

Appendix 4-J: Letters of Approval for Research

The following pages contain letters of approval from a regional National Research Ethics Service (NRES) committee in the UK and from relevant research and development departments in UK Trusts.

NHS
Health Research Authority
National Research Ethics Service

[redacted]

26 September 2013

Mr Diarmaid Ó Lonargáin
Lancaster University
Doctorate in Clinical Psychology Programme
Division of Health Research
Room C27 Furness College
Lancaster
Lancashire
LA1 4YG

Dear Mr Ó Lonargáin

Study title:	**Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives**
REC reference:	**13/NW/0636**
Protocol number:	**N/A**
IRAS project ID:	**135328**

The Research Ethics Committee reviewed the above application at the meeting held on 19 September 2013. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact [redacted]

Ethical opinion

The Committee understood that you would be conducting the study at three different sites and asked if you could explain the strategy for dealing with distress. What support would be readily available? You explained that you would have the name of the participants care co-ordinator. You would also follow Trust protocol which could vary between the sites.

The Committee had noted that if there was a problem the participants would be given telephone numbers for organisations including the Samaritans. The Committee asked whether there would be an individual who could assess the case. You advised that you could call the crisis or recovery team who could be available at all of the times that you would be conducting the interviews.

The Committee asked what phone number would be given as a contact number on the Participant Information Sheet. You explained that it would be a number for a phone provided by the University and not a personal telephone number.

The Committee specified that in the Participant Information Sheet it is important that it is clear that 'no' patients do not have to take part. You agreed.

The Committee asked whether the audio recordings would be destroyed in 3 months as this was not clear. You confirmed that they would.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

The Committee specified the following additional condition:

- Please add the sentence *'No, you do not have to take part.'* to the Participant Information Sheet as the first sentence under the heading *'Do I have to take part…?'*

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

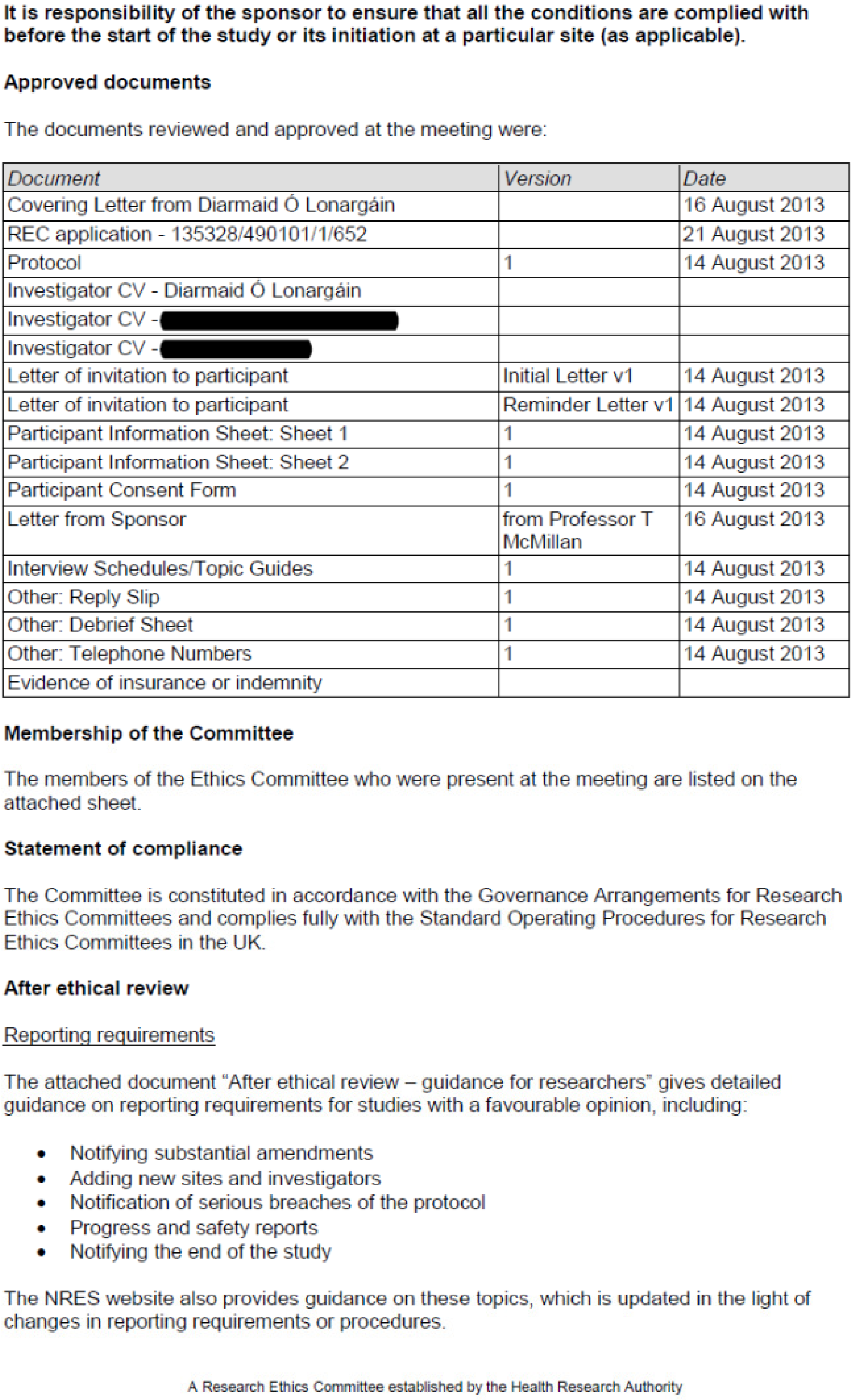
Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations



It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Covering Letter from Diarmaid Ó Lonargáin		16 August 2013
REC application - 135328/490101/1/652		21 August 2013
Protocol	1	14 August 2013
Investigator CV - Diarmaid Ó Lonargáin		
Investigator CV - [redacted]		
Investigator CV - [redacted]		
Letter of invitation to participant	Initial Letter v1	14 August 2013
Letter of invitation to participant	Reminder Letter v1	14 August 2013
Participant Information Sheet: Sheet 1	1	14 August 2013
Participant Information Sheet: Sheet 2	1	14 August 2013
Participant Consent Form	1	14 August 2013
Letter from Sponsor	from Professor T McMillan	16 August 2013
Interview Schedules/Topic Guides	1	14 August 2013
Other: Reply Slip	1	14 August 2013
Other: Debrief Sheet	1	14 August 2013
Other: Telephone Numbers	1	14 August 2013
Evidence of insurance or indemnity		

