Experiences of patients with borderline personality disorder in Mentalization based psychoeducation groups: A qualitative study

Neli Zheleva

DClinPsy thesis, (Volume 1), 2024

University College London

Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Name: Neli Zheleva

Date: 19th July 2024

Overview

Part I: *Literature review of Mentalization Based Treatment-Psychoeducation for Borderline Personality Disorder.*

This section provides a conceptual review of the literature on Mentalization Based Therapy (MBT) psychoeducation for borderline personality disorder (BPD). This review explores the positive early indicators of efficacy of MBT-psychoeducation and identifies important gaps in its evidence base. Positive indicators include patients' engagement and symptom reduction, however comprehensive clinical trials and meta-analyses are needed to robustly establish its efficacy. Generic group psychoeducation programs for BPD lack strong evidence and exhibit high variability, underscoring the need for more targeted and effective interventions like MBT-I. This review suggests future research on specific mechanisms through which MBT-I operates, its long-term impacts, and patient experiences to optimise its implementation and improve clinical outcomes for individuals with BPD.

Part II: *Qualitative exploration of MBT-psychoeducational groups for patients with BPD.*

As part of a joint project, my contribution involved the qualitative exploration of the experiences of individuals diagnosed with BPD who participated in MBT-

psychoeducational groups across the National Health Service (NHS). Fourteen patients who had completed the MBT-psychoeducation group were interviewed. The objective was to gain insights into the perceived benefits from the intervention, identify elements they found less beneficial, and explore any functional changes resulting from their participation in the groups. Reflexive thematic analysis was employed to analyse the data (Braun & Clarke, 2022). The analysis resulted in six themes and twelve subthemes. The findings suggest that the MBT-psychoeducational group was predominantly perceived as beneficial. Participants reported improvements in their mentalizing abilities, emotional regulation, and interpersonal functioning. However, the analysis also revealed areas where participants felt additional support was necessary.

Part III: *Critical appraisal of the research process.*

This section provides a critical appraisal of the research process presented in Part II, focusing on personal reflexivity, epistemological reflexivity, and broader reflections on individuals diagnosed with BPD.

Table of Contents

Acknowledgments

I would like to express my deep gratitude to my supervisors, Tobias Nolte, Peter Fonagy and Janet Feigenbaum, for their unwavering support throughout my research journey. Their insightful feedback has been invaluable, and it has been an honour to work with them. Their encouragement, empathy and consideration of my ideas has been both inspiring and empowering.

I am also deeply grateful to my brother, who has been an important source of support through the highs and lows of my doctorate. His care and love have provided me with strength and comfort throughout this challenging process.

Additionally, I would like to thank my friends for the support and encouragement, which have inspired me to persevere and keep growing.

Part I: Literature Review

MBT-Psychoeducation in Borderline Personality Disorder

List of Abbreviations

APA	American Psychiatric Association
BPD	Borderline Personality Disorder
CAMHS	Children and Adolescents Mental Health Service
CBT	Cognitive Behaviour Therapy
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EM	Epistemic Mistrust
ET	Epistemic Trust
ICD-11	International Classification of Diseases, Eleventh Edition.
MBT	Mentalisation-Based Treatment
MBT-Ai	Mentalisation-Based Treatment Introductory Phase for Adolescents
MBT-G	Mentalisation-Based Treatment Group
MBT-I	Mentalisation-Based Treatment Introductory Phase
NICE	National Institute for Health and Care Excellence
OP CMHTs	Older People Community Mental Health Teams
TAU	Treatment as Usual
WHO	World Health Organisation

Abstract

Borderline Personality Disorder (BPD) is a complex mental health condition that often leads to significant functional impairment and considerable public health implications. One of the primary therapeutic approaches for treating BPD is Mentalisation-Based Treatment (MBT), which aims to enhance the mentalising skills of patients, thereby promoting symptom remission. The initial phase of MBT involves an introductory psychoeducational group called MBT-I, designed to familiarise patients with the specific difficulties associated with BPD and the MBT process itself. Although MBT has demonstrated positive therapeutic outcomes in both clinical and research settings, the research on the role and clinical significance of MBT-I remains limited.

This conceptual review explores the relevant literature on MBT-I for BPD, highlighting the strengths and limitations of the current evidence base. Initial research provides substantial evidence supporting the acceptability and effectiveness of MBT-I psychoeducation in ameliorating BPD symptoms. However, there are currently no registered or published clinical trials, and thus no meta-analytic reviews, apart from one pilot RCT, that assess the efficacy of MBT-I in isolation rather than as part of the MBT programme. Consequently, the literature does not clarify which aspects of MBT-I are effective, the underlying theory of change, the effect size of this change, its longitudinal impact, or how patients experience MBT-I in clinical settings.

Future research directions are discussed in light of the positive preliminary indicators of MBT-I efficacy and the significant gaps in its evidence base.

1. Introduction

“My skin is so thin that the innocent

words of others burn holes

right through me”

— BPD Pieces of Me Community,

BPD Voices Project Vol. 1

Borderline personality disorder (BPD) is a severe mental health condition that significantly limits patients' lives and imposes a substantial burden on family members and healthcare systems (Bohus et al., 2021). Persistent patterns of emotional dysregulation, impaired interpersonal function, inconsistent identity, considerable functional impairment, increased self-harm, and suicidal attempts are consistently linked to the clinical manifestation of BPD (Leichsenring et al., 2023). Despite initial beliefs that BPD was difficult or impossible to treat (Gunderson, 2009), advances in understanding and clinical management have enabled earlier diagnosis and more beneficial treatment outcomes (Rameckers et al., 2021).

Mentalisation-Based Treatment (MBT) is a leading psychotherapeutic approach for BPD. MBT is psychoanalytically informed, evidence-based, and time-limited, conceptualising impaired mentalising ability as an etiological factor and central difficulty for people with BPD (Bateman & Fonagy, 2004). The MBT process focuses

on developing more effective mentalising skills to improve BPD symptoms. MBT-psychoeducation serves as the pivotal first stage of MBT, aiming to socialise patients to the MBT model by imparting knowledge about mentalising, mentalised affectivity, and an understanding of the treatment (Allen et al., 2008; Haslam-Hopwood et al., 2006). This psychoeducation is delivered within group settings using a manualised approach called MBT-I, developed by Bateman & Fonagy (2016).

Evidence indicates that MBT is effective in reducing BPD symptoms (Vogt & Norman, 2019; Volkert, Hauschild, & Taubner, 2019). However, there is a notable gap in research concerning MBT-I and its effectiveness. Specifically, it is unclear how MBT-I is beneficial, why it works, how patients experience it, and how it complements MBT in providing effective psychological support for individuals with BPD. This conceptual review aims to integrate the concepts of BPD and MBT-I. It provides an overview of BPD and its developmental link to epistemic trust and mentalising, followed by a detailed discussion of MBT and its evidence base in treating BPD. The review concludes by discussing the clinical implications, barriers to effective MBT-I, and potential future research directions.

2. Borderline Personality Disorder

BPD is a chronic mental health condition affecting 0.7 to 2.7% of the adult population worldwide (Eaton & Greene, 2018; Winsper et al., 2020). Symptoms typically emerge in early adulthood (Leichsenring et al., 2023). In clinical settings,

prevalence studies show that women experience BPD at higher rates than men, though gender differences in community settings are less clear (Eaton & Greene, 2018). Gender minority studies assessing the prevalence of Axis 2 Cluster B personality disorders in transgender and non-binary individuals indicate a prevalence range from 2% to 81% (Beckwith et al., 2019; Madeddu et al., 2009). These contrasting results are expected, considering variations in research methodologies, including eligibility criteria and measures to evaluate gender minority identities and psychiatric morbidity (Patterson et al., 2017). Most epidemiological studies do not show consistent racial and ethnic differences in BPD prevalence (Ellison et al., 2018). However, the paucity of such studies suggests a need for further research.

Clinically, BPD is characterised by intense emotions, impulsivity, poor self-image, and unstable interpersonal relationships (APA, 2013). Patients may go to considerable lengths to prevent abandonment, express disproportionate anger, experience persistent feelings of emptiness, and engage in repeated self-harm or suicide attempts (Leichsenring et al., 2024). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases (ICD-11) criteria for BPD both focus on patterns of instability in diagnosis. While the DSM-5 highlights specific symptomatic features, such as impulsivity, the ICD-11 places additional importance on borderline personality dysfunction (see Table 1). BPD is associated with increased morbidity and mortality, higher suicide rates, and significant

functional impairment, which can lead to extensive treatment resource utilisation or treatment dropouts (Leichsenring et al., 2011; Skodol et al., 2002). The condition is also linked to higher economic costs for psychiatric services and patients, possibly due to repeated hospitalisations, comorbid conditions, and overall treatment costs (Lewis et al., 2019; Meuldijk et al., 2017).

The aetiology of BPD is complex. Individuals with BPD are more likely to report adverse childhood events such as physical, sexual, or emotional abuse and neglect (Porter et al., 2020; Tate et al., 2022). However, not all individuals with BPD have a history of traumatic childhood experiences (Stepp et al., 2016). The prevalence of BPD is higher among those with a family history of the condition (Gunderson et al., 2018). For example, a population-based study in Sweden estimated the heritability of BPD at 46%, with non-shared environmental events accounting for the remaining 54% of the variance (Skoglund et al., 2021). The hazard ratio was higher for full siblings and even higher for identical twins. Despite this evidence, genome-wide association studies have not identified any single-nucleotide variations to explain the familial clustering of BPD (Witt et al., 2017). Until such genetic evidence is available, it is crucial to robustly identify environmental factors that may partially explain the condition's aetiology, as some of these factors might be preventable. One significant environmental factor is the impaired interpersonal relationships often observed in BPD (Howard et al., 2022).

Table 1

DSM-5 and ICD-11 criteria for the diagnosis of borderline personality disorder

DSM-5	ICD-11
A pervasive pattern of instability of interpersonal relationships, self- image and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following: 1. Frantic efforts to avoid real or imagined abandonment. 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealisation and devaluation. 3. Identity disturbance: markedly and persistently unstable self- image or sense of self. 4. Impulsivity in at least two areas that are potentially self- damaging	The diagnostician assigns a severity rating to personality (dys)function on three different levels in the dimensional ICD-11 model: mild, moderate, or severe (Bach et al., 2020). Although the majority of BPD patients are likely to be classed as having a severe personality disorder in a clinical context, the ICD-11 allows patients with BPD to be rated as having a moderate personality disorder if certain aspects of their personality functioning are significantly less impaired (First & Bach, 2018). Only BPD has continued to be recognised as a separate diagnosis out of the ten previously recognised discrete personality disorders. This is identified

5. Recurrent suicidal behaviour, gestures or threats, or self- mutilating behaviour. 6. Affective instability due to a marked reactivity of mood 7. Chronic feelings of emptiness. 8. Inappropriate, intense anger or difficulty in controlling anger. 9. Transient, stress-related paranoid ideation or severe dissociative symptoms.	as the “borderline pattern qualifier” (Bach et al., 2020).

Note. DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (APA, 2013); ICD-11 = International Classification of Diseases, Eleventh Edition (WHO, 2018).

