

Ó Lonergáin, D., Hodge, S. and Line, R. (2017), Service User Experiences of Mentalisation-Based Treatment for Borderline Personality Disorder, *Mental Health Review Journal*. DOI:10.1108/MHRJ-04-2016-0008.

### **Abstract**

**Purpose:** Previous research indicates that mentalisation-based treatment (MBT) is an effective therapeutic programme for difficulties associated with borderline personality disorder (BPD). The aim of this study was to explore service user experiences of the therapy.

**Design/Methodology/Approach:** Seven adults (five female and two male), recruited via three NHS Trusts, were interviewed. Participants were attending intensive out-patient MBT for BPD for between three and 14 months. Data were analysed using interpretative phenomenological analysis.

**Findings:** Participants experienced the group component of MBT as challenging and unpredictable. They highlighted developing trust as key to benefitting from MBT. This was much more difficult to achieve in group sessions than in individual therapy, particularly for those attending MBT for less than five or six months. The structure of MBT generally worked well for participants but they identified individual therapy as the core component in achieving change. All participants learned to view the world more positively due to MBT.

**Practical Implications:** Enhanced mentalisation capacity may help address specific challenges associated with BPD, namely impulsivity and interpersonal difficulties. MBT therapists are confronted with the ongoing task of creating a balance between sufficient safety and adequate challenge during MBT. Potential benefits and drawbacks of differing structural arrangements of MBT programmes within the UK are considered.

**Originality/Value:** Learning about service user perspectives has facilitated an enhanced understanding of experiences of change during MBT in addition to specific factors that may impact mentalisation capacity throughout the programme. These factors, in addition to implications for MBT and suggestions for future research, are discussed.

**Keywords:** Mentalisation-Based Treatment; Borderline Personality Disorder; Qualitative Research; Interpretative Phenomenological Analysis; Service User Experiences.

**Article Classification:** Research Paper

**Disclosure Statement:** The authors report no conflict of interest.

## Introduction

Mentalisation-based treatment (MBT) is a therapeutic programme developed by Anthony Bateman and Peter Fonagy to enhance mentalisation capacity in individuals who have been given a diagnosis of borderline personality disorder (BPD) (Bateman and Fonagy, 2001; Bateman and Fonagy, 1999; Bateman and Fonagy, 2003). Mentalisation refers to the ability to understand, question and be aware of one's own mental states and those of others (Allen et al., 2008). Bateman and Fonagy (2006) theorise that an impaired ability to mentalise is at the root of many of the core difficulties associated with BPD such as impulsivity, interpersonal difficulties, and self-harm. The development of mentalisation capacity is associated with close attachment relationships, and may become impaired where a lack of safety is experienced in those relationships. For example, a child who has experienced abuse may be unable to think about the mental states of their abuser. The resulting impaired ability to mentalise leads to difficulties with future attachment relationships and to further complications such as psychic equivalence (i.e. the experience of inner states as absolute representations of outer reality, sometimes resulting in paranoid hostility), pretend mode (i.e. inner reality and outer reality are completely separate sometimes leading to dissociation) and teleological mode (i.e. observable behaviour must occur in order to facilitate a change in mental state).

MBT is a manualised therapy designed to stimulate mentalisation capacity using a combination of individual and group components. It was initially developed as two separate programmes: a day hospital programme and an intensive out-patient programme. The out-patient treatment, which is the focus of this paper, consists of one individual and one group therapy session per week for 18 months. 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).

The aim of individual sessions is to develop the client's mentalisation capacity by exploring its limits. In order to do this the therapist remains in close emotional proximity to the client, probing and stimulating feelings until the client is close to losing mentalisation capacity. At this point the therapist decreases emotional arousal by reducing the intensity of the session. When the client resumes mentalising the therapist can return to emotional proximity (Bateman and Fonagy, 2012). In this way, the therapist attempts to maintain a balance between cognitive and affective learning throughout therapy.