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

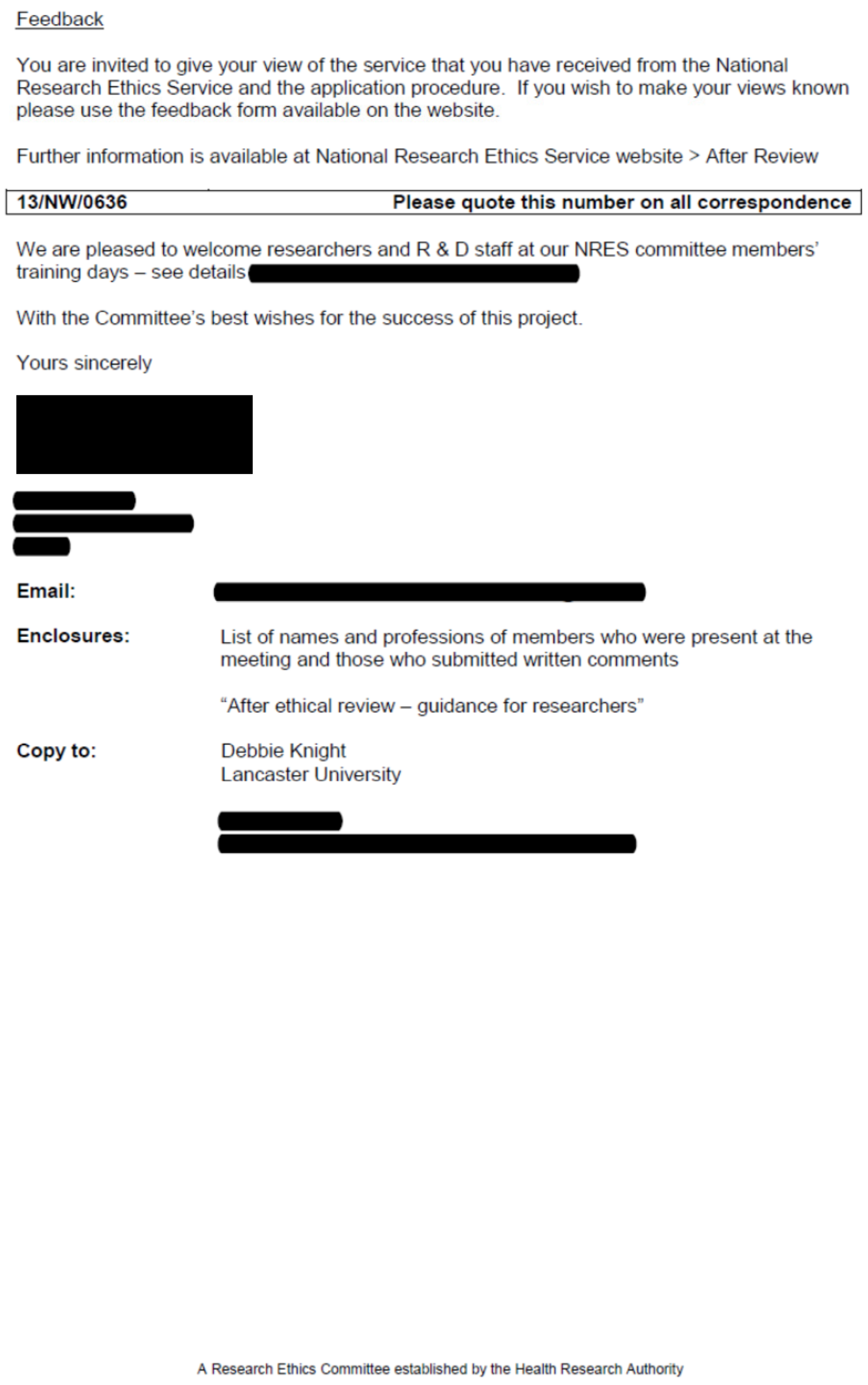
After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.



Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/NW/0636 **Please quote this number on all correspondence**

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details [redacted]

With the Committee's best wishes for the success of this project.

Yours sincerely

[redacted]

[redacted]

Email:	[redacted]
Enclosures:	List of names and professions of members who were present at the meeting and those who submitted written comments "After ethical review – guidance for researchers"
Copy to:	Debbie Knight Lancaster University [redacted]