A more relational approach to understanding the interpersonal difficulties of people with BPD might add richness and depth to the current etiological conceptualisation of the condition. Increased sensitivity to social rejection and exclusion, past and current unstable relationships involving unresolved conflict related to separation, and difficulty in developing trust in others have all been systematically linked to BPD (Lazarus et al., 2014; Lis & Bohus, 2013). These interpersonal difficulties could be explained by impaired mentalising ability and a lack of epistemic trust (ET; Leichsenring et al., 2024). Mentalising and ET are psychodynamically

informed concepts central to the MBT approach, offering a unique framework to understand the difficulties observed in BPD and facilitating a more structured approach to treatment (Bateman & Fonagy, 2009).

2.1 Mentalisng in BPD

The origins of the term mentalisation are rooted in the Ecole Psychosomatique de Paris and the work of developmental researchers studying theory of mind (Leslie, 1989; Marty, 1990). Peter Fonagy first used it in 1989 in a publication on theory of mind in BPD patients, describing mentalisation as a "capacity to conceive of mental states" (Fonagy, 1989). Since then, mentalisation theory has been well studied and further developed, contributing to the understanding of various mental health difficulties, including BPD, which was then considered untreatable (Duschinsky & Forster, 2021).

Mentalising can be defined as a complex social cognitive process through which we understand, by attributing intentional mental states, the actions and behaviours of ourselves and others (Bateman & Fonagy, 2006). By understanding oneself and others in relation to internal mental states such as feelings, thoughts, attitudes, and desires, individuals can make sense of their behaviours and those of others (Allen, Fonagy & Bateman, 2008). This ability to mentalise appears to be rooted in early development and the quality of children's relationships with trusted individuals,

specifically the ability of these individuals to adequately mirror and respond to the child's subjective experiences (Fonagy et al., 2018; Fonagy & Luyten, 2009). According to this developmental psychopathology model, adverse childhood experiences and complex trauma in early life are systematically linked to impaired mentalising ability (Luyten, Campbell, & Fonagy, 2020; Luyten & Fonagy, 2019).

Ineffective mentalising is significantly present in people with BPD, often manifesting as an impaired ability to reflect on mental states, including self and others, within an attachment relationship (Fonagy et al., 1996). Mentalising difficulties have been associated with affect dysregulation, interpersonal disturbance, and impulsivity in individuals with BPD (Euler et al., 2021; Bateman & Fonagy, 2010). The damaging consequences of impaired mentalisation in BPD include unstable mentalising ability in emotionally stressful relationships, reverting to pre-mentalising cognitive patterns during periods of elevated stress, a tendency to externalise internal states, interference with attempts to repair interpersonal relationships, and an impaired process of learning from trusted others (Bateman, Campbell, and Fonagy, 2021). Therefore, improving mentalisation could be a fundamental strategy in alleviating BPD symptoms. The mentalisation model has not only contributed to a better and more comprehensive understanding of BPD but also provided a clear and defined treatment target: improving mentalisation ability.

To fully understand mentalisation and its developmental antecedents, and to conceptualise interventions to improve mentalising skills, it is important to clarify the roles of attachment and epistemic trust in enabling or disabling mentalisation.

2.2 Epistemic Trust in BPD

Trust in sources of knowledge is known as epistemic trust (ET; Wilson & Sperber, 2012). More specifically, ET is the ability to accurately identify other people as trustworthy and to rely on and trust the information they deliver as generalisable and personally relevant. Additionally, an evolutionarily advantageous natural sense of scepticism has evolved regarding the accuracy and pertinence of communicated information to guard against misinformation (Mascaro & Sperber, 2009). This stance is known as epistemic vigilance. While it plays a crucial role in discriminating credible information, it is also important for this protective caution to be temporarily suspended to allow for the assimilation of new information and the development of ET (Fonagy & Alison, 2014).

ET is conceptualised as being rooted in early development. Secure attachment in early life supports children in recognising whom they can trust (Fonagy et al., 2017). Children who are more securely attached tend to develop a more agentive epistemic stance, enabling them to show strong adaptive ET while resisting misinformation when appropriate (Campbell et al., 2021). In contrast, children exposed to significantly adverse childhood experiences tend to develop epistemic mistrust (EM), characterised

by higher opposition to social learning (Fry et al., 2018) and epistemic credulity, which involves disproportionate trust in new information without adequately appraising its credibility (Campbell et al., 2021). Epistemic stance is closely linked to the quality of social functioning, as it influences how individuals engage with interpersonal communications. Therefore, the theory and evidence surrounding ET and EM provide a deeper understanding of the psychopathology of BPD, particularly shedding light on the impaired interpersonal functioning observed in the condition.

Nolte et al. (2023) propose that ET or its disruption may be a central factor and common pathway leading to the development of BPD and other psychopathologies. This theory is based on a biopsychosocial framework, suggesting that these disorders result from the interaction between early caregiving experiences and other constitutional factors. For instance, neurobiological traits can affect the development of brain structures involved in social learning and emotional regulation. Such interactions can shape personality and brain structures, which are further influenced by and influence later experiences (Knapen et al., 2020). Additionally, the link between ET deficits and BPD is further supported by research on adolescent inpatients (Orme et al., 2019).

It is crucial to consider ET in BPD interventions, as patients with distrust and disturbed attachment patterns may struggle with being open to social learning in therapy. When epistemic trust is lacking or absent, the potential for new learning and

subsequent change can be significantly impaired (Fonagy, Luyten, & Allison, 2015). Additionally, difficulties in trusting the personal relevance of knowledge and authenticity within an attachment relationship may complicate the therapeutic alliance and impact treatment outcomes (Bo et al., 2017). Cultivating and improving ET can facilitate social learning and enhance the quality of life for BPD patients by enabling the development of interpersonal interactions, the formation of positive social communications, and a more beneficial therapeutic prognosis in MBT (Fonagy & Campbell, 2017). The value of ET extends across contexts and therapeutic modalities, as a lack of ET in any mental health condition can hinder social learning and the therapeutic relationship in any therapeutic model. This underscores ET as a highly important transtheoretical construct that facilitates successful psychotherapy.

Engendering epistemic matches and we-mode experiences within therapeutic settings, such as MBT, is critical for restoring ET and enabling social learning. The co-creation of we-mode experiences, in which therapist and patient engage in joint attention to mental states, can lead to the development of complex representations of self and others. This relational process, emphasising joint attention and co-mentalising, is essential for generating mutual understanding and reappraising experiences. We-mode experiences help patients feel understood, fostering a sense of "we-ness" that transcends individual perspectives. This process can regulate

emotions and remove defensive barriers, opening pathways for more effective knowledge transfer (Fonagy et al., 2022).

Additionally, mutual validation and shared mental states within the therapeutic relationship enhance patients' ability to trust and learn from the therapist, promoting social adaptation and reducing epistemic isolation (Fisher et al., 2022). These processes underpin the restoration of ET, enabling patients to generalise renewed trust to relationships outside therapy and fostering resilience (Knapen et al., 2020).

3. Mentalisation-Based Treatment

MBT was initially developed by Anthony Bateman and Peter Fonagy, integrating attachment theory and cognitive theory within a psychodynamic framework. MBT is a psychotherapy primarily focused on enhancing the mentalising skills of patients and is delivered in a protocol-driven manner, usually over a period of 18 months (Bateman & Fonagy, 1989; 2009). The treatment is organised into three distinct phases: an initial introductory psychoeducation phase, a treatment phase, and an ending phase. Each phase has specific strategies and goals designed according to the evolving understanding of BPD (Leichsenring et al., 2024).

The first phase, called MBT-I, is an introductory group course aimed at socialising patients to MBT while strengthening the therapeutic alliance. Following MBT-I, the treatment phase focuses on improving interpersonal relationships, one of the most central challenges for individuals with BPD, by enhancing mentalising skills

to better understand oneself and others (Bateman & Fonagy, 2006). Techniques during this phase focus on maintaining mentalisation even in emotionally charged situations, helping patients manage their emotions and related behaviours more effectively. Additionally, the treatment phase includes strategies for risk management, supportive validation around anxiety regulation, and managing impulsivity through mentalising in affective states (Bateman & Fonagy, 2006).

The final phase of MBT involves reviewing the overall therapy process and considering the experience of termination for both the patient and therapist. This phase aims to help patients consolidate the mentalising skills they have developed and prepare for the transition out of therapy (Bateman & Fonagy, 2006). The overarching aim is to sustain the improvements achieved throughout treatment.

There is a growing evidence base for MBT (Hajek et al., 2024; Volkert et al., 2019). Research has consistently shown that MBT can effectively improve BPD symptoms and functioning in individuals with BPD (Bateman & Fonagy, 2006). Systematic reviews have highlighted MBT's effectiveness in achieving substantial improvements in the severity of BPD symptoms and enhancing the overall quality of life for patients (Den & Wang, 2022; Vogt & Norman, 2019). A Cochrane systematic review examining 75 RCTs for BPD involving a total of 4507 participants demonstrated MBT’s effectiveness compared to treatment as usual (TAU) and no treatment (Storebø

et al., 2020). MBT was found to be more effective than TAU at reducing self-harm, suicidality, and depression. Today, MBT has become one of the most established evidence-based treatments for BPD in the UK and other European countries (Ellison, 2020).

4. Generic group psychoeducation programmes for BPD

Psychoeducation programmes vary significantly depending on the therapeutic model they follow, but broadly speaking, psychoeducation is a psychosocial intervention focused on providing patients with up-to-date information about a mental condition, encompassing diagnosis, aetiology, treatment, and preliminary management strategies. Well-tailored psychoeducation programmes across therapeutic approaches have shown beneficial effects in introducing the treatment rationale and goals, as well as facilitating positive post-treatment outcomes (Constantino et al., 2018; Wampold & Imel, 2015). Evidence has shown that psychoeducation is beneficial across a variety of psychiatric conditions, settings, and clinical populations, and is therefore recommended in the NICE guidelines for personality disorders (Christensen et al., 2004; Donker et al., 2009; Smith et al., 2010; NICE, 2009; Xia et al., 2011). Brief psychoeducation can be useful as a preparatory phase for BPD patients who might not be ready for long-term therapy and can be

viewed as an initial stage of therapy for patients who might not wish to engage in intensive and long therapy (Paris, 2013).

Several studies have reported findings on the efficacy of group psychoeducational programmes for BPD, as well as the experiences of patients who have participated in those groups. These are generic group psychoeducational programmes that have not followed a specific therapeutic model but can nevertheless provide further evidence and insight into the efficacy and overall value of group psychoeducational programmes for BPD.

Two seminal RCTs by Zanarini and colleagues investigated the efficacy of psychoeducation for BPD. In the first study, Zanarini and Frankenburg (2008) examined the efficacy of a 12-week in-person psychoeducation workshop for women with a recent BPD diagnosis. The psychoeducation content did not follow the theory of a particular established psychotherapeutic model but instead provided thorough education on aetiology, symptoms, comorbidities with other conditions, available treatments, and long-term outcomes. Results showed that the immediate psychoeducational programme following diagnosis was associated with significant improvement in general impulsivity and disturbances in close relationships, two core features of the clinical picture of BPD. However, there was no significant improvement in psychosocial functioning. The generalisability of this study was limited to women

with moderately severe BPD aged 18-30, and practical constraints such as cost and location restrictions prevented the wider application of this programme.