The primary aim of group sessions is to provide a platform for learning how to mentalise in a group environment. There will be times during group interactions when service users (and therapists) will lose mentalisation capacity. The focus of the group sessions is thus on identifying and exploring such instances, and regaining the ability to mentalise in the group environment (Karterud and Bateman, 2012). Thus concurrent individual and group psychotherapy are seen as essential to MBT (Bateman and Fonagy, 2006).

There is increasing quantitative evidence supporting the use of MBT for people with a BPD diagnosis. Evidence from a number of randomised controlled trials suggests that it is effective in addressing difficulties such as self-harm, suicidal behaviours, depression and interpersonal functioning difficulties (Bales et al., 2012; Bateman and Fonagy 1999; Bateman and Fonagy, 2009; Rossouw and Fonagy, 2012). Research also indicates that improvements can remain for at least five years post-treatment (Bateman and Fonagy, 2008). However, whilst evidence for the clinical effectiveness of the intervention is amassing, there is as yet very little qualitative research. Such evidence is of value both in helping to inform the further development of the approach and as a learning resource for health professionals and future MBT therapists seeking to gain an understanding of what the therapy is like. Perhaps most importantly, however, there is a strong ethical imperative for developing a body of research evidence that incorporates first-hand accounts of experiences which quantitative research renders invisible through the processes of categorisation and quantification. This is important because it provides the basis for more nuanced understandings of the phenomena we are investigating, and also creates the space for critically questioning categories and constructs which quantitative research assumes as givens.

To our knowledge, only two qualitative research papers focusing specifically on the experiences of MBT for people with a BPD diagnosis have as yet been published (Dyson and Brown, 2016; Johnson et al., 2016), with a third exploring the role of the therapists in MBT group sessions (Inderhaug and Karterud, 2015). Johnson et al. (2016) used thematic analysis to study the experiences of life after MBT, highlighting the medium-term benefits of the intervention, and particularly the value for participants of being understood through MBT. Of most direct relevance to the research reported here, Dyson and Brown's (2016) study used interpretative phenomenological analysis (IPA) to explore in depth the experiences of MBT of six women who had completed at least six months in MBT. Participants were recruited via social media rather than directly through services; some were still in MBT whilst others had completed therapy several years previously. One overarching theme was identified, 'the battle between BPD and me'. Contained within this were three subordinate themes: 'I'm

much better now [laugh]. Hopefully?'; 'You've got to be ready for therapy...you've got to be able to change'; and 'We are One (but not Together)'. These themes clearly reflect an intrapsychic focus on how the experience of being in (and leaving) MBT impacted on the participants individually. Whilst these findings provide a useful contribution to the evidence base, what they do not do is provide much detailed insight into the ongoing experience of being in MBT. The study reported here sets out to fill this gap, adding to this modest qualitative evidence base, by exploring how adults with difficulties associated with BPD experience intensive out-patient MBT.

## **Method**

### ***Design***

A study design based on interpretative phenomenological analysis (IPA) was adopted. IPA is concerned with understanding the meanings people attach to their experiences. IPA is used to scrutinise major life experiences and has an idiographic focus that results in in-depth analysis of individual participant experiences within a broader set of collective themes (Smith, 2004; Smith et al., 2009; Smith and Osborn, 2008).

IPA is influenced by Husserl's phenomenology and by hermeneutic phenomenology as espoused by Heidegger and Gadamer (Smith et al., 2009). The former tradition places a focus on how we perceive and experience phenomena as a means of understanding them. The latter tradition highlights the role of historical experiences in creating meaning on both individual and social levels. Thus individual experiences are viewed as interpretive in nature. Furthermore, in research influenced by phenomenology, the researcher's own perceptions and experiences are recognised as influencing the interpretative process, so bracketing one's own biases and assumptions is seen as an important part of the research process. This involves actively reflecting on what those assumptions are, in order to prevent their undue influence on the research findings (Laverly et al., 2003). IPA builds on these traditions by emphasising a double hermeneutic in the analysis process in which the participant attempts to make sense of his or her experiences of the world, and the researcher then endeavours to make sense of these interpretations.