A Research Ethics Committee established by the Health Research Authority

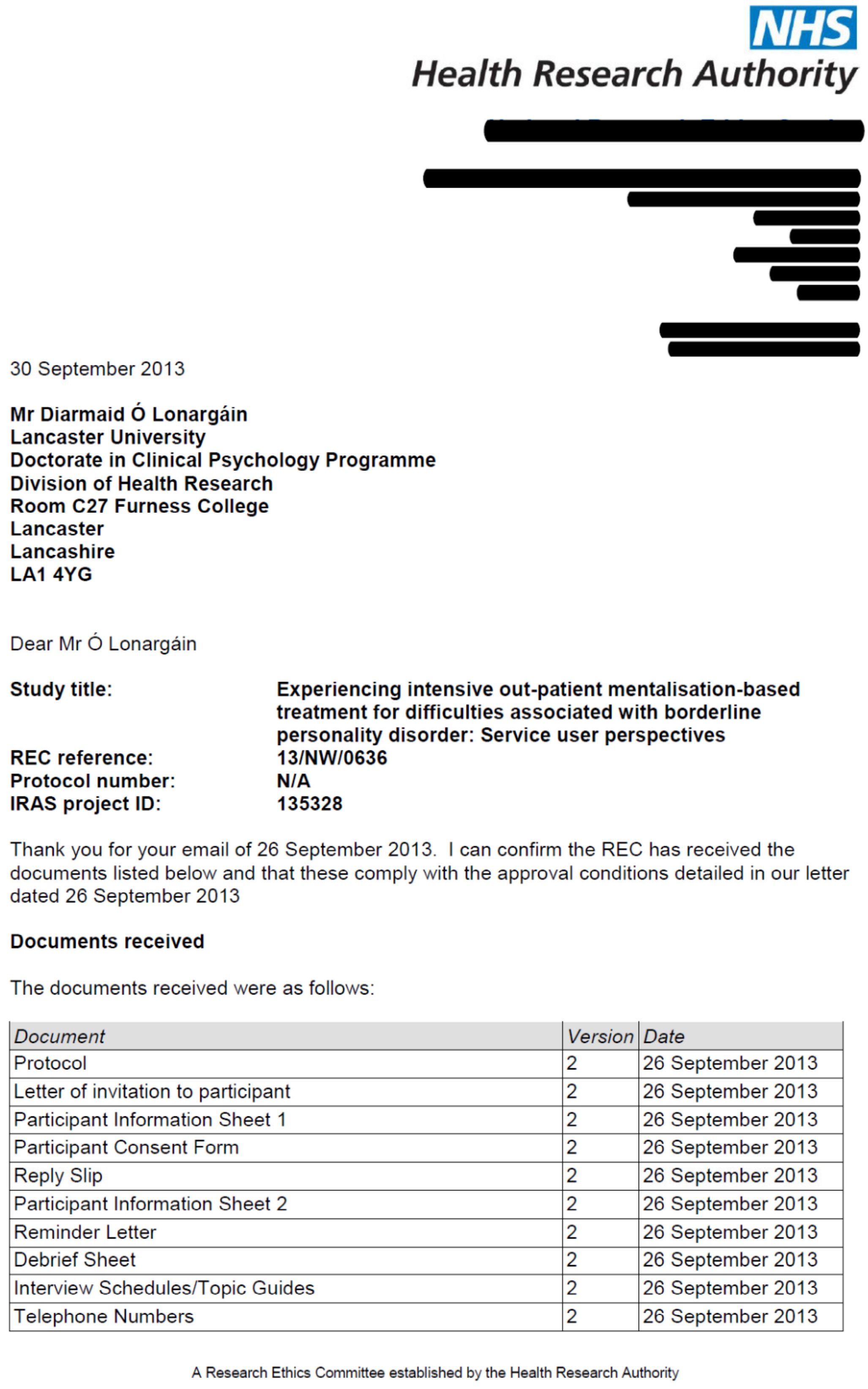
NRES Committee North West - Liverpool East

Attendance at Committee meeting on 19 September 2013

Committee Members:

Name	*Profession*	*Present*	*Notes*
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	

A Research Ethics Committee established by the Health Research Authority



NHS
Health Research Authority

[redacted]

[redacted]

[redacted]

30 September 2013

Mr Diarmaid Ó Lonargáin
Lancaster University
Doctorate in Clinical Psychology Programme
Division of Health Research
Room C27 Furness College
Lancaster
Lancashire
LA1 4YG

Dear Mr Ó Lonargáin

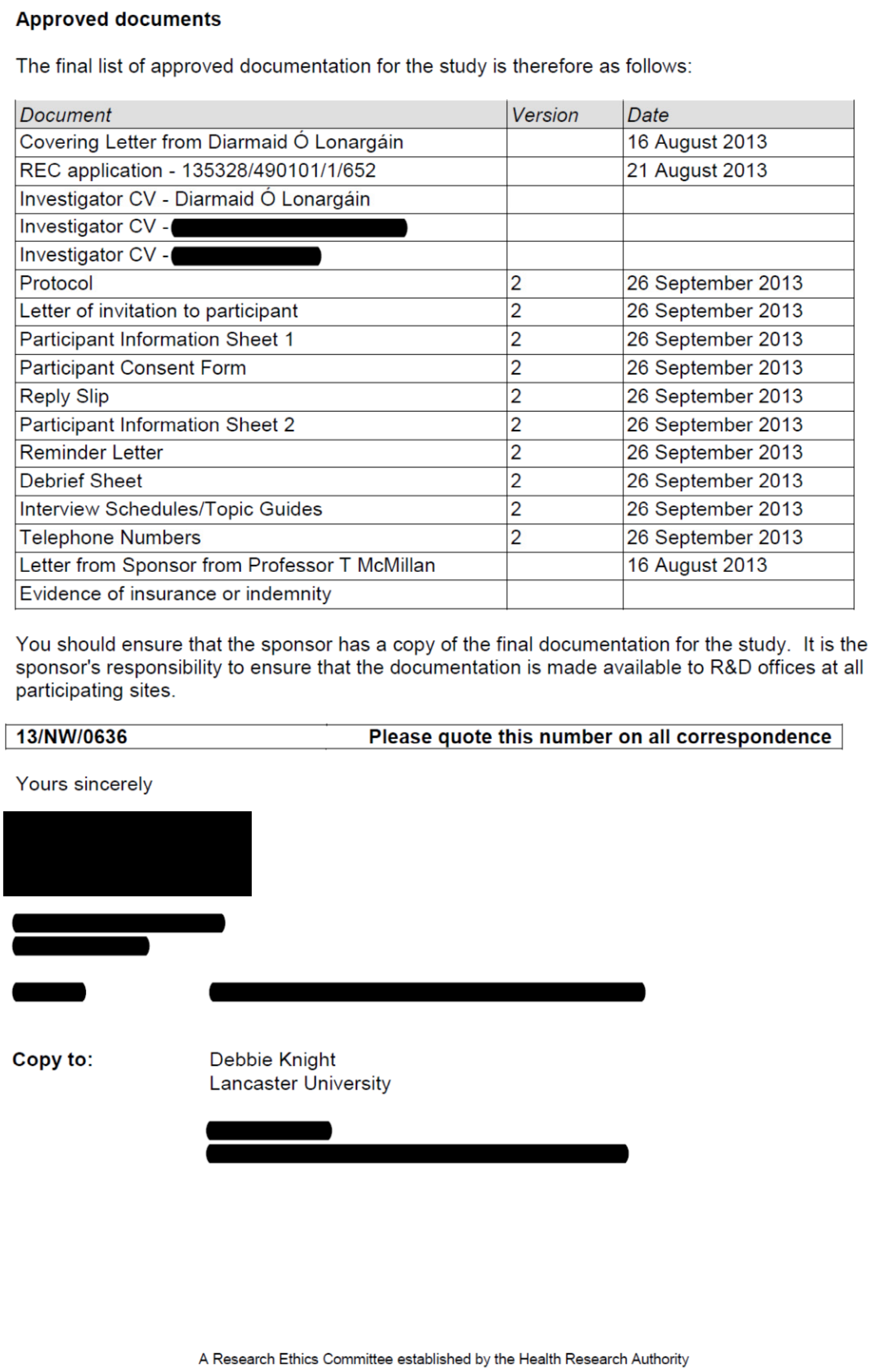
Study title:	**Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives**
REC reference:	**13/NW/0636**
Protocol number:	**N/A**
IRAS project ID:	**135328**