Later, the same team developed an internet-based psychoeducation programme for BPD patients and completed an RCT to examine its effectiveness (Zanarini et al., 2017). The online programme spanned 12 weeks, covering thorough psychoeducation on BPD, including the history of diagnosis and associated stigma, aetiology, symptoms, comorbidities with other conditions, and psychosocial and medication treatment options. Results showed that the online psychoeducation group experienced significant improvements in borderline psychopathology, psychosocial functioning, and impulsivity, with these gains observed at the 12-month follow-up. The web-based programme tested in this trial proved cost-effective and feasible for broader clinical implementation, with gains maintained for at least a year. However, the generalisability of findings was limited to female patients from the Boston area.

Ridolfi et al. (2019) assessed the effectiveness of a brief psychoeducational group intervention for BPD patients. This study included 48 BPD patients who participated in six psychoeducation sessions and 48 participants who remained on a waitlist receiving TAU. The results showed significant improvements in all BPD traits except impulsivity following the brief group psychoeducational intervention. These benefits remained stable at the two-month follow-up. The findings suggested that even a brief group psychoeducational intervention can effectively support BPD patients.

This indicates that a cost-effective and easily accessible group intervention, such as the one investigated, could be beneficial in improving symptoms and access to support.

Rocca et al. (2021) studied an 11-week group-based psychoeducational programme aimed at helping BPD patients understand their symptoms and the impact of BPD on their emotions, thoughts, and interpersonal relationships. The course included management strategies and information on available support and treatments for BPD. Sixty-eight participants completed the study and the outcome measures. Results showed significant reductions in overall BPD symptoms, negative feelings and thoughts, and destructive behaviours. However, the authors did not specify what they meant by destructive behaviours or how this reduction was measured. Furthermore, participants reported improvements in work and social functioning. No improvements were noted in positive behaviours, but again, the authors did not clarify what they meant by positive behaviours or how these were measured. There was no control group, and participants did not have a formal BPD diagnosis, despite the significant reported reductions in BPD symptoms. Therefore, while this study signals improvement and hope about the positive impact of a group psychoeducational course, its significant limitations prevent firmer conclusions on the efficacy of the intervention.

Koivisto et al. (2021) conducted a qualitative content analysis study to explore the experiences of BPD patients who attended a 40-session psychoeducational group intervention. The programme was run by psychiatric nurses in community settings, and the course content was based on ideas from CBT and schema therapy but did not follow a particular therapeutic model. Eight participants were interviewed, and results revealed three key areas of change: improved understanding of mental events, reduced emotional disconnection, and more adaptive self-experience and agency. Group inflexibility and aggression were noted as obstacles by the participants. The study's strengths include perspective triangulation and investigator triangulation, which could add credibility to the reported results.

Long, Fulton, and Dolley (2015) piloted a psychoeducational programme in a medium-security setting with 36 women diagnosed with BPD, most of whom had previous experiences of detention under the Mental Health Act. The programme aimed to enhance knowledge of BPD, decrease stigma, and improve engagement in treatment. Participants who completed all six sessions showed significant improvements in treatment engagement, mental health symptoms, and decreased suicidal ideation and self-harm. However, the lack of a control group and qualitative interviews limited the ability to infer cause-and-effect relationships between the psychoeducational course and the positive outcomes observed.

Martín-Vázquez and Sekade-Gutiérrez (2023) examined a brief six-session group psychoeducation course for BPD, which did not follow a specific therapy model but focused on providing information about the condition itself. After the course, patients would enter more intensive DBT group therapy. The researchers reported data from 40 patients, comparing hospitalisations and emergency visits in the six months before and after the psychoeducation group. The findings showed a significant reduction in urgent appointments, emergency visits, and hospitalisation days, suggesting potential cost-effectiveness and efficacy. However, larger samples and the inclusion of clinical outcome measures are needed to better understand the efficacy and cost-effectiveness of this BPD group psychoeducation programme.

Collectively, these studies provide initial evidence for the benefits and effectiveness of short-term and more extensive group psychoeducation interventions in treating BPD. Results indicated longer-lasting benefits, including improved symptoms, reduced healthcare utilisation, and better treatment engagement. However, the evidence base for the benefits of group psychoeducation programmes is still in its developmental stage. The studies exhibit significant variability in intervention design, symptom measurement, participant characteristics, BPD diagnosis methods, and the presence or absence of control groups. Addressing these issues is necessary to determine the true efficacy of group psychoeducation programmes in improving BPD symptoms. Additionally, exploring patient perspectives

on psychoeducation programmes through qualitative methods could help refine and optimise these interventions to best meet the needs of BPD patients.

5. MBT-I

The MBT psychoeducation programme, often referred to as MBT Introductory Process/Group or MBT-I, is the pivotal first stage of MBT. It follows the assessment stage and precedes the primary treatment phase. MBT-I was initially based on the MBT manual by Karterud and Bateman (2011) and was later adapted into a highly structured, manualised programme by Bateman and Fonagy (2016). It is organised as a 10 to 12-week group psychoeducation programme for up to ten patients, with each session lasting around 1.5 hours. Certain modules may span two sessions due to their higher content density. Patients are encouraged to attend at least two-thirds of the sessions to facilitate their progression to further MBT treatment. However, if the intervention is found to be unhelpful for a particular participant, other options may be considered.

Each group session follows a similar format: the content of the previous session is reviewed, homework feedback is explored, a new topic is introduced, and patients are encouraged to reflect on their experiences through a mentalising approach. These reflections are discussed and processed, and the session ends with a summary followed by a discussion about the home tasks for the next session.

MBT-I has five overarching goals (Bateman & Fonagy, 2016):

1. Provide psychoeducation to patients about mentalising and BPD.

2. Prepare patients for long-term MBT treatment.

3. Increase motivation.

4. Further information about the mentalising ability of participants.

5. Support and confirm the initial assessment and diagnosis, or provide additional information to determine whether further assessments might be needed.

In summary, the main goal of MBT-I is to ensure that patients start treatment with a comprehensive understanding of the treatment they are undertaking. This includes awareness of the treatment's focus, the expectations placed on them, and the potential expectations they may have for the treatment process (Bateman & Fonagy, 2016).

The group facilitator in MBT-I is usually a member of staff, typically two clinicians, who play a significant role in implementing the intervention by facilitating the group sessions and maintaining a structured environment throughout the 12 weeks. This facilitatorship is not autocratic but ensures that each topic is thoroughly covered and discussed in sufficient detail, focusing on engendering a social learning process, including interactions between group members. The facilitator frequently uses tools like whiteboards or slides to highlight key points and note participant contributions, enhancing clarity and engagement. Crucially, the group facilitator embodies a

mentalising stance, balancing their expert knowledge with openness to group input and sharing of experiences encouraged through the "not-knowing" stance underpinning MBT. This balance is vital, as it demonstrates that the facilitator's understanding can be enriched by the perspectives of group members, fostering a dynamic and interactive learning environment while modelling mentalisation in vivo. By stimulating discussions and valuing participants' contributions, the facilitator helps prevent passivity and encourages active engagement. A lecturing style of psychoeducation is discouraged to avoid the risk of disengagement. Instead, the aim is to generate a process-oriented group dynamic related to the session's topic. While it is important to follow the session manual closely to ensure all material is covered, the group facilitator also encourages learning through participant activities and uses their examples to illustrate key points. This approach ensures that the group remains focused and that the psychoeducational goals of the program are met effectively (Bateman & Fonagy, 2016).

The MBT-I intervention incorporates twelve modules that cover topics such as mentalising and ineffective mentalising, social mentalising modes, the "not-knowing" stance, emotions and emotion regulation, attachment, trauma, anxiety, depression, self-harm, and BPD as a whole, taking a dimensional approach using mentalising as a primary dimension. For a more detailed description of each module, please see Table 2 below. The MBT-I modules are guided by several key principles. Firstly,

exercises are structured to move from less emotionally intense scenarios to more personalised ones. Personal experiences are discussed only after the group has formed a cohesive and trusting atmosphere. Unlike other psychotherapeutic approaches, homework is voluntary and generally aims to help participants focus more on their mental states. Additionally, sessions work towards creating a directory of indicators for both ineffective and effective mentalising.

The current review suggests that MBT-I can influence and be influenced by patients' epistemic stance by providing a structured therapeutic environment that facilitates the restoration of ET. MBT-I potentially achieves this through psychoeducation and the co-creation of "we-mode" experiences, where both patients and facilitators engage in mentalising and joint attention. These processes are essential for decreasing epistemic vigilance and enhancing ET, which in turn can foster the transmission of knowledge and facilitate self-calibration. This dynamic occurs as therapists adapt to patients' needs, reinforcing the three communication systems to ensure the development of a therapeutic alliance and good treatment outcomes.

5.1Communication systems

To understand and conceptualise effective psychotherapy in BPD and other psychopathologies, Bateman et al. (2018) introduced the idea of three communication systems. These systems are essential across interventions and describe the

mechanisms through which therapeutic interventions activate, maintain, and implement mentalizing and social learning, ultimately developing epistemic trust and improving patients' social functioning. These systems are not exclusive to MBT; any therapeutic support involves the communication, internalisation, and reapplication of new understanding and relational learning. MBT and other manualised treatments address the improvement of epistemic stance and learning through these systems. These systems facilitate self-discovery within the context of relationships with others, remaining central to MBT.

Communication system 1: Teaching and learning content

The first communication system involves the learning and teaching of content. This entails the therapist conveying a model that helps the patient understand their mind in a way that feels relevant to them, providing a sense of being understood and recognised. This therapeutic model requires the therapist's ability to mentalize and communicate it in a manner that resonates with the patient, creating an epistemic match. The therapist's ability to mentalize the patient is a crucial aspect of this system. This communication system is vital during the initial phase of MBT, particularly during the psychoeducation phase, which takes place in group settings. The group setting offers patients the opportunity to rethink themselves, view themselves from a different perspective, and build curiosity about social interactions. Therefore, the capacity of the therapist to introduce mentalizing to patients in a way that feels relevant to them

and their perceptions of themselves and others is fundamental to their engagement in treatment.

Communication system 2: Re-emergence of mentalising

This system occurs when patients regain their openness to social communication in situations previously “blocked” by epistemic disruption. This process is fostered by the therapist's curious and open stance. The re-emergence of mentalization creates a positive feedback loop, where patients' curiosity and interest in social learning and mental states reinforce each other, thereby enhancing their capacity to mentalise. As patients' interest in the clinician’s mind and use of feelings and thoughts increases, their capacity to mentalise is strengthened.

Communication system 3: Applying social learning in the wider environment

When patients are mentalised by the therapist, their capacity to learn is reactivated, releasing them from potential social isolation and improving their relationships outside therapy. This system underscores the importance of patients' ability to understand mental states and learn socially, enhancing their functioning by enabling different interactions with their environment. In MBT-psychoeducation groups, this system is crucial for patients to apply what they learn in therapy to their daily lives, thereby enhancing their social interactions.

Table 2.

Summary of the twelve MBT-I modules.