IPA was considered particularly suitable for this research for a number of reasons. Committing to an 18 month intensive programme in an attempt to find support for significant and often enduring interpersonal and/or emotional difficulties was deemed to be a major life event. In addition, it was felt that the strong emphasis on a double hermeneutic and interpretation could enhance and enrich participant experiences associated with MBT and

perhaps assist in the discovery of more meaningful findings. Furthermore, the idiographic component of IPA ensured that individual experiences would not be lost amongst the commonalities discerned from the data.

### ***Participants***

Participants needed to be over 18 years of age and to have been accessing MBT for between two and 15 months. This time range was chosen in order to ensure that participants had had time to settle into the treatment, build therapeutic relationships and were able to describe their experiences, whilst avoiding the potential insecurity created by therapeutic endings.

Participants were recruited from four MBT groups within three NHS trusts in the UK. All therapists involved completed basic MBT training at the Anna Freud Centre, London and some completed the advanced MBT training at the same centre. Each therapist received supervision at least every fortnight and some had supervision on a weekly basis. Therapists from two Trusts used videos of sessions as part of the supervision process and one Trust used an adherence scale to monitor quality. It was not possible to attain the level of experience of each therapist. However, research indicates that years of experience among therapists does not significantly impact therapy outcomes (Okiishi et al., 2006).

Twenty eight individuals were identified as meeting the inclusion criteria and provided with recruitment packs by a MBT therapist in their trust. Recruitment packs included a letter introducing the research, a participant information sheet and a consent form. Seven individuals took part (see Table 1 for demographic details). This is a good sample size for an IPA study in which small numbers are typically used in order to facilitate in-depth analysis (Smith, 2004). It is interesting to note that only a quarter of potential participants took part which may be reflective of the chaotic lifestyle often associated with BPD.

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### ***Procedure***

#### ***Ethics.***

Approvals were obtained from a regional NHS research ethics committee and from the research and development departments of the three trusts. Prior to approval these

committees and departments reviewed a range of documents including a fully completed NHS Research Ethics Committee form, NHS Research and Development forms and a research protocol with recruitment documents appended. Each participant provided informed consent by reviewing the information in the recruitment pack, contacting the first author for further information where required and signing the consent form. All personal names cited in this report are pseudonyms.

#### *Data collection.*

Semi-structured interviews lasting for an average of 60 minutes were conducted by the first author, using a topic guide. Each interview took place in a pre-booked room within the relevant Trust. The first author used a reflective diary to highlight potential biases and assumptions and to reflect on each interview. These reflections were utilised to continually enhance interview performance and optimise the opportunity for participants to elicit experiences relevant to the research question. They also resulted in some small amendments to the topic guide. All interviews were recorded and transcribed verbatim by the first author.

#### *Analysis.*

Drawing on guidelines provided by Smith et al. (2009) the first author began analysis by reading each transcript several times. He then made exploratory comments on the transcript about how he felt the participant was making sense of their experiences of MBT. The reflective diary was reviewed in order to bracket assumptions and biases as much as possible. In the next stage, more interpretative emergent themes were noted on the transcript, based on the exploratory comments and the transcript itself. The next stage involved grouping emergent themes together where connections were apparent, creating a small number of superordinate themes. A summary was written for each superordinate theme. This process was repeated for each transcript.

Once each transcript had been analysed individually all of the emergent themes from each transcript were collated and grouped together according to similarities and connections, therefore producing final or group superordinate themes which are presented below. This process involved re-reading exploratory comments relating to each emergent theme in addition to the superordinate themes of each individual participant to ensure that the idiographic element of IPA was present in the final superordinate themes.

## Findings

Analysis of participant data resulted in four major themes. Each major theme contains a series of minor themes and these are outlined below.

### *Experiencing Group MBT as Unpredictable and Challenging*

All participants reported experiencing group MBT as very intense and difficult at some stage and this experience continued on an ongoing basis for most. Most participants described wanting individual sessions only and some did not see the purpose of group MBT.

#### *Beginning group MBT: initial challenges.*

Six of the participants attended a rolling MBT group where members joined and left on a continuous basis. All but one person (Laura) described joining the group as difficult thus taking them time to settle, "At first I...felt a bit distant...bearing in mind that there were people already in the group...And it took me about two month to engage..." (Kevin). Ruth had found this experience very challenging, feeling that she was "invading" the group. Laura, however, felt she was able to blend in by concealing her insecurities, "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."