Thank you for your email of 26 September 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 26 September 2013

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Protocol	2	26 September 2013
Letter of invitation to participant	2	26 September 2013
Participant Information Sheet 1	2	26 September 2013
Participant Consent Form	2	26 September 2013
Reply Slip	2	26 September 2013
Participant Information Sheet 2	2	26 September 2013
Reminder Letter	2	26 September 2013
Debrief Sheet	2	26 September 2013
Interview Schedules/Topic Guides	2	26 September 2013
Telephone Numbers	2	26 September 2013



Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Covering Letter from Diarmaid Ó Lonargáin		16 August 2013
REC application - 135328/490101/1/652		21 August 2013
Investigator CV - Diarmaid Ó Lonargáin		
Investigator CV - [redacted]		
Investigator CV - [redacted]		
Protocol	2	26 September 2013
Letter of invitation to participant	2	26 September 2013
Participant Information Sheet 1	2	26 September 2013
Participant Consent Form	2	26 September 2013
Reply Slip	2	26 September 2013
Participant Information Sheet 2	2	26 September 2013
Reminder Letter	2	26 September 2013
Debrief Sheet	2	26 September 2013
Interview Schedules/Topic Guides	2	26 September 2013
Telephone Numbers	2	26 September 2013
Letter from Sponsor from Professor T McMillan		16 August 2013
Evidence of insurance or indemnity		

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

13/NW/0636 **Please quote this number on all correspondence**

Yours sincerely

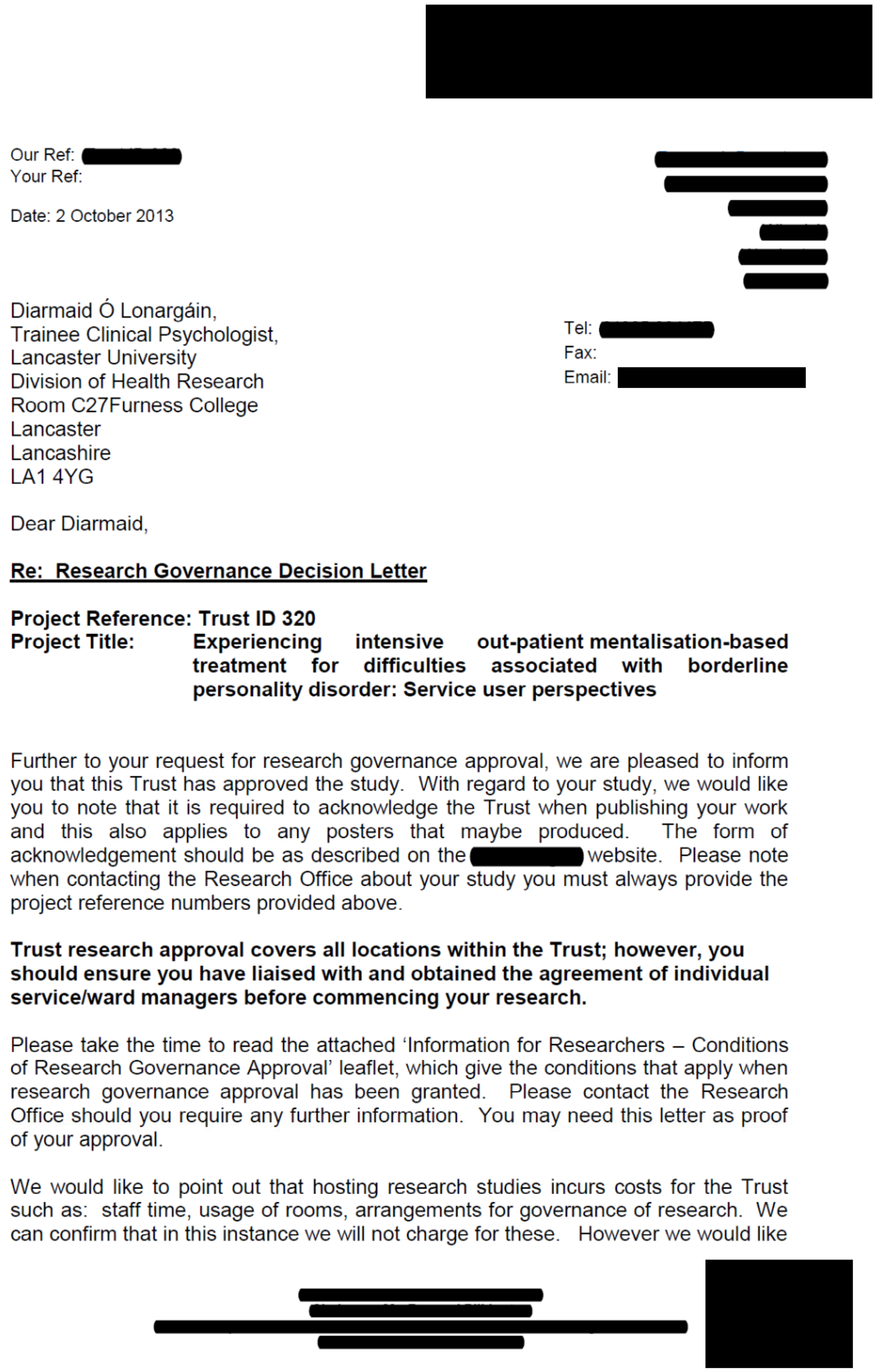
[redacted]

[redacted]

[redacted] [redacted]

Copy to: Debbie Knight
Lancaster University

[redacted]



[redacted]

Our Ref: [redacted]
Your Ref:

Date: 2 October 2013

[redacted]

Tel: [redacted]
Fax:
Email: [redacted]

Diarmaid Ó Lonargáin,
Trainee Clinical Psychologist,
Lancaster University
Division of Health Research
Room C27Furness College
Lancaster
Lancashire
LA1 4YG

Dear Diarmaid,

Re: Research Governance Decision Letter

Project Reference: Trust ID 320
Project Title: Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study. With regard to your study, we would like you to note that it is required to acknowledge the Trust when publishing your work and this also applies to any posters that maybe produced. The form of acknowledgement should be as described on the [redacted] website. Please note when contacting the Research Office about your study you must always provide the project reference numbers provided above.