Module	Topic	Summary
1	What is mentalising and a mentalising stance?	Following initial introductions to the group, the main topic of mentalising is introduced, explained, and discussed, highlighting its importance in understanding intentions, thoughts, beliefs, and emotions. The session covers the dimensions of mentalising (automatic/controlled, emotions/thoughts, self/other, external/internal) and introduces the concept of hypermentalising. Activities, such as interpreting scenarios, help participants understand the difference between mentalising and non-mentalising interpretations. The session concludes with discussing the benefits of mentalising in various interpersonal situations, emphasising its role in effective communication and emotional regulation.
2	What does it mean to have	The focus here is on understanding problems with mentalising. The session begins with a summary of the previous session,

	problems with mentalizing?	emphasizing that everyone has mentalising abilities, which help in interpreting others. The group discusses issues such as misunderstandings and defensiveness due to impaired mentalising. A group activity involving a scenario two characters is used to illustrate different levels of mentalising. Key points about poor mentalising, such as black-and-white thinking and lack of empathy, are highlighted. The consequences of poor mentalising are discussed, including relationship problems and emotional instability. The session also covers the impact of strong emotional activation on mentalising abilities and introduces concepts like fight/flight responses. Participants reflect on their own emotional triggers and response thresholds. The session ends with a discussion on how emotional intensity can be managed and improved, setting the stage for future sessions. Homework involves noting instances where mentalising was undermined during the week.
3	Why do we have emotions and	Module 3 explores the role and types of emotions, building on the previous session's discussion of mentalising difficulties. The group facilitator starts with a brief recap of key points, such as indicators of good and poor mentalising, challenges in reading

	what are the basic types?	minds, emotional regulation, and the impact of interpersonal sensitivity. Emphasizing the day's topic, the facilitator prompts participants to brainstorm various emotions and their importance, distinguishing between basic and social emotions. The group discusses how basic emotions can lead to secondary emotions, which often complicate or overshadow initial reactions. The facilitator underscores that understanding and embracing these emotions enhance mentalising capabilities. The session concludes with a group activity on personal emotional experiences and a homework assignment to reflect on prominent emotions during the past week.
4	Mentalizing emotions	Module 4 focuses on mentalising emotions, building on previous discussions about the range and types of emotions. The session begins with a review of basic and social emotions, and the physiological nature of emotional reactions versus the conscious awareness of these reactions as feelings. The group explores how emotions are recognised in others and in oneself, emphasising the role of facial expressions, body language, and mirror neurons in empathy. Participants engage in exercises to

		enhance emotional awareness and discuss their personal experiences. The session also covers emotional regulation, particularly through others, and includes a role-playing activity to practice consoling someone. The facilitator introduces strategies for managing impaired emotional regulation. The session concludes with a discussion on reducing unmentalised feelings and a homework assignment to note successful emotional regulation during the past week.
5	The significance of attachment relationships	Module 5 delves into the significance of attachment relationships and their impact on emotional regulation. The facilitator introduces attachment, defined as the emotional bond between individuals, initially formed with parents or caregivers. The group learns about secure and insecure attachment patterns, the latter including ambivalent/overinvolved and distancing/avoidant types. These patterns are illustrated through a "strange situation" test. The session emphasises that attachment strategies are not fixed and can change over time, impacting adult relationships. Activities include discussing hypothetical scenarios and personal attachment patterns, encouraging participants to reflect on their

		own relationships. Homework involves noting typical behaviours in their attachment relationships.
6	Attachment and mentalizing	Module 6 explores the interplay between attachment and mentalising. Participants initially share their homework on typical attachment behaviours. The main topic is how a mentalising culture, characterised by open discussions about people's behaviours and emotions, fosters secure attachment and mentalising abilities. The session includes discussions on family cultures of mentalising, potential attachment conflicts, and their impact on mentalising abilities. Activities involve reflecting on personal attachment conflicts and difficult topics in close relationships. Homework involves noting recent challenges in discussing emotions in close relationships.
7	What is a personality disorder? What is borderline	Module 7 delves into personality disorders with an emphasis on BPD. The session begins with a review of the impact of growing up in a mentalising culture and the difficulties caused by major attachment conflicts in childhood. The group facilitator introduces the concept of personality disorders, emphasising maladaptive

	personality disorder? What is antisocial personality disorder?	traits affecting self-image, relationships, and daily functioning. Participants explore their own challenging and positive personality traits. The changeability of personality disorders and their origins in genetic and environmental influences are discussed. The facilitator outlines various personality disorders, focusing on BPD's criteria and its relationship with mentalising. Criteria for BPD, adapted into everyday language, are presented for discussion, with the facilitator ensuring a mentalising perspective. Homework involves noting challenging personality traits over the next week. Participants receive a leaflet summarising aspects of BPD for further reflection.
8	Mentalisation-based treatment—part 1	Module 8 focuses on MBT and its aims, structure, and practice. The group facilitator defines the aim of MBT as enhancing mentalising abilities in close relationships, leading to emotional robustness and better conflict management. The aims of MBT are discussed, and how it can improve interpersonal relationships and overall BPD symptomatology. Group activities focus on sharing recent life events, practicing mentalising skills, and bonding with the group and clinicians. Homework involves

		reflecting on one's feelings about joining unfamiliar groups or social situations.
9	Mentalisation-based treatment—part 2	Module 9 focuses on the attachment aspect of MBT and its challenges. The main focus is on forming therapeutic relationships, particularly with individual and group clinicians, and other group members. Common objections to forming these bonds include fears of separation, failure, betrayal, and trust issues. Participants may question the authenticity of these relationships and express concerns about boundaries and the lack of disclosure from clinicians. The discussion highlights the importance of addressing interpersonal dynamics and implicit mentalising processes in therapy. The session concludes with homework to observe reactions to feeling let down, misunderstood, or ignored by others during the week.
10	Anxiety, attachment, and mentalising	Module 10 addresses anxiety in the context of attachment and mentalising. The group facilitator introduces anxiety as a common symptom motivating treatment seekers, connecting it to fear, a basic emotion, vital for survival. Group activities involve

		identifying common anxiety triggers and discussing experiences with panic attacks, agoraphobia, and social phobia. Treatment strategies, including controlled exposure and the role of trusted others in calming anxiety, are explored. The session emphasizes the importance of openness about personal anxieties within the therapeutic context, acknowledging the resistance and hypervigilance often associated with discussing fears. Homework focuses on reflecting on interactions with others when feeling anxious and identifying reasons for success or failure in seeking support.
11	Depression, attachment, and mentalising	Module 11 looks into depression within the framework of attachment and mentalising. The group facilitator introduces depression, highlighting its association with separation anxiety and sadness, which stem from disruptions in attachment. Group activities involve identifying triggers for depressive responses and sharing experiences with depression. The session emphasises the connection between depression and grief reactions, discussing how early experiences of loss can predispose individuals to depression later in life. Treatment

		strategies, including the use of antidepressants and the importance of questioning depressive thoughts through mentalising, are explored. The session concludes with homework focusing on recognising and challenging depressive thoughts.
12	Summary and conclusion	Module 12 serves as a recap of the entire MBT-I course. The initial focus is on depression's connection to separation anxiety and the role of mentalising in sustaining or alleviating depressive states. The group facilitator invites participants to share insights from their homework and facilitates a discussion on any lingering questions or topics. Reflecting on the course's progression, the facilitator guides the group through key themes and exercises from each session. As the session draws to a close, participants are encouraged to express their feelings about the group's end, followed by feedback.

Note. The module structure presented on this table follows the structure outlines in Bateman and Fonagy (2016).

Research has indicated that group psychotherapy can pose challenges for individuals with BPD, given their interpersonal difficulties and potential activation of attachment anxieties in group settings (Bateman, Fonagy & Allen, 2009). However, evidence suggests that psychoeducation in group settings can be valuable for patients with BPD in managing their anxiety and may contribute to reducing drop-out rates (Bradley-Scott, 2017; Kvarstein et al., 2015). It seems plausible that MBT-I could serve as a fundamental tool for patients' socialisation to MBT, enhancing their engagement with the therapeutic process and preparing them for further therapy, which could subsequently reduce drop-out rates and improve overall therapeutic outcomes.

A conceptual understanding of the above findings indicates that psychoeducational groups may alleviate some of the patients' attachment-related and interpersonal anxiety by providing an informative and structured environment that enhances their understanding of their condition. This educational foundation can foster improvements in interpersonal interactions within the group and emotional regulation. Consequently, MBT-I could serve as a pivotal tool in preparing patients for more intensive treatment by promoting their engagement with the therapeutic process and facilitating their socialisation to MBT. The introductory phase likely decreases drop-out rates by acclimating patients to the therapeutic environment, thereby improving therapeutic outcomes. Therefore, MBT-I might not only deliver benefits related to

engagement and symptom management but also lay the groundwork for more sustained and profound therapeutic progress.

5.2 Preliminary MBT-I research

A study by Bradley-Scott (2017) used Interpretative Phenomenological Analysis (IPA) to explore the lived experiences of MBT-I groups among individuals with BPD. Following a series of 10-12 weekly sessions, eight patients receiving care in NHS secondary care settings were interviewed to gather insights into their group experience. The three key themes that emerged related to participants' efforts to navigate complex group dynamics, the fear and power of enhanced self-reflection, and strategies for customising personal knowledge. Participants reported that the group positively impacted their understanding of others, sense of self, and tendency towards impulsivity, notably in interpersonal interactions. Additionally, findings highlighted that having a structure and shared purpose within the MBT-I group helped participants manage their anxiety, evoked a sense of secure functioning, and facilitated engagement. A possible limitation of the study was the potential for bias stemming from participants feeling compelled to report positive experiences during the MBT-I group in the hope of accessing further individual or MBT group therapy. The author suggested that future research should evaluate different treatment components, such

as group, individual, and psychoeducation elements, to improve understanding of their roles in MBT-I and subsequently maximise the effectiveness of this intervention.

Ditlefsen and colleagues (2021) investigated the experiences of MBT-I for patients with BPD by analysing data from 12 patients who attended 13 sessions of MBT-I, using IPA. Therapists applied a range of psychoeducational methods used in MBT-I, including teaching, self-reflection, role-plays, and open reflection with others in the group. The main findings indicated that MBT-I contributed significantly to a sense of optimism among BPD patients. Despite the sometimes-demanding nature of group attendance, participants found the psychoeducational content in MBT-I helpful for the therapeutic process. They reported positive experiences in four themes: the group format, learning new skills or "tools," preparation for longer-term therapy, and the challenges they faced. The group format helped participants with interpersonal learning and reduced feelings of shame, which can be critical for patients with difficulties around impaired interpersonal connections and attachment patterns. Participants valued acquiring new knowledge and the practical application of new skills outside therapy sessions. Moreover, the psychoeducational content enhanced the trust participants had in therapists and the therapy process. This trust is fundamental for developing a therapeutic relationship that could facilitate engagement throughout MBT-I and later components of MBT, such as MBT-Group or individual MBT, while building further mentalising skills.

Clinically, these findings are significant because they suggest that MBT-I can enhance patient engagement and expectations for subsequent therapy, possibly improving overall treatment outcomes. This aligns with Kvarstein et al. (2015), who highlighted that MBT-I could contribute to the lower drop-out rates observed in MBT for BPD patients. This is particularly essential for BPD patients, who frequently report higher drop-out rates and less successful treatments (Arntz et al., 2023; Busmann et al., 2019; de Freixo Ferreira et al., 2023).

The study by Ditlefsen and colleagues (2021) is important and original; however, it had methodological limitations. The qualitative design does not allow for generalisation of the findings or strong conclusions about the effectiveness of MBT-I. Consequently, despite the positive results related to the group experience, psychoeducation, symptom reduction, and engagement improvement, it is not possible to conclude that this will be the experience of all future patients participating in an MBT-I intervention due to the study's design. Additionally, the sample was limited in gender diversity and age, and voluntary participation may have introduced a bias towards more positive experiences. The researchers were also open about their allegiance to the MBT model, which might have influenced the study design and interpretation of results, despite efforts to ensure reflexivity and transparency.