#### *Experiencing a lack of safety.*

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

Other challenges were more overt. Ruth reported that during her first group session 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 another group member whom she found "direct" and "intimidating" while John's ongoing 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.

*The struggle to express oneself in group MBT.*

John’s experience of feeling unable to speak in the group was shared by most participants. Lisa found that some group members did most of the talking and that she did not get an opportunity to contribute, resulting in her feeling worse after group sessions. 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. Jo had also struggled during the initial stages but was now determined to contribute as she had not done so during a previous therapeutic group she was involved with.

***Building Trust: A Gradual but Necessary Process during MBT***

Learning to trust and feel comfortable both with therapists and group members was perceived by all participants as an essential process in order to benefit from MBT. This was achieved with much more ease in individual sessions than group sessions.

*Building trust in individual sessions with minimal difficulty.*

Despite initially feeling uncertain about their individual therapists participants seemed to quickly build trust with them. Sarah and Jo described their individual therapist as "caring" and Laura became “unbelievably comfortable" with her therapist after the first few sessions 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 found individual sessions very supportive and were able to express personal difficulties there, 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). All of the participants were able to build enough trust with their individual therapists for them to feel they were benefitting from individual sessions.

*Acquiring trust in group sessions: an arduous challenge.*

Participants found building trust in group sessions to be a gradual and more difficult process. Kevin felt that trust was essential to the group because individuals would not open up without it. It took Sarah six months before she started to open up in the group and building trust was a key factor in facilitating 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 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 helping other participants 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 group member whom she found intimidating. This may suggest that for her the group was potentially an unsafe place where people could hurt each other and this was possibly exacerbated by the change associated with rolling groups.

*The impact of programme structure and duration of attendance on building trust.*

Six of the participants attended rolling groups and most found the arrival of new members disruptive to the therapy. Kevin believed that it interfered with the trust that had already been built among members and others felt that openness was 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). 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 the value of 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, again highlighting 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 MBT by reflecting on the structure of different aspects of the programme.

*Preparing for intensive outpatient MBT.*

Each participant had engaged in introductory sessions to MBT. Six participants reported attending these sessions for three to four weeks and this worked well for most of them. Jo felt that it prepared her for the full programme as she got to know her individual therapist and learned what to expect from MBT. Ruth found that learning some mentalisation techniques helped her prepare for the group whilst the main benefit for Laura was becoming familiar with attending therapy on a weekly basis. Although Lisa found what they learned to be too basic she enjoyed the task-oriented structure of sessions.

John described a different type of introduction that was more intensive, lasted longer (i.e. 12 weeks) and with a five week gap between the introduction and full programme. He felt that 12 weeks without one-to-one support was too long, that he was provided with too much information and he 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.

*Individual therapy: "where it all comes together".*

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 providing them with a designated space in which they felt comfortable to express themselves freely, these sessions were 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 were able to discuss in individual sessions and this sometimes then gave them the courage to bring them to the group.

*Making sense of concurrent individual and group therapy in MBT.*

The majority of participants also seemed to view group sessions as an important part of MBT, their main value being the opportunity they provided to reflect on them 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 learned in individual sessions could be tested in group sessions before being used outside.

Most participants emphasised the importance of having individual sessions very soon after group sessions. When this did not happen it seemed to impede participants' ability to reflect on the group, which was deemed extremely important. For Sarah, a long gap 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. For Ruth a long gap meant an absence of her "safety net" following group sessions.

### ***Seeing the World Differently Due to MBT: A Positive Shift in Experience***

All participants described experiencing positive change through MBT and understood this as an ability to see the world in a different way. This manifested in varying ways as outlined below.

#### *Reflecting on personal situations and opening up to different perspectives.*

Having an opportunity to reflect during individual sessions assisted Lisa to think about personal situations in which she had not been mentalising in a more balanced way, "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 had also acquired. Through MBT he learned to give himself space before acting which enabled him to develop a range of explanations outside his immediate assumptions and thus see the world in a more balanced way.