Trust research approval covers all locations within the Trust; however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research.

Please take the time to read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the Research Office should you require any further information. You may need this letter as proof of your approval.

We would like to point out that hosting research studies incurs costs for the Trust such as: staff time, usage of rooms, arrangements for governance of research. We can confirm that in this instance we will not charge for these. However we would like

[redacted]

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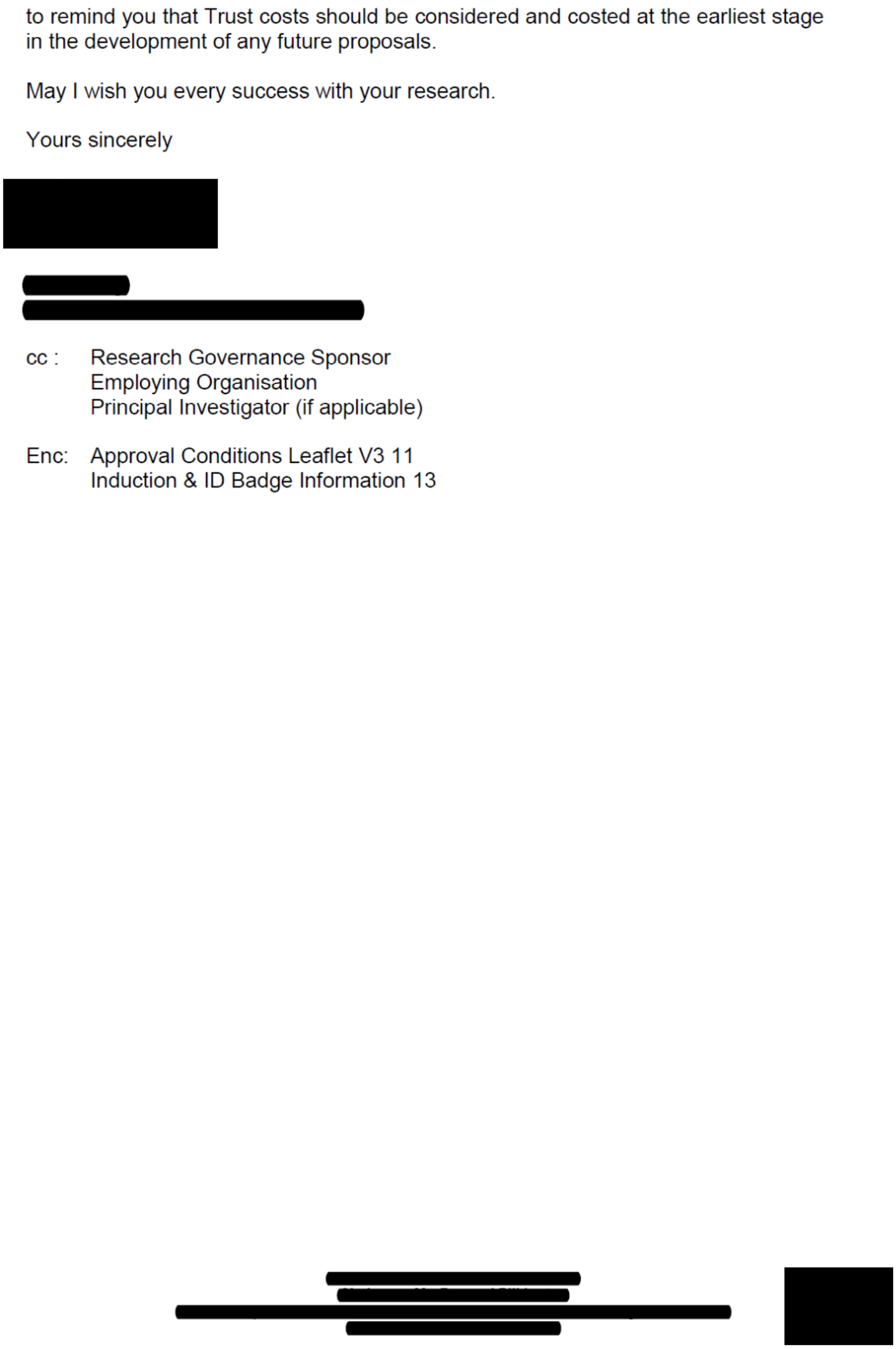


to remind you that Trust costs should be considered and costed at the earliest stage in the development of any future proposals.

May I wish you every success with your research.

Yours sincerely

[redacted]