Overall, while the study demonstrated that tailored psychoeducation in the form of MBT-I can be a powerful and beneficial component of therapy for BPD patients, it

also highlighted the need for further research to explore the broader applicability and long-term impact of MBT-I. These findings underscore the value of integrating patient experiences in the development and qualitative assessment of therapeutic interventions, offering important insights that could help improve treatment strategies for BPD.

5.3 MBT-I in adolescents

Griffiths and colleagues (2019) conducted a single-blind feasibility and acceptability RCT of an MBT-I intervention for adolescents (MBT-Ai). The study aimed to investigate the adaptation of MBT-I for adolescents, examining consent rates, attrition and attendance, and self-harm. Fifty-three adolescents were assigned to MBT-Ai + TAU or just TAU. Despite the study demonstrating reductions in self-reported self-harm, hospital use, and significant improvements in social anxiety, emotional regulation, and BPD symptoms, these improvements were observed in both the MBT-Ai +TAU group and the TAU-only group. No significant differences between the treatment and control groups were detected, suggesting that while MBT-Ai was acceptable and feasible, the lack of a difference could be due to the limited power (small sample) of the RCT to detect small effects or an absence of superiority of MBT-Ai over TAU in this setting. Therefore, while the study indicates the potential of MBT-Ai, further research with larger sample is necessary to support this claim.

In summary, the research on MBT-I so far shows its potential in addressing the complex needs of individuals with BPD. Components of MBT-I have been shown to improve engagement, enhance understanding, and reduce attachment-related anxiety, thereby decreasing drop-out rates and promoting better therapeutic outcomes. Studies highlight the positive impact of MBT-I on patients' interpersonal interactions, emotional regulation, and self-reflection (Bradley-Scott, 2017; Ditlefsen et al., 2021). Griffiths et al. (2019) adapted MBT-I for adolescents (MBT-Ai) and showed potentially promising outcomes; however, no significant differences were observed between MBT-Ai and TAU groups. This suggests that further research is necessary to confirm MBT-Ai's benefits.

5.4 Clinical implications

The clinical implications of MBT-I are significant, warranting further investigation and application as both a preparatory and possibly a standalone intervention. MBT-I serves as a critical foundational stage in MBT, enhancing patients' understanding and engagement with the therapeutic process by providing comprehensive psychoeducation about mentalising and BPD. MBT-I aims to improve patients' mentalising abilities, boost motivation, and refine diagnostic assessments, leading to more effective long-term therapy outcomes.

Preliminary research indicates that MBT-I may foster a supportive and interactive group dynamic and also reduce anxiety, which are crucial factors in the treatment of BPD patients who often struggle with interpersonal difficulties and attachment anxieties in group settings. Preliminary research suggests that MBT-I may help reduce drop-out rates. A study by Kvarstein at al. (2015) provides initial support, showing that patients with BPD in MBT had lower drop-out rates (5%) during the first six months compared to psychodynamic treatment, which had a higher drop-out rate (42%). The early phase of MBT, which is MBT-I, typically lasts the first 2-3 months and may contribute to this result. Furthermore, the positive experiences reported by participants, such as improved self-reflection and interpersonal understanding, suggest that MBT-I could enhance therapeutic engagement and efficacy.

Despite some methodological limitations in existing studies, the potential benefits of MBT-I, including its adaptability for adolescents, underscore the need for more extensive research to confirm its effectiveness and optimise its implementation in diverse clinical settings. MBT-I's structured approach and focus on psychoeducation can provide patients with a clearer understanding of their condition, leading to better management of symptoms and a stronger therapeutic alliance.

Moreover, integrating MBT-I into treatment plans may help reduce healthcare utilisation by preparing patients for more intensive therapy, thus potentially lowering costs associated with emergency visits and hospitalisations. Given the preliminary

evidence that suggest its potential efficacy, MBT-I holds promise for improving the overall treatment outcomes for BPD patients, making it a valuable component of therapeutic interventions.

6. Limitations of the evidence base & future directions for MBT-I

6.1 Limited evidence base

First and foremost, there is a significant shortage of studies examining MBT-I for people with BPD. MBT-I has been included in numerous studies and trials, always as an addition to standard group or individual MBT. However, to the best of our knowledge, only one study has administered post-MBT-I measures to explore the efficacy of MBT-I alone (Griffiths et al., 2019). Similarly, only two studies have explored the experiences of people attending MBT-I (Bradley-Scott, 2017; Ditlefsen et al., 2021), which has provided some valuable insights but not enough. This complicates the evaluation of MBT-I and its efficacy as a standalone intervention. Additionally, questions about what people like about MBT-I groups, which components they find most beneficial, and which they find least beneficial remain largely unanswered. Given the initial positive research findings regarding the benefits of MBT-I, the lack of research attention on this intervention seems to be a significant omission and one worth studying further.

6.2 Inconsistencies in MBT-I delivery in research settings

MBT-I appears to be studied and delivered with significant variability within research settings. Researchers often reduce MBT-I sessions to as few as six sessions, frequently without providing a specific clinical or research-based justification for such reductions. These adjustments may be linked to feasibility and cost reduction issues. However, this lack of standardisation in delivery methods highlights the need for more consistent and systematic research approaches. Following a standardised protocol for MBT-I (Karterud & Bateman, 2011; Bateman & Fonagy, 2016) seems essential to ensure uniform delivery. This would allow for more reliable comparisons across studies and a valid assessment of the efficacy of this protocol-based intervention.

6.3 Variable severity of BPD and the role of MBT-I

Another significant point is the highly variable clinical manifestation of BPD (Choi-Kain et al., 2016); not all patients present with severe, chronic difficulties demanding extended periods of high-intensity treatments. This aligns with the relatively new diagnostic approach in the International Classification of Diseases, which interprets personality disorders on a spectrum of severity ranging from mild to severe difficulties (ICD-11; WHO, 2018). Consequently, some propose adopting a public health approach that offers various interventions with different intensities, similar to a "stepped care" model. Therefore, tailored interventions that incorporate

new evidence-based information seem essential to improve outcomes for patients who do not respond to current established interventions. In this context, it seems logical to consider whether psychoeducation alone, such as MBT-I, could be sufficient as a standalone intervention for people with mild BPD symptoms or those who have had extensive treatments, have recovered, and need a top-up treatment to remain in remission. This represents an important next step for research to explore the performance of MBT-I in such contexts.

6.4 Lack of established psychoeducational intervention for BPD and MBT-I

The key treatment approaches for BPD vary in their psychological models of what drives the condition's difficulties. For example, impaired mentalisation (Fonagy & Bateman, 2008), emotional dysregulation (Linehan, 1993), excessive aggression (Kernberg, 1985), and interpersonal hypersensitivity (Gunderson & Lyons-Ruth, 2008) have all been primary focuses of different therapeutic approaches. This variability reflects evidence suggesting that psychological, relational, and psychosocial treatment approaches can all be beneficial in treating BPD symptoms (Choi-Kain et al., 2017). The body of literature on treatment approaches in BPD is vast and extends beyond the scope of the present review. However, it is worth noting that current available treatments often require extensive training for therapists and can be expensive and lengthy (Meuldijk et al., 2017).

These limitations have led to the development of brief interventions for BPD. A recent systematic review identified 27 RCTs of brief interventions for BPD, lasting six months or less. The authors reported indications of benefit in the improvement of BPD symptoms and social functioning (Spong et al., 2021). However, there was high heterogeneity in the pooled data, higher levels of bias in terms of reporting and attrition, post-intervention results were deemed unreliable, and long-term outcomes of the interventions were not reported (Spong et al., 2021). Thus, while there are indications that short-term interventions for BPD can be effective, more robust research is needed to establish their effectiveness, the magnitude of their effect, and their long-term sustainability.

Given the lack of established short-term interventions for BPD and the initial positive indications about the efficacy of MBT-I, future research should focus on the potential of MBT-I as a beneficial short-term intervention for some people living with BPD.

7. The unmet needs of people with BPD & future directions for MBT-I

7.1 Unmet needs in different age groups.

The current body of research on BPD is insufficiently comprehensive for different age populations, with the vast majority focusing on working-age adults. While some progress has been made in understanding BPD among adolescents, much

remains unknown about how early interventions could effectively support adolescent patients and whether this support would have long-term effects in addressing the emergence of symptoms early on (Chanen & Nicol, 2021). This gap may be linked to the complexities of diagnosing adolescents with a personality disorder and the associated stigma for that age group (Well, Kerr, & Sharp, 2021). Nevertheless, some studies suggest that early intervention could potentially mitigate the severity of BPD symptoms and improve long-term outcomes (Allison et al., 2022; Chanen et al., 2022). More research is needed to understand which types of interventions best support adolescents with BPD symptoms, whether psychotherapeutically or through other means.

BPD symptomatology does not disappear as patients age; yet evidence-based support is scarce and difficult to access for older adults (Hutsebaut et al., 2019; Videler et al., 2019). It is common practice to provide support for individuals with personality disorders through non-specialist services (Dale et al., 2017). For example, older adults with BPD, particularly those supported in outpatient community mental health teams (OP CMHTs), often receive generic support provided to all other patients accessing community services. This can pose challenges, as the complex needs associated with BPD may not be directly addressed under the care of generic services due to a lack of resources and expertise. Furthermore, this population might be particularly

vulnerable due to potential comorbidities and the stigma associated with both ageing and mental health conditions (Lavingia, Jones, & Asghar-Ali, 2020).

Further insight and research are needed to explore how to tailor interventions to meet the specific needs of adults in later life, considering any differences in how BPD presents in older age, possible physical abilities, and accessibility to treatment facilities. Questions about the feasibility of attending group and individual sessions, considering factors like transportation and physical mobility, are crucial for designing inclusive, equitable, and effective treatment programmes for this population.

7.2 The Intersection of identities, culture, and psychological distress.

Understanding the specific needs in different cultural contexts is crucial for improving current BPD interventions and making them culturally sensitive, thus better meeting the idiosyncratic needs of communities served in the NHS. Campbell and Allison (2022) highlighted the relationship between mentalising, epistemic trust, and social systems, emphasising the impact that social inequalities have on these factors and psychological distress. They argue that optimal therapeutic outcomes can hardly be achieved without first considering the wider social environment and its impact on individuals.

For example, LGBTQIA+ individuals belong to a community with a unique yet highly variable culture (Liddle et al., 2007), where the social context might directly contribute to their mental health difficulties. Without considering social context and culture, these unique difficulties might be overlooked or misunderstood. Specifically, it is important to consider the overlap between BPD symptoms and those resulting from chronic societal abuse in the form of discrimination, homophobia, or transphobia. Recognising this overlap is essential for informing culturally sensitive formulations, irrespective of the therapeutic modality (Ackerman, 2023; Cardona et al., 2022).

As MBT literature moves towards discussions about the role of culture in mental health distress (Campbell & Allison, 2022; Fonagy & Allison, 2023), it is essential to consider how cultural adaptations can be introduced into MBT formulations and interventions to better meet the unique needs of culturally distinct communities.