#### *Perceiving challenging incidents in a new way.*

This ability to look for different perspectives and to see events in a new way seemed to help participants 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 using 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 she moved into a state of psychic equivalence by automatically believing 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 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 polarised way.

*Developing a more positive outlook about others and oneself.*

Participants described learning to see others differently, as well as themselves. Supportive and positive interactions with group members assisted Kevin to see that not everyone is "void, callous and cold", which he had previously believed following an abusive past. Ruth described wanting to use the trust she had developed in group members to change her perception of other people outside the group in a positive way. Furthermore, John seemed to have learned to see intense emotions in a more accepting way and he learned in MBT that he could have a better life even with depression, "...now I know that, even if 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 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 intensive outpatient MBT programme for BPD in the UK. The findings show 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 essential to benefit from MBT but was much more difficult to achieve in the group component. Most participants found that the individual and group components of MBT were helpful in combination but individual therapy was perceived by them as the most important element in terms of change. MBT supported all participants to view the world more positively. This impacted them in a number of ways including enhancing their ability

to interact with others and to manage challenging incidents in addition to developing a more positive view of other people and themselves.

### ***The Purpose of MBT: Learning to Mentalise***

Bateman and Fonagy's suppression of mentalisation model of BPD (Bateman and Fonagy, 2006) provides a useful framework to make sense of the participants' understanding of mentalisation as well as the impact that MBT had on them. 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. Some participants also described becoming more aware of their own mental states which enabled them to reflect on and view personal situations in a more balanced way. This enhanced ability to mentalise appears to have been particularly helpful for specific difficulties associated with BPD that may arise from a compromised mentalising capacity, in particular impulsivity and interpersonal difficulties.

### ***Challenges to Mentalising During MBT***

Findings from this study also point towards certain aspects of MBT that may challenge participants' mentalising capacity. These relate to concurrent individual and group therapy and to pre-treatment.

#### ***Concurrent individual and group therapy.***

Concurrent individual and group therapy is utilised in full programme MBT in order to focus on stimulating and enhancing mentalisation capacity via direct experience (i.e. implicit mentalising) in contrasting environments. Both components are viewed not only as essential but also as complementary and unified (Karterud and Bateman, 2012). However, this sense of unity between both components was largely absent for participants in this study who generally perceived the group component as less helpful in terms of change than the individual component. This is in contrast with research that highlights the importance of group-based intervention for specific difficulties associated with BPD such as self-harm and interpersonal functioning (Omar et al., 2014). Furthermore, within the MBT model group sessions are viewed as a valuable and necessary opportunity to mentalise and to tolerate intense emotional experiences in a group environment (Bateman and Fonagy, 2006; Karterud and Bateman, 2012).

In the group component of MBT certain factors are deemed necessary to facilitate the process of change. An important aspect involves not moving to challenge until clarification,

support and empathic interventions have been used and the therapeutic relationship has been developed (Bateman and Fonagy, 2012). This is similarly reflected in the wider literature on group-based therapies (e.g. Hummelen et al., 2007; Yalom, 2005) and it is suggested that containment, belonging and safety need to be firmly in place in therapeutic communities before a culture of openness, curiosity, questioning and challenging of others can thrive (Haigh, 1999).

Bearing this in mind, all participants in this study appeared to struggle to tolerate intense feelings triggered in the group component during the initial few months and only those attending for five or six months or more reported starting to perceive benefits to the group. Furthermore, those who had been attending for more than ten months had begun to recognise conflict and/or unpredictability within the group as tools for enhancing mentalisation capacity. Thus participants who had been in MBT for a longer period appear to have come to experience the group as more secure and predictable, whereas those who had only been attending for three months had yet to experience a sense of trust and containment within the group environment. Moreover, certain factors impacted participants' perception of safety in the group. For example, some participants who had the same therapist in individual and group sessions felt more reassured and supported during group sessions whilst most participants in rolling groups felt anxious, uneasy and untrusting when a new member joined the group.