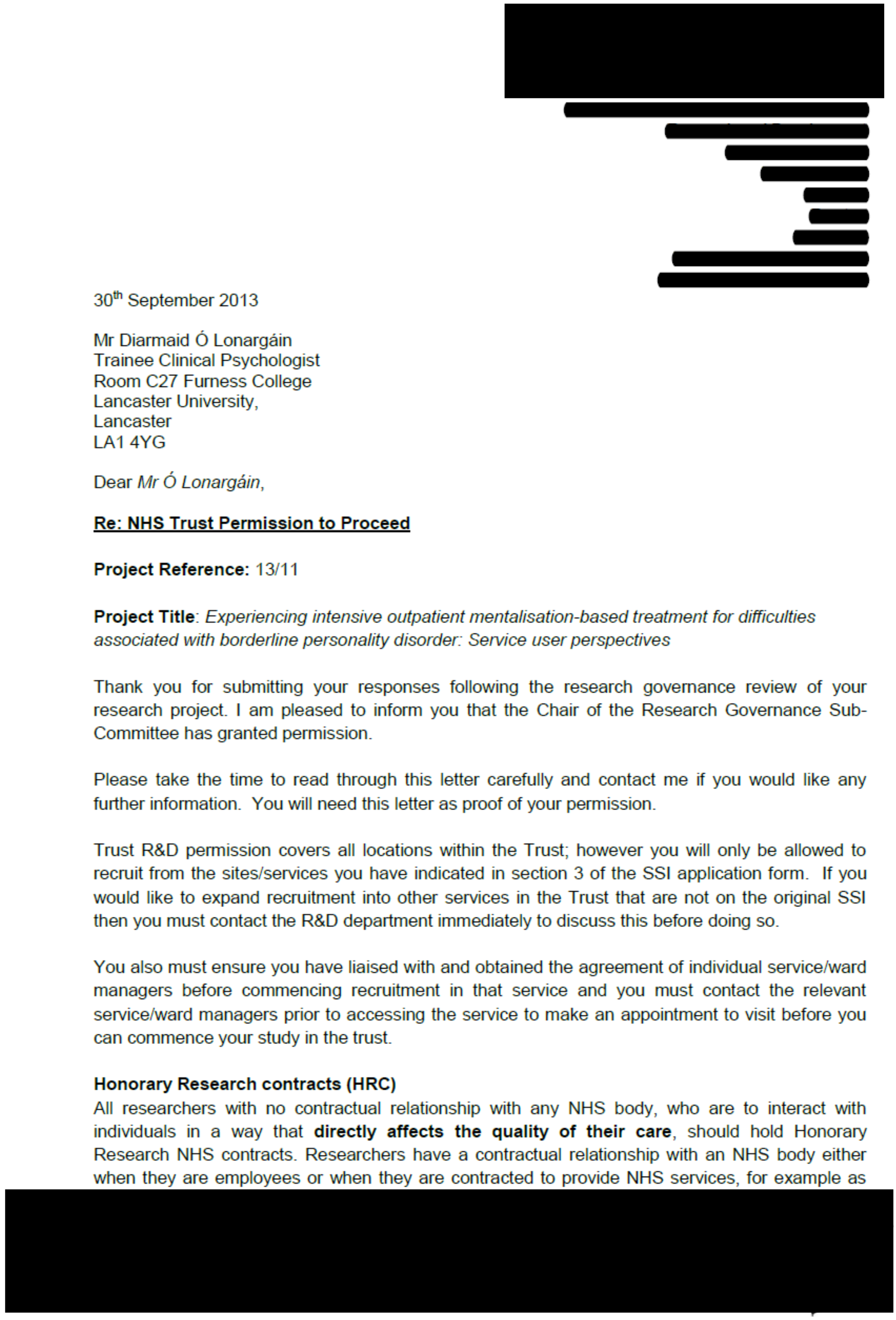
[redacted]

cc : Research Governance Sponsor
Employing Organisation
Principal Investigator (if applicable)

Enc: Approval Conditions Leaflet V3 11
Induction & ID Badge Information 13

[redacted]

[redacted]



[redacted]

[redacted]

30th September 2013

Mr Diarmaid Ó Lonargáin
Trainee Clinical Psychologist
Room C27 Furness College
Lancaster University,
Lancaster
LA1 4YG

Dear *Mr Ó Lonargáin*,

<u>Re: NHS Trust Permission to Proceed</u>

Project Reference: 13/11

Project Title: *Experiencing intensive outpatient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives*

Thank you for submitting your responses following the research governance review of your research project. I am pleased to inform you that the Chair of the Research Governance Sub-Committee has granted permission.

Please take the time to read through this letter carefully and contact me if you would like any further information. You will need this letter as proof of your permission.

Trust R&D permission covers all locations within the Trust; however you will only be allowed to recruit from the sites/services you have indicated in section 3 of the SSI application form. If you would like to expand recruitment into other services in the Trust that are not on the original SSI then you must contact the R&D department immediately to discuss this before doing so.

You also must ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing recruitment in that service and you must contact the relevant service/ward managers prior to accessing the service to make an appointment to visit before you can commence your study in the trust.

Honorary Research contracts (HRC)

All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that **directly affects the quality of their care**, should hold Honorary Research NHS contracts. Researchers have a contractual relationship with an NHS body either when they are employees or when they are contracted to provide NHS services, for example as

[redacted]

[redacted]

independent practitioners or when they are employed by an independent practitioner (*Research Governance Framework for Health and Social Care,* 2005). If a researcher does not require an HRC, they would require a Letter of Access (LoA). For more information on whether you or any of your research team will require an HRC or LoA please liaise with this office. It is your responsibility to inform us if any of your team do not hold Honorary Research NHS contracts/Letters of Access.

Staff involved in research in NHS organisations may frequently change during the course of a research project. Any changes to the research team or any changes in the circumstances of researchers that may have an impact on their suitability to conduct research MUST be notified to the Trust immediately by the Principal Investigator (or nominated person) so that the necessary arrangements can be put in place

Research Governance

The Research Governance Sponsor for this study is Lancaster University. Whilst conducting this study you must fully comply with the Research Governance Framework. This can be accessed at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv
For further information or guidance concerning your responsibilities, please contact your research governance sponsor or your local R&D office.

Good Clinical Practice (GCP)

GCP is an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects. It is the responsibility of all researchers who are carrying out a research project involving NHS patients and carers to complete GCP training and to update this every 2 years. All training certificates must be forwarded to the R&D department to comply with Trust permission. Please note that student projects are exempt in this process.