The unmet needs of BPD patients highlight significant gaps in research and practice. Initial discussions around these unmet needs are beginning to emerge in research (Kantor et al., 2022; Paris, 2020), and addressing these gaps requires a commitment to studying diverse populations while considering the intersectionality of identities and the impact of culture on formulation and treatment. Advancing research in these areas might lead to the development of more effective, inclusive, and compassionate approaches to support people living with BPD. It will be important to

study and understand how MBT-I performs across different contexts and cultures to tailor it to the diverse populations served by NHS services.

8. Final Conclusions

BPD is a complex mental health condition with a profound impact on individuals and healthcare systems. Advancements in understanding BPD through the lenses of mentalisation and epistemic trust have significantly enhanced therapeutic approaches, notably with MBT. MBT has demonstrated efficacy in reducing BPD symptoms and improving patient outcomes, and its initial stage, MBT-I, shows promise in preparing patients for the main treatment, potentially reducing drop-out rates, and enhancing overall therapy outcomes.

However, the evidence for MBT-I as a standalone intervention is still preliminary and limited. While initial studies indicate positive effects on patient engagement and symptom reduction, comprehensive clinical trials and meta-analyses are needed to robustly establish its efficacy. Generic group psychoeducation programmes for BPD lack strong evidence and exhibit high variability, underscoring the need for more targeted and effective interventions like MBT-I.

Clinically, it is imperative to address the limitations in research evidence and the unique unmet needs of BPD patients more effectively. This includes exploring and validating the benefits of MBT-I. Future research should focus on elucidating the specific mechanisms through which MBT-I operates, its long-term impacts, and patient

experiences to optimise its implementation and improve clinical outcomes for individuals with BPD. By addressing these areas, the therapeutic community can better support those living with BPD and enhance the overall effectiveness of treatment strategies.

9. References

Ackerman, S. L. (2023). *Bias in Diagnostic Decision Making: Borderline Personality Disorder and Gender Minorities* (Doctoral dissertation, Adelphi University).

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in clinical practice*. American Psychiatric Pub.

Allison, S., Bastiampillai, T., Looi, J. C., & Mulder, R. (2022). Adolescent borderline personality disorder: Does early intervention 'bend the curve'?. *Australasian Psychiatry*, *30*(6), 698-700.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, 5th edn. American Psychiatric Press: Washington, DC.

Arntz, A., Mensink, K., Cox, W. R., Verhoef, R. E., van Emmerik, A. A., Rameckers, S. A., ... & Grasman, R. P. (2023). Dropout from psychological treatment for borderline personality disorder: a multilevel survival meta-analysis. *Psychological Medicine*, *53*(3), 668-686.

Bach, B., Kerber, A., Aluja, A., Bastiaens, T., Keeley, J. W., Claes, L., ... & Zimmermann, J. (2020). International assessment of DSM-5 and ICD-11 personality disorder traits: toward a common nosology in DSM-5.1. *Psychopathology*, *53*(3-4), 179-188.

Bateman, A., Campbell, C., & Fonagy, P. (2021). Rupture and repair in mentalization-based group psychotherapy. *International Journal of Group Psychotherapy*, *71*(2), 371-392.

Bateman, A., Campbell, C., Luyten, P., & Fonagy, P. (2018). A mentalization-based approach to common factors in the treatment of borderline personality disorder. *Current opinion in psychology*, *21*, 44-49.

Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *American journal of Psychiatry*, *156*(10), 1563-1569.

Bateman, A. W., & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal of personality disorders*, *18*(1), 36-51.

Bateman, A., & Fonagy, P. (2006). Mentalizing and borderline personality disorder. *Handbook of mentalization-based treatment*, 183-200.

Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *American journal of Psychiatry*, *166*(12), 1355-1364.

Bateman, A., & Fonagy, P. (Eds.). (2012). Handbook of mentalizing in mental health practice. American Psychiatric Publishing.

Bateman, A., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide*. OUP Oxford.

Bateman, A., Psych, F. R. C., Fonagy, P., FBA, J. G. A., & Allen, J. G. (2009). 28Theory and Practice of Mentalization-Based Therapy.

Bateman, A., Fonagy, P., Campbell, C., Luyten, P., & Debbané, M. (2023). *Cambridge Guide to Mentalization-Based Treatment (MBT)*. Cambridge University Press.

Barnicot, K., Katsakou, C., Marougka, S., & Priebe, S. (2011). Treatment completion in psychotherapy for borderline personality disorder–a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, *123*(5), 327-338.

Beckwith, N., McDowell, M. J., Reisner, S. L., Zaslow, S., Weiss, R. D., Mayer, K. H., & Keuroghlian, A. S. (2019). Psychiatric epidemiology of transgender and nonbinary adult patients at an urban health center. *LGBT health*, *6*(2), 51-61.

Bradley-Scott, C. C. (2017). *Exploring mentalization-based psychoeducation groups for people with borderline personality disorder*. Canterbury Christ Church University (United Kingdom).

Bo, S., Sharp, C., Fonagy, P., & Kongerslev, M. (2017). Hypermentalizing, attachment, and epistemic trust in adolescent BPD: Clinical illustrations. *Personality Disorders: Theory, Research, and Treatment*, *8*(2), 172.

Bohus, M., Stoffers-Winterling, J., Sharp, C., Krause-Utz, A., Schmahl, C., & Lieb, K. (2021). Borderline personality disorder. *The Lancet*, *398*(10310), 1528-1540.

Busmann, M., Wrege, J., Meyer, A. H., Ritzler, F., Schmidlin, M., Lang, U. E., ... & Euler, S. (2019). Alternative Model of Personality Disorders (DSM-5) predicts dropout in inpatient psychotherapy for patients with personality disorder. *Frontiers in psychology*, *10*, 952.

Campbell, C., & Allison, E. (2022). Mentalizing the modern world. *Psychoanalytic Psychotherapy*, *36*(3), 206-217.

Campbell, C., Tanzer, M., Saunders, R., Booker, T., Allison, E., Li, E., ... & Fonagy, P. (2021). Development and validation of a self-report measure of epistemic trust. *PloS one*, *16*(4), e0250264.

Cardona, N. D., Madigan, R. J., & Sauer-Zavala, S. (2022). How minority stress becomes traumatic invalidation: An emotion-focused conceptualization of minority stress in sexual and gender minority people. *Clinical Psychology: Science and Practice*, *29*(2), 185.

Chanen, A. M., Betts, J. K., Jackson, H., Cotton, S. M., Gleeson, J., Davey, C. G., ... & McCutcheon, L. (2022). Effect of 3 forms of early intervention for young people with borderline personality disorder: The MOBY randomized clinical trial. *JAMA psychiatry*, *79*(2), 109-119.

Chanen, A. M., & Nicol, K. (2021). Five failures and five challenges for prevention and early intervention for personality disorder. *Current Opinion in Psychology*, *37*, 134-138.

Christensen, H., Griffiths, K. M., & Jorm, A. F. (2004). Delivering interventions for depression by using the internet: randomised controlled trial. *Bmj*, *328*(7434), 265.

Choi-Kain, L. W., Albert, E. B., & Gunderson, J. G. (2016). Evidence-based treatments for borderline personality disorder: Implementation, integration, and stepped care. *Harvard Review of Psychiatry*, *24*(5), 342-356.

Choi-Kain, L. W., Finch, E. F., Masland, S. R., Jenkins, J. A., & Unruh, B. T. (2017). What works in the treatment of borderline personality disorder. *Current behavioral neuroscience reports*, *4*, 21-30.

Constantino, M. J., Coyne, A. E., Boswell, J. F., Iles, B. R., & Vîslă, A. (2018). A meta-analysis of the association between patients' early perception of treatment credibility and their posttreatment outcomes. *Psychotherapy*, *55*(4), 486.

de Freixo Ferreira, L., Guerra, C., & Vieira-Coelho, M. A. (2023). Predictors of psychotherapy dropout in patients with borderline personality disorder: A systematic review. *Clinical Psychology & Psychotherapy*, *30*(6), 1324-1337.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR). American Psychiatric Association. (2022).

Ditlefsen, I. T., Nissen-Lie, H. A., Andenæs, A., Normann-Eide, E., Johansen, M. S., & Kvarstein, E. H. (2021). “Yes, there is actually hope!”—A qualitative investigation of how patients experience mentalization-based psychoeducation tailored for borderline personality disorder. *Journal of Psychotherapy Integration*, *31*(3), 257.

D’Agostino, A., Monti, M. R., & Starcevic, V. (2018). Models of borderline personality disorder: recent advances and new perspectives. *Current Opinion in Psychiatry*, *31*(1), 57-62.

Donker, T., Griffiths, K. M., Cuijpers, P., & Christensen, H. (2009). Psychoeducation for depression, anxiety and psychological distress: a meta-analysis. *BMC medicine*, *7*(1), 1-9.

Duschinsky, R., & Foster, S. (2021). *Mentalizing and epistemic trust: The work of Peter Fonagy and colleagues at the Anna Freud Centre*. Oxford University Press.

Eaton, N. R., & Greene, A. L. (2018). Personality disorders: community prevalence and socio-demographic correlates. *Current opinion in psychology*, *21*, 28-32.

Ellison, W. D. (2020). Psychotherapy for borderline personality disorder: Does the type of treatment make a difference?. *Current Treatment Options in Psychiatry*, *7*, 416-428.

Ellison, W. D., Rosenstein, L. K., Morgan, T. A., & Zimmerman, M. (2018). Community and clinical epidemiology of borderline personality disorder. *Psychiatric Clinics*, *41*(4), 561-573.

Euler, S., Nolte, T., Constantinou, M., Griem, J., Montague, P. R., Fonagy, P., & Personality and Mood Disorders Research Network. (2021). Interpersonal problems in borderline personality disorder: associations with mentalizing, emotion regulation, and impulsiveness. *Journal of Personality Disorders*, *35*(2), 177-193.

First, M. B., & Bach, B. (2018). Application of the ICD-11 classification of personality disorders. *Journal of Psychiatry Reform, 6* (3).

Fisher, S., Zilcha-Mano, S., & Fonagy, P. (2022). Conceptualizing epistemic trust in psychotherapy: A triadic model. *Psychotherapy Bulletin*, *57*(2), 29-35.

Folmo, E., Langjord, T., Myhrvold, N., Stänicke, Lind, M., & Kvarstein, E. (2022). Pedagogical stance in mentalization-based treatment. Journal of Clinical Psychology, 78(9), 1764-1784. https://doi.org/10.1002/jclp.23335

Fonagy, P. (1989). On tolerating mental states: Theory of mind in borderline patients. *Bulletin of the Anna Freud Centre*, *12*, 91-115.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, *51*(3), 372.

Fonagy, P., & Allison, E. (2023). Beyond mentalizing: Epistemic trust and the transmission of culture. *The Psychoanalytic Quarterly*, *92*(4), 599-640.

Fonagy, P., & Bateman, A. W. (2016). Adversity, attachment, and mentalizing. *Comprehensive psychiatry*, *64*, 59-66.

Fonagy, P., Campbell, C., Constantinou, M., Higgitt, A., Allison, E., & Luyten, P. (2022). Culture and psychopathology: An attempt at reconsidering the role of social learning. *Development and Psychopathology*, *34*(4), 1205-1220.

Fonagy, P., Gergely, G., & Jurist, E. L. (2018). *Affect regulation, mentalization and the development of the self*. Routledge.