Even though all participants experienced the group as unsafe and uncontained during the initial stages, all viewed individual sessions as a secure place where trust with the individual therapist was built with relative ease. Individual sessions were described as a "safety net" where challenges could be discussed in a contained environment. If this safety net was not available within a day or two after a group session the group seemed to feel less safe. 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 which needs to be readily available to return to. This understanding may also explain the possible tendency of participants to idealise the role of individual sessions in relation to change and simultaneously downplay the importance of the group component. This may in turn cast light on why participants sometimes viewed both components as disconnected and separate rather than as parts of a unified multimodal approach.

### *Preparing for MBT and the process of mentalising.*

The primary focus during MBT pre-treatment is on psychoeducation (i.e. explicit mentalising) (Karterud and Bateman, 2012) rather than on preparation for the actual experience of engaging in the intensive outpatient programme. (i.e. implicit mentalising). Thus, when the participants began group MBT, a less structured and less predictable environment than in pre-treatment, the contrast appeared to be difficult for them to manage. It appears that some of the participants were unaware that one of the primary purposes of the group component of MBT is to learn to mentalise in an intense and challenging environment. Mayerson (1984) highlights the need for service users to know what to expect from group therapy in order to maximise benefit and participants did not appear ready for the challenging nature of the group.

Finally, the only participant who had attended pre-treatment for more than four weeks (i.e. 12 weeks) found the amount of information presented overwhelming which may suggest an over-emphasis on cognitive rather than experiential learning. Furthermore, this participant experienced a gap between pre-treatment and MBT which he found disruptive. It seems that he managed to develop a sense of containment in the pre-treatment group but the gap in treatment may have activated his attachment system thus possibly leading to feelings of abandonment and uncertainty.

### ***Implications for MBT***

Providing a balance between explicit and implicit knowing during pre-treatment may reduce the likelihood of service users becoming overwhelmed by too much information and may limit excessive contrast between pre-treatment and group MBT. Gradual access to an unpredictable environment during pre-treatment may reduce service users' apparent struggle to obtain a sufficient degree of safety during the initial three to six months. Moreover, the potential value of discomfort and perceived lack of safety in group MBT should be highlighted to service users throughout the programme in order to optimise the therapeutic potential of challenging encounters within the group. Minimising the gap between pre-treatment and full programme MBT may also ease the transition for service users. In cases where this is not possible opportunities should be available for service users to explore and understand uncomfortable feelings (e.g. abandonment, uncertainty) that may arise as a result of hypermentalising or activation of the attachment system. Mutually contracted telephone calls by a member of the MBT team could be an effective way of achieving this until the beginning of full programme MBT.

A considerable emphasis on fostering safety and building trust during the first three to six months of the group component seems particularly important for service users.

Interjection by facilitators may be necessary in order to maximise a secure environment during these opening months (Inderhaug and Karterud, 2015) and in rolling groups additional attention might need to be paid to facilitating the involvement of newer members. Ensuring the delivery of certain elements of the MBT model appear especially necessary: adapting MBT interventions according to the mentalising ability of the service user and length of time in the programme, sufficiently integrating the individual and group components of MBT, and gradually exposing service users to intense affect states in an interpersonal environment so that mentalisation capacity is maximised throughout (Bateman and Fonagy, 2012; Bateman and Fonagy, 2006; Karterud and Bateman, 2012).

MBT therapists are presented with the challenge of maintaining a balance between facilitating sufficient safety and challenge throughout the programme. Bearing in mind the particular challenges experienced by participants during the initial months of MBT the value of some potential structural components of MBT is unclear from this paper. For example, having the same therapist in both group and individual sessions increased security and containment for some participants whilst they were generally critical of rolling groups which tended to heighten anxiety. However, having different therapists in individual and group sessions may foster a valuable opportunity for service users to develop trust and relationships with separate attachment figures which could in turn facilitate generalisation outside of therapy. Furthermore, the lack of predictability that rolling groups bring may provide a valuable opportunity to mentalise during intense circumstances as well as providing ongoing opportunities to build trust with new members. Participants appeared to either be unaware of these potential benefits and therefore could not process them, or were aware of them but still found the increased anxiety too difficult to manage. It is unclear whether the possible benefits outweigh the perceived drawbacks identified by participants and this should be further explored in future research.