Risk and Incident Reporting

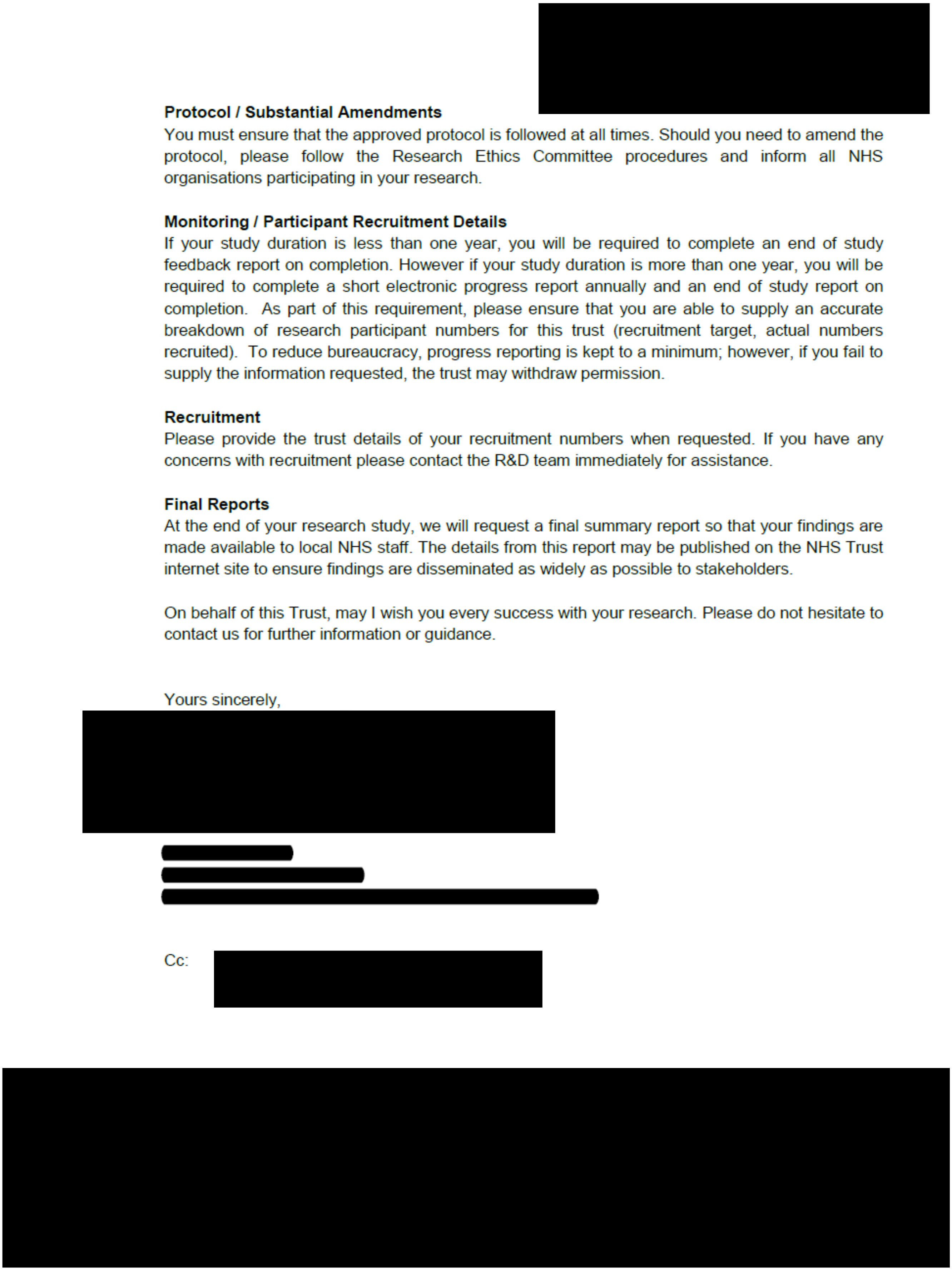
Much effort goes into designing and planning high quality research which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system. If you are in any doubt whatsoever whether an incident should be reported, please contact us for support and guidance.

Regardless of who your employer is when undertaking the research within [redacted] you must adhere to trust policies and procedures at all times.

Confidentiality and Information Governance

All personnel working on this project are bound by a duty of confidentiality. All material accessed in the trust must be treated in accordance with the Data Protection Act (1998) For good practice guidance on information governance contact us.

[redacted]



[redacted]

Protocol / Substantial Amendments
You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

Monitoring / Participant Recruitment Details
If your study duration is less than one year, you will be required to complete an end of study feedback report on completion. However if your study duration is more than one year, you will be required to complete a short electronic progress report annually and an end of study report on completion. As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum; however, if you fail to supply the information requested, the trust may withdraw permission.

Recruitment
Please provide the trust details of your recruitment numbers when requested. If you have any concerns with recruitment please contact the R&D team immediately for assistance.

Final Reports
At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the NHS Trust internet site to ensure findings are disseminated as widely as possible to stakeholders.

On behalf of this Trust, may I wish you every success with your research. Please do not hesitate to contact us for further information or guidance.