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., & Gerber, A. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of consulting and clinical psychology*, *64*(1), 22.

Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and psychopathology*, *21*(4), 1355-1381.

Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of personality disorders*, *29*(5), 575-609.

Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2017). What we have changed our minds about: Part 2. Borderline personality disorder, epistemic trust and the

developmental significance of social communication. *Borderline Personality Disorder and Emotion Dysregulation, 4*, 9. https://doi. org/10.1186/s40479-017-0062-8

Fry, D., Fang, X., Elliott, S., Casey, T., Zheng, X., Li, J., ... & McCluskey, G. (2018). The relationships between violence in childhood and educational outcomes: A global systematic review and meta-analysis. *Child abuse & neglect*, *75*, 6-28.

Griffiths, H., Duffy, F., Duffy, L., Brown, S., Hockaday, H., Eliasson, E., ... & Schwannauer, M. (2019). Efficacy of Mentalization-based group therapy for adolescents: the results of a pilot randomised controlled trial. *BMC psychiatry*, *19*, 1-13.

Groat, M., & Allen, J. G. (2011). Promoting mentalizing in experiential psychoeducational groups: From agency and authority to authorship. Bulletin of the Menninger Clinic, 75(4), 315-343.

Gunderson, J. G. (2009). Borderline personality disorder: ontogeny of a diagnosis. *American Journal of Psychiatry*, *166*(5), 530-539.

Gunderson, J. G., Herpertz, S. C., Skodol, A. E., Torgersen, S., & Zanarini, M. C. (2018). Borderline personality disorder. *Nature reviews disease primers*, *4*(1), 1-20.

Hajek Gross, C., Oehlke, S. M., Prillinger, K., Goreis, A., Plener, P. L., & Kothgassner, O. D. (2024). Efficacy of mentalization-based therapy in treating self-harm: A systematic review and meta-analysis. *Suicide and Life-Threatening Behavior*, *54*(2), 317-337.

Haslam-Hopwood, G. T. G., Allen, J. G., Stein, A., & Bleiberg, E. (2006). Enhancing mentalizing through psychoeducation. *Handbook of mentalization-based treatment*, 249-267.

Howard, K. P., Lazarus, S. A., & Cheavens, J. S. (2022). A longitudinal examination of the reciprocal relationship between borderline personality features and interpersonal relationship quality. *Personality Disorders: Theory, Research, and Treatment*, *13*(1), 3.

Hutsebaut, J., Videler, A. C., Verheul, R., & Van Alphen, S. P. (2019). Managing borderline personality disorder from a life course perspective: Clinical staging and health management. *Personality Disorders: Theory, Research, and Treatment*, *10*(4), 309.

Jacob, G. A., Hauer, A., Köhne, S., Assmann, N., Schaich, A., Schweiger, U., & Fassbinder, E. (2018). A schema therapy–based eHealth program for patients with borderline personality disorder (priovi): naturalistic single-arm observational study. *JMIR Mental Health*, *5*(4), e10983.

Kantor, K., Prasko, J., Ociskova, M., Holubova, M., Nesnidal, V., Vanek, J., Minarikova, K., Hodny, F., Slepecky, M., & Zatkova, M. (2022). Unmet emotional, interpersonal, and treatment needs in patients with borderline personality disorder. *Neuroendocrinology Letters*, *43*(3), 180-197.

Karterud, S., & Bateman, A. (2011). *Manual for mentaliseringsbasert psykoedukativ gruppeterapi (MBT-I)*. Gyldendal akademisk.

Knapen, S., Hutsebaut, J., van Diemen, R., & Beekman, A. (2020). Epistemic trust as a psycho-marker for outcome in psychosocial interventions. *Journal of Infant, Child, and Adolescent Psychotherapy*, *19*(4), 417-426.

Kvarstein, E. H., Pedersen, G., Urnes, Ø., Hummelen, B., Wilberg, T., & Karterud, S. (2015). Changing from a traditional psychodynamic treatment programme to mentalization-based treatment for patients with borderline personality disorder–Does it make a difference?. *Psychology and Psychotherapy: Theory, Research and Practice*, *88*(1), 71-86.

Koivisto, M., Melartin, T., & Lindeman, S. (2021). “If you don’t have a word for something, you may doubt whether it’s even real”–how individuals with borderline personality disorder experience change. *Psychotherapy research*, *31*(8), 1036-1050.

Lavingia, R., Jones, K., & Asghar-Ali, A. A. (2020). A systematic review of barriers faced by older adults in seeking and accessing mental health care. *Journal of Psychiatric Practice®*, *26*(5), 367-382.

Lazarus, S. A., Cheavens, J. S., Festa, F., & Rosenthal, M. Z. (2014). Interpersonal functioning in borderline personality disorder: A systematic review of behavioral and laboratory-based assessments. *Clinical psychology review*, *34*(3), 193-205.

Leichsenring, F., Fonagy, P., Heim, N., Kernberg, O. F., Leweke, F., Luyten, P., ... & Steinert, C. (2024). Borderline personality disorder: a comprehensive review of diagnosis and clinical presentation, etiology, treatment, and current controversies. *World Psychiatry*, *23*(1), 4-25.

Leichsenring, F., Heim, N., Leweke, F., Spitzer, C., Steinert, C., & Kernberg, O. F. (2023). Borderline personality disorder: a review. *JAMA*, *329*(8), 670-679.

Leslie, A. M. (1987). Pretense and representation: The origins of" theory of mind.". *Psychological review*, *94*(4), 412.

Lewis, K. L., Fanaian, M., Kotze, B., & Grenyer, B. F. (2019). Mental health presentations to acute psychiatric services: 3-year study of prevalence and readmission risk for personality disorders compared with psychotic, affective, substance or other disorders. *BJPsych Open*, *5*(1), e1.

Liddle, B. J. (2007). The challenge of understanding LGBTQ lives and experiences. *Out in psychology: Lesbian, gay, bisexual, trans and queer perspectives*, 119-123.

Lis, S., & Bohus, M. (2013). Social interaction in borderline personality disorder. *Current psychiatry reports*, *15*, 1-7.

Long, C. G., Fulton, B., & Dolley, O. (2015). Using psychoeducation to motivate engagement for women with personality disorder in secure settings. *Journal of Psychiatric Intensive Care*, *11*(1), 18-26.

Luyten, P., Campbell, C., & Fonagy, P. (2020). Borderline personality disorder, complex trauma, and problems with self and identity: A social-communicative approach. *Journal of personality*, *88*(1), 88-105.

Luyten, P., & Fonagy, P. (2019). Mentalizing and trauma. *Handbook of mentalizing in mental health practice*, *2*, 79-99.

Lysaker, P. H., George, S., Chaudoin–Patzoldt, K. A., Pec, O., Bob, P., Leonhardt, B. L., ... & Dimaggio, G. (2017). Contrasting metacognitive, social cognitive and alexithymia profiles in adults with borderline personality disorder, schizophrenia and substance use disorder. *Psychiatry Research*, *257*, 393-399.

Madeddu, F., Prunas, A., & Hartmann, D. (2009). Prevalence of Axis II disorders in a sample of clients undertaking psychiatric evaluation for sex reassignment surgery. *Psychiatric Quarterly*, *80*, 261-267.

Martín-Vázquez, M. J., & Sekade-Gutiérrez, N. (2023). Efficacy of Psychoeducation in Borderline Personality Disorder: Results of a Mirror Study. *European Journal of Theoretical and Applied Sciences*, *1*(5), 327-333.

Marty, P. (1990). *Mentalisation et psychosomatique*. FeniXX.

Mascaro, O., & Sperber, D. (2009). The moral, epistemic, and mindreading components of children's vigilance towards deception. *Cognition*, *112*(3), 367-380.

McMurran, M., Huband, N., & Overton, E. (2010). Non-completion of personality disorder treatments: A systematic review of correlates, consequences, and interventions. *Clinical psychology review*, *30*(3), 277-287.

Meuldijk, D., McCarthy, A., Bourke, M. E., & Grenyer, B. F. (2017). The value of psychological treatment for borderline personality disorder: Systematic review and cost offset analysis of economic evaluations. *PloS one*, *12*(3), e0171592.

National Institute for Health and Clinical Excellence. (2009). Borderline personality disorder: Treatment and management (CG78). London: Author.

National Institute for Clinical and Health Excellence. (2009). Borderline personality disorder: recognition and management [CG78], available at: www.nice.org.uk/guidance/cg78

Nolte, T., Hutsebaut, J., Sharp, C., Campbell, C., Fonagy, P., & Bateman, A. (2023). The role of epistemic trust in mentalization-based treatment of borderline psychopathology. *Journal of Personality Disorders*, *37*(5), 633-659.

O'Madagain, C., & Tomasello, M. (2021). Joint attention to mental content and the social origin of reasoning. *Synthese*, *198*(5), 4057-4078.

Orme, W., Bowersox, L., Vanwoerden, S., Fonagy, P., & Sharp, C. (2019). The relation between epistemic trust and borderline pathology in an adolescent inpatient sample. *Borderline Personality Disorder and Emotion Dysregulation*, *6*, 1-9.

Paris, J. (2020). Unmet needs in the treatment of personality disorders. *New directions in psychiatry*, 101-107.

Paris, J. (2013), "Stepped care: an alternative to routine extended treatment for patients with borderline personality disorder", Psychiatric Services, Vol. 64 No. 10, pp. 1035-1037.

Patterson, J. G., Jabson, J. M., & Bowen, D. J. (2017). Measuring sexual and gender minority populations in health surveillance. *LGBT health*, *4*(2), 82-105.

Porter, C., Palmier-Claus, J., Branitsky, A., Mansell, W., Warwick, H., & Varese, F. (2020). Childhood adversity and borderline personality disorder: a meta-analysis. *Acta Psychiatrica Scandinavica*, *141*(1), 6-20.

Rameckers, S. A., Verhoef, R. E., Grasman, R. P., Cox, W. R., van Emmerik, A. A., Engelmoer, I. M., & Arntz, A. (2021). Effectiveness of psychological treatments for borderline personality disorder and predictors of treatment outcomes: a multivariate multilevel meta-analysis of data from all design types. *Journal of Clinical Medicine*, *10*(23), 5622.

Ridolfi, M. E., Rossi, R., Occhialini, G., & Gunderson, J. G. (2019). A clinical trial of a psychoeducation group intervention for patients with borderline personality disorder. *The Journal of Clinical Psychiatry*, *81*(1), 16069.

Rocca, F., Finamore, C., Stamp, S., Kuhn-Thompson, F., & Dale, O. (2021). Psychoeducation for borderline personality difficulties: a preliminary study. *Mental Health Review Journal*, *26*(3), 226-237.

Skoglund, C., Tiger, A., Rück, C., Petrovic, P., Asherson, P., Hellner, C., ... & Kuja-Halkola, R. (2021). Familial risk and heritability of diagnosed borderline personality disorder: a register study of the Swedish population. *Molecular psychiatry*, *26*(3), 999-1008.

Smith, D., Jones, I., & Simpson, S. (2010). Psychoeducation for bipolar disorder. *Advances in psychiatric treatment*, *16*(2), 147-154.

Spong, A. J., Clare, I. C. H., Galante, J., Crawford, M. J., & Jones, P. B. (2021). Brief psychological interventions for borderline personality disorder. A systematic

review and meta-analysis of randomised controlled trials. *Clinical psychology review*, *83*, 101937.