### ***Limitations and Future Research***

As a qualitative study with a small sample the generalisability of the findings is limited. 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).

Further qualitative research on service user experiences of MBT is needed that builds on the findings of this study. Qualitative research should further explore service user experiences of MBT programmes with varying structures; rolling groups versus fixed groups and MBT programmes that involve the same therapist in all components versus those with different therapists. Quantitative research should also be conducted to compare and evaluate the benefits and drawbacks of these different types of MBT programmes. There should be a particular focus on which of the above structural arrangements, if any, maximise benefits for service users.

Other suggestions for future research include qualitative research on the experiences of individuals who have dropped out of MBT as well as therapist and service user perspectives on the process of change during MBT. Service user experiences of the multimodal aspect to MBT should also be specifically explored in order to determine whether other participants also experience both components as disjointed. If so, potential reasons for this should be identified (e.g. are changes to the MBT model suggested or is stricter supervision regarding delivery of the model required?).

In addition, there is a suggestion from this study that safety and trust may be most likely to develop between the three month and six month stage and is possibly maintained by the 12 month stage. Quantitative research measuring and comparing service users' perceptions of safety in group MBT at separate three month intervals could provide valuable information regarding this. Finally, this study provides a tentative suggestion that MBT may be particularly helpful for impulsivity and interpersonal difficulties. Quantitative research should compare measures relating to such challenges with other difficulties associated with BPD, such as frequency of self-harm, in order to build further understanding of 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, in particular impulsivity and interpersonal difficulties. However, participants reported finding certain aspects of MBT challenging and potentially disruptive to their treatment at certain stages of the programme. The unpredictability and lack of safety associated with the early stages of the group component present a challenge for service users. Preparing service users as much as possible for this unpredictability and for the opportunities that discomfort and conflict present, particularly during the group component, would appear to be beneficial. Although these findings need to be further explored through future research, taking measures to

develop such aspects of MBT may facilitate further enhancement of mentalisation capacity for service users during the programme and possibly reduce drop-out rates. MBT programmes in the UK are currently composed of varying structures and it is unclear from this paper which, if any, maximise benefit to service users. This should be further explored via future research.

## References

- Allen, J. G., Fonagy, P. and Bateman, A. (2008), *Mentalizing in Clinical Practice* (1<sup>st</sup> ed.), American Psychiatric Publishing, Inc., Arlington, VA, London.
- Bales, D., van Beek, N., Smits, M., Willemsen, S., Busschbach, J. J. V., Verheul, R. and Andrea, H. (2012), "Treatment outcome of 18-month, day hospital mentalization-based treatment (MBT) in patients with severe borderline personality disorder in the Netherlands", *Journal of Personality Disorders*, Vol. 26 No. 4, pp. 568-582.
- Bateman, A., Bales D. and Hutsebaut, J. (2012), "MBT: A quality manual", available at <https://www.unige.ch/formcont/reseaumentalisation/ressources-du-rf-tbm/> (accessed 24 March 2016).
- Bateman, A. and Fonagy, P. (1999), "Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial", *The American Journal of Psychiatry*, Vol. 156 No. 10, pp. 1563-1569.
- Bateman, A. and Fonagy, P. (2001), "Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up", *American Journal of Psychiatry*, Vol. 158 No. 1, pp. 36-42.
- Bateman, A. and Fonagy, P. (2003), "Health service utilization costs for borderline personality disorder patients treated with psychoanalytically oriented partial hospitalization versus general psychiatric care", *American Journal of Psychiatry*, Vol. 160 No. 1, pp. 169-171.
- Bateman, A. and Fonagy, P. (2006), *Mentalization-Based Treatment for Borderline Personality Disorder: A Practical Guide*, Oxford University Press, Oxford, UK.
- Bateman, A. and Fonagy, P. (2008), "8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual", *The American Journal of Psychiatry*, Vol. 165 No. 5, pp. 631-638.
- Bateman, A. and Fonagy, P. (2009), "Randomized controlled trial of outpatient