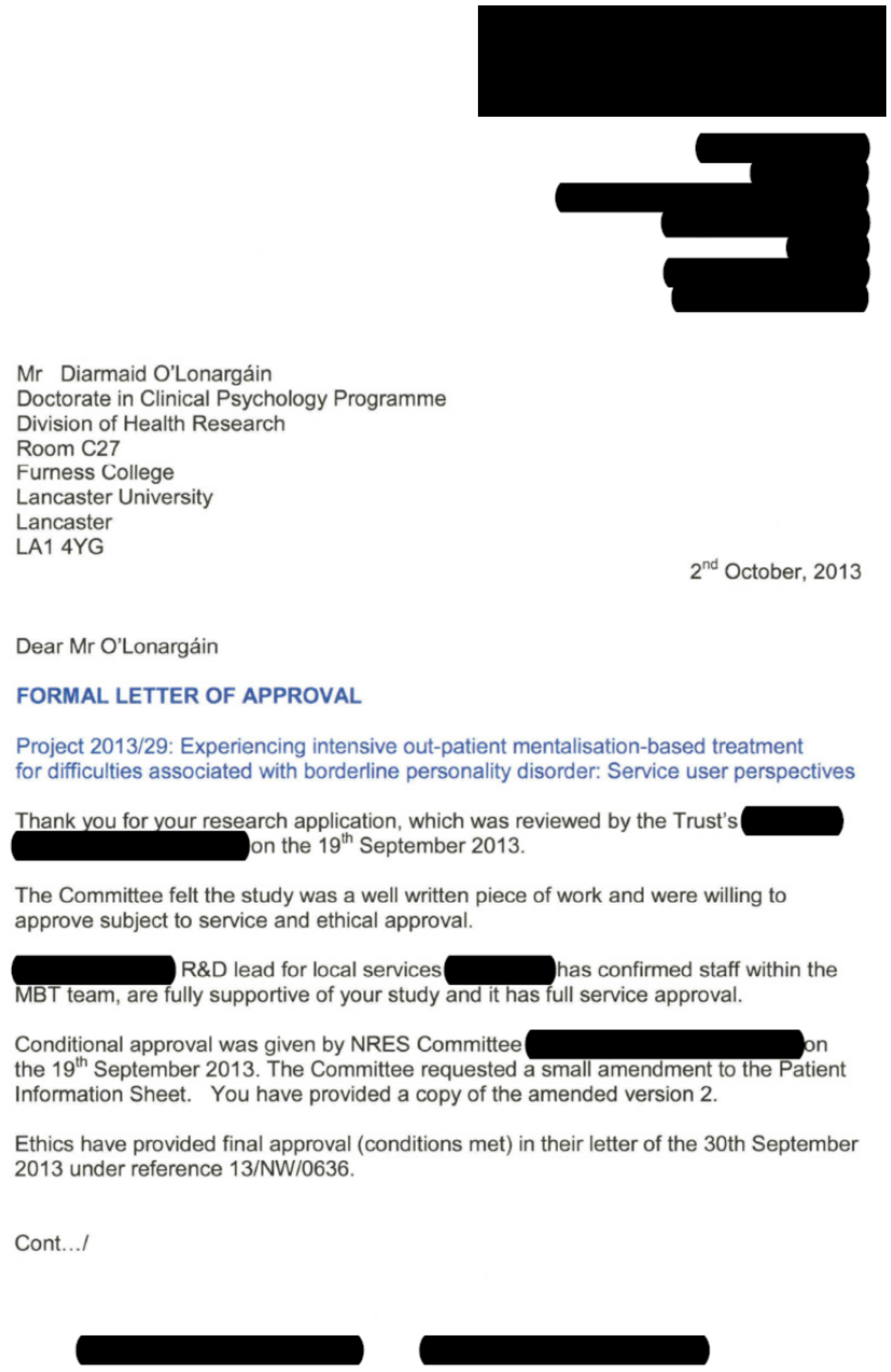
Yours sincerely,

[redacted]

[redacted]

Cc: [redacted]

[redacted]



[redacted]

[redacted]

Mr Diarmaid O'Lonargáin
Doctorate in Clinical Psychology Programme
Division of Health Research
Room C27
Furness College
Lancaster University
Lancaster
LA1 4YG

2nd October, 2013

Dear Mr O'Lonargáin

FORMAL LETTER OF APPROVAL

Project 2013/29: Experiencing intensive out-patient mentalisation-based treatment for difficulties associated with borderline personality disorder: Service user perspectives

Thank you for your research application, which was reviewed by the Trust's [redacted] [redacted] on the 19th September 2013.

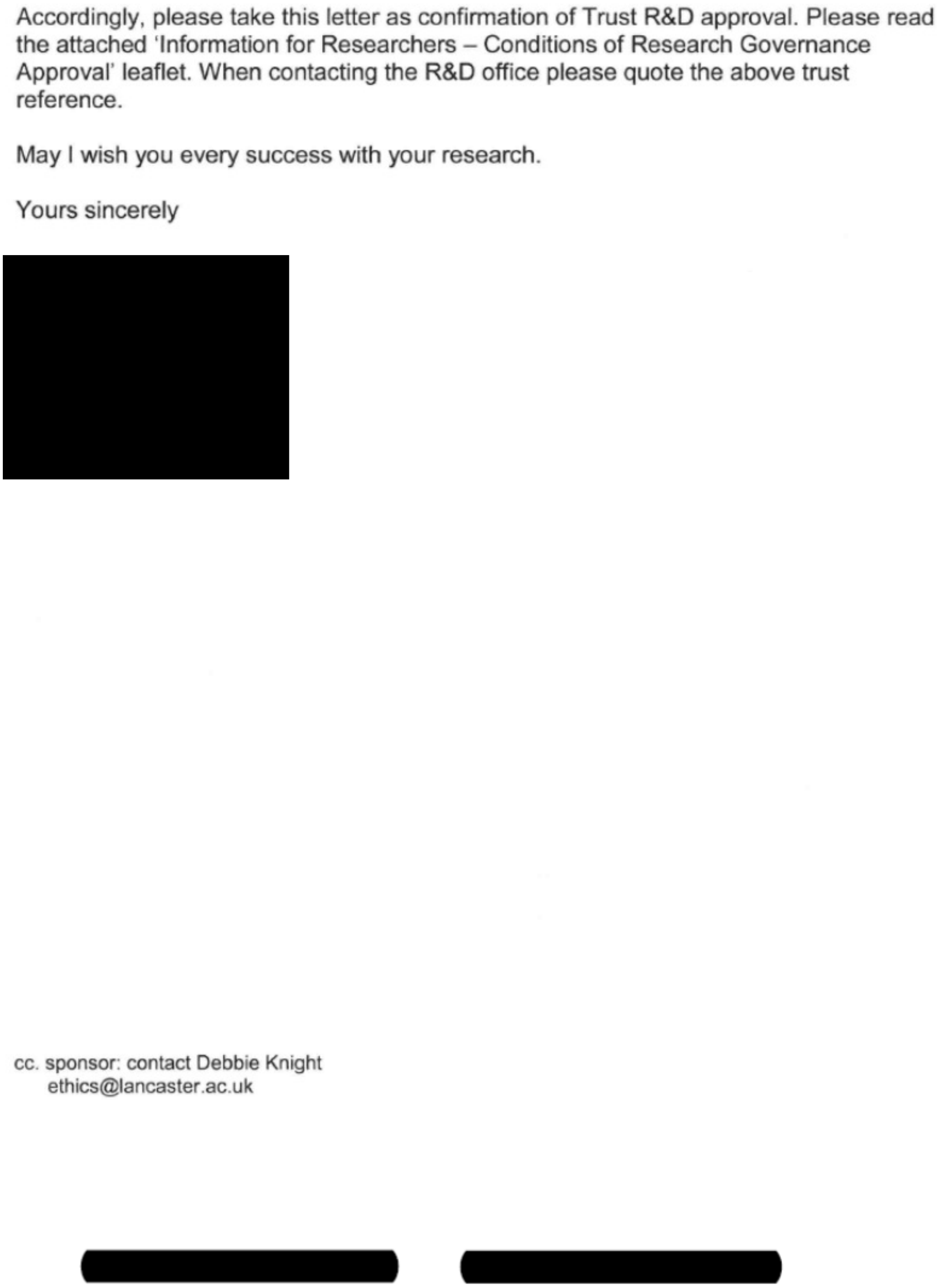
The Committee felt the study was a well written piece of work and were willing to approve subject to service and ethical approval.

[redacted] R&D lead for local services [redacted] has confirmed staff within the MBT team, are fully supportive of your study and it has full service approval.

Conditional approval was given by NRES Committee [redacted] on the 19th September 2013. The Committee requested a small amendment to the Patient Information Sheet. You have provided a copy of the amended version 2.

Ethics have provided final approval (conditions met) in their letter of the 30th September 2013 under reference 13/NW/0636.

Cont…/



Accordingly, please take this letter as confirmation of Trust R&D approval. Please read the attached ‘Information for Researchers – Conditions of Research Governance Approval’ leaflet. When contacting the R&D office please quote the above trust reference.

May I wish you every success with your research.

Yours sincerely

[redacted]

cc. sponsor: contact Debbie Knight
ethics@lancaster.ac.uk

[redacted] [redacted]