Stepp, S. D., Lazarus, S. A., & Byrd, A. L. (2016). A systematic review of risk factors prospectively associated with borderline personality disorder: Taking stock and moving forward. *Personality disorders: Theory, research, and treatment*, *7*(4), 316.

Storebø, O. J., Stoffers-Winterling, J. M., Völlm, B. A., Kongerslev, M. T., Mattivi, J. T., Jørgensen, M. S., Faltinsen, M. S., , E., Todorovac, A., Sales, C.P., Callesen, H.E., Lieb, K & Simonsen, E. (2020). Psychological therapies for people with borderline personality disorder. *The Cochrane database of systematic reviews*, *2020*(5).

Tate, A. E., Sahlin, H., Liu, S., Lu, Y., Lundström, S., Larsson, H., ... & Kuja-Halkola, R. (2022). Borderline personality disorder: associations with psychiatric disorders, somatic illnesses, trauma, and adverse behaviors. *Molecular Psychiatry*, *27*(5), 2514-2521.

Videler, A. C., Hutsebaut, J., Schulkens, J. E., Sobczak, S., & Van Alphen, S. P. (2019). A life span perspective on borderline personality disorder. *Current psychiatry reports*, *21*, 1-8.

Vogt, K. S., & Norman, P. (2019). Is mentalization-based therapy effective in treating the symptoms of borderline personality disorder? A systematic review. *Psychology and Psychotherapy: Theory, Research and Practice*, *92*(4), 441-464.

Volkert, J., Hauschild, S., & Taubner, S. (2019). Mentalization-based treatment for personality disorders: efficacy, effectiveness, and new developments. *Current Psychiatry Reports*, *21*, 1-12.

Wall, K., Kerr, S., & Sharp, C. (2021). Barriers to care for adolescents with borderline personality disorder. *Current opinion in psychology*, *37*, 54-60.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.

Winsper, C., Bilgin, A., Thompson, A., Marwaha, S., Chanen, A. M., Singh, S. P., Wang, A., & Furtado, V. (2020). The prevalence of personality disorders in the community: a global systematic review and meta-analysis. *The British Journal of Psychiatry*, *216*(2), 69-78.

Woodbridge, J., Townsend, M., Reis, S., Singh, S., & Grenyer, B. F. (2022). Non-response to psychotherapy for borderline personality disorder: a systematic review. *Australian & New Zealand Journal of Psychiatry*, *56*(7), 771-787.

World Health Organization. (2018). International classification of diseases – 11th revision. Retrieved from https://icd.who.int/en

Wilson, J., Gee, B., Martin, N., Maxwell, S., Murdoch, J., Clarke, T., ... & Fonagy, P. (2022). Brief education supported psychological treatment for adolescent borderline personality disorder: the BEST feasibility RCT. *Health and Social Care Delivery Research*, *10*(37), 1-112.

Wilson, D. B., & Sperber, D. (2012). *Meaning and relevance.* Cambridge University Press.

Witt, S. H., Streit, F., Jungkunz, M., Frank, J., Awasthi, S., Reinbold, C. S., ... & Lieb, K. (2017). Genome-wide association study of borderline personality disorder reveals genetic overlap with bipolar disorder, major depression and schizophrenia. *Translational psychiatry*, *7*(6), e1155-e1155.

Xia, J., Merinder, L. B., & Belgamwar, M. R. (2011). Psychoeducation for schizophrenia. *Cochrane database of systematic reviews*, (6).

Zanarini, M. C., & Frankenburg, F. R. (2007). The essential nature of borderline psychopathology. *Journal of Personality Disorders*, *21*(5), 518-535.

Zanarini, M. C., & Frankenburg, F. R. (2008). A preliminary, randomized trial of psychoeducation for women with borderline personality disorder. *Journal of personality disorders*, *22*(3), 284-290.

Zanarini, M. C., Conkey, L. C., Temes, C. M., & Fitzmaurice, G. M. (2017). Randomized controlled trial of web-based psychoeducation for women with borderline personality disorder. *The Journal of clinical psychiatry*, *78*(3), 16065.

Part II: Empirical Paper

Experiences of patients with borderline personality disorder in mentalization based psychoeducation groups: A qualitative study

Abstract

Borderline Personality Disorder (BPD) is a complex mental health condition that often leads to significant functional impairment and substantial public health implications. Previous research on Mentalization Based Therapy (MBT) has examined individuals' experiences of treatment within MBT groups for BPD. However, the psychoeducational component of MBT has not been systematically studied. This study aims to enhance our understanding of the experiences of individuals diagnosed with BPD in Mentalization Based Treatment Introductory (MBT-I) psychoeducational groups. It utilises qualitative semi-structured interviews to evaluate five MBT-I groups within the NHS. Fourteen participants were interviewed after completing the 10-week psychoeducation group to explore their experiences, identify perceived benefits and functional changes, and highlight less beneficial aspects of the groups. Reflexive thematic analysis was used to analyse the data, resulting in six themes and twelve subthemes.

Conclusion: The MBT-I groups were perceived as predominantly beneficial, with significant improvements noted in mentalizing abilities, emotional regulation, and interpersonal functioning. However, a few participants reported that complex group dynamics led to uncomfortable feelings and nervousness about attending. Some participants also highlighted the need for additional support from group facilitators.

Keywords: Borderline personality disorder, psychoeducation, mentalization-based therapy

Impact statement

This study explores the experiences of patients with BPD participating in MBT-psychoeducation groups. By examining both the beneficial aspects and challenges of MBT-I, this research provides valuable insights with potential implications for clinical practice, policy enhancement, and the broader understanding of BPD treatment. The findings highlight the benefits of MBT-I in enhancing mentalization skills, emotional regulation, and interpersonal relationships among BPD patients. Clinicians can use these insights to improve therapeutic interventions for BPD, emphasising techniques such as breathing exercises, grounding while remaining curious, and MBT-psychoeducation. The improvements in emotional regulation and interpersonal interactions suggest that incorporating mentalization techniques into standard therapeutic practice and psychoeducation groups for BPD could be highly beneficial.

The study also underscores the critical role of facilitators in creating a safe, empathetic, and supportive therapeutic environment, which can enhance patient engagement and therapeutic outcomes. Addressing participants' concerns regarding the perceived lack of additional support and containment from facilitators could improve their experience and therapeutic outcomes. The study's emphasis on the need for additional support between sessions and after the intervention highlights

areas for policy enhancement, such as the provision of continuous care and support structured for patients.

Additionally, the research contributes to the educational domain by providing an understanding of the mechanisms through which MBT-I facilitates change in BPD patients. This can inform the training and development of mental health professionals, ensuring they are equipped with the necessary skills and knowledge to effectively facilitate MBT-I groups.

In conclusion, the study's findings suggest potential implications for clinical practice, policy enhancement and education in BPD treatment. However, further research is necessary before recommending MBT-I as a standalone treatment. By improving MBT-I interventions and addressing the identified challenges, it is possible to enhance the quality of treatment for individuals with BPD, improving their engagement in treatment and overall experience within therapy.

1. Introduction

1.1 BPD and Mentalizing

BPD is a prevalent chronic psychiatric condition affecting approximately 0.7% to 2.7% of the adult population, significantly impacting their functioning and wellbeing (Winsper et al., 2020; Paris, 2009). It is characterised by intense emotions, impulsivity, poor self-image, and unstable interpersonal relationships, along with comorbid, self-harm, and suicidal behaviours (DSM-5; APA, 2013). BPD is associated with frequent utilisation of healthcare services and has been described as a public issue (Álvarez-Tomás et al., 2024; Bender et al., 2001). The severity of this public health issue is linked to considerable functional impairment, increased self-harm, and suicidal attempts in patients with BPD (Leichsenring et al., 2023; Leichsenring et al., 2011; Skodol et al., 2002).

Understanding the interpersonal difficulties of individuals with BPD through a relational lens can enhance the current etiological conceptualisation of the condition. Individuals with BPD often exhibit heightened sensitivity to social rejection and exclusion, past and present unstable relationships involving unresolved conflict related to separation, and difficulty in developing trust in others (Lazarus et al., 2014; Lis & Bohus, 2013). These challenges may stem from impaired mentalising ability and a lack of epistemic trust (ET; Leichsenring et al., 2024). Mentalizing and ET are central to the

psychodynamically informed MBT, providing a unique framework for understanding BPD and facilitating a more structured treatment approach (Bateman & Fonagy, 2009).

Mentalizing is a complex social cognitive process through which we understand and attribute mental states to the actions and behaviours of ourselves and others (Bateman & Fonagy, 2006). This ability, rooted in early development and relationships with trusted individuals, aids in understanding behaviours (Allen, Fonagy & Bateman, 2008; Fonagy et al., 2018; Fonagy & Luyten, 2009). According to this developmental psychopathology model, adverse childhood experiences and complex trauma in early life are systematically linked to impaired mentalising ability (Luyten, Campbell, & Fonagy, 2020; Luyten & Fonagy, 2019). In BPD, impaired mentalizing results in affect dysregulation, interpersonal disturbances, and impulsivity (Euler et al., 2021; Bateman & Fonagy, 2010). Therefore, enhancing mentalizing could be a fundamental strategy in alleviating BPD symptoms.

The mentalisation model has not only contributed to a more comprehensive understanding of BPD but also provided a clear and defined treatment target: improving mentalisation ability. However, to fully understand mentalizing, it is important to clarify the role of epistemic trust (ET) in enabling or disabling mentalizing.

1.2 BPD and Epistemic Trust

Epistemic trust (ET) refers to the trust in the reliability of information sources (Wilson & Sperber, 2012). ET involves accurately recognising trustworthy information sources while balancing this with scepticism to protect from misinformation (Mascaro & Sperber, 2009). This stance, known as epistemic vigilance, plays a crucial role in the discrimination of credible information. However, it is also important for this protective caution to be temporarily suspended to allow for the assimilation of new information and the development of ET (Fonagy & Alison, 2014). Secure attachment fosters a balanced epistemic stance, enabling strong adaptive ET while resisting misinformation when appropriate (Campbell et al., 2021). Epistemic stance is closely linked to the quality of social functioning, influencing how individuals with BPD engage with interpersonal communications and social learning (Knapen et al., 2020).

Considering ET in BPD interventions is crucial, as patients with distrust and disturbed attachment patterns may struggle to be open to social learning in therapy. When ET is lacking or absent, the potential for new learning and subsequent change becomes significantly impaired (Fonagy, Luyten, & Allison, 2015). In MBT, creating collaborative therapeutic processes, such as we-mode experiences, is vital for restoring ET and enabling social learning. The we-mode represents a collaborative

and integrative process within the therapeutic relationship, crucial for reappraisal and mentalising. This relational process emphasises joint attention and co-mentalising, essential for generating mutual understanding and reappraising experiences.

We-mode experiences help patients to feel understood and regulate emotions, facilitating knowledge transfer (Fonagy et al., 2022). Additionally, mutual validation and shared mental states within the therapeutic relationship enhance patients' ability to trust and learn from the therapist, promoting social adaptation and reducing epistemic isolation (Fisher et al., 2022). These processes support the restoration of ET, allowing patients to extend renewed trust to relationships outside therapy and build resilience (Knapen et al., 2020).

1.3 Mentalization