- mentalization-based treatment versus structured clinical management for borderline personality disorder", *The American Journal of Psychiatry*, Vol. 166 No. 12, pp. 1355-1364.
- Bateman, A. W. and Fonagy, P. (2012), "Individual techniques of the basic model", in Bateman, A. W. and Fonagy, P. (Eds.), *Handbook of Mentalizing in Mental Health Practice*, American Psychiatric Publishing, Inc., Washington, DC, London, pp. 67-80.
- Bowlby, J. (1973), *Attachment and Loss: Vol. 2, Separation Anxiety and Anger*, Basic Books, New York.
- Bowlby, J. (1988), *A Secure Base: Clinical Applications of Attachment Theory*, Routledge, London.
- Dyson, H. and Brown, D. (2016), "The experience of mentalization-based treatment: an interpretative phenomenological study", *Issues in Mental Health Nursing*, Vol. 37 No. 8, pp. 1-10.
- Haigh, R. (1999), "The quintessence of a therapeutic environment: five universal qualities", in Campling, P. and Haigh, R. (Eds.), *Therapeutic Communities: Past, Present and Future*, Jessica Kingsley Publishers, London, Philadelphia, Pa, pp. 246-257.
- Hummelen, B., Wilberg, T. and Karterud, S. (2007), "Interviews of female patients with borderline personality disorder who dropped out of group psychotherapy", *International Journal of Group Psychotherapy*, Vol. 57 No. 1, pp. 67-91.
- Inderhaug, T. S. and Karterud, S. (2015), "A qualitative study of a mentalization-based group for borderline patients", *Group Analysis*, Vol. 48 No. 2, pp. 150-163.
- Johnson, E. L, Mutti M. F., Springham, N, and Xenophontes, I. (2016), "Mentalizing after mentalization based treatment", *Mental Health and Social Inclusion*, Vol. 20 No. 1, pp. 44-51.
- Karterud, F. and Bateman, A. W. (2012), "Group therapy techniques", in Bateman, A. W. and Fonagy, P. (Eds.), *Handbook of Mentalizing in Mental Health Practice*, American Psychiatric Publishing, Inc, Washington, DC, London, England, pp. 81-105.
- Laverty, S. M. (2003), "Hermeneutic phenomenology and phenomenology: a comparison of historical and methodological considerations", *International Journal of Qualitative Methods*, Vol. 2 No. 3, pp. 21-35.
- Mayerson, N. H. (1984), "Preparing clients for group therapy: a critical review and theoretical formulation", *Clinical Psychology Review*, Vol. 4 No. 2, pp. 191-213.
- Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L. and Dayton, D. D. (2006), "An analysis of therapist treatment effects: toward providing feedback to individual therapists on

- their clients' psychotherapy outcome", *Journal of Clinical Psychology*, Vol. 62 No. 9, pp. 1157-1172.
- Omar, H., Tejerina-Arreal, M. and Crawford, M. J. (2014), "Are recommendations for psychological treatment of borderline personality disorder in current UK guidelines justified? Systematic review and sub-group analysis", *Personality and Mental Health*, Vo. 8 No. 3, pp. 228-237.
- Rossouw, T. I. and Fonagy, P. (2012), "Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial", *Journal of the American Academy of Child & Adolescent Psychiatry*, Vo. 51 No. 12, pp. 1304-1313.
- Smith, J. A. (2004), "Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology", *Qualitative Research in Psychology*, Vol. 1 No. 1, pp. 39-54.
- Smith, J. A., Flowers, P. and Larkin, M. (2009), *Interpretative Phenomenological Analysis: Theory, Method and Research*, Sage, London.
- Smith, J. A. and Osborn, M. (2008), "Interpretative phenomenological analysis", in Smith, J. A. (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (2<sup>nd</sup> ed.), Sage, London, pp. 53-80.
- Yalom, I. D. (with Leszcz, M.) (2005), *The Theory and Practice of Group Psychotherapy*, Basic Books, New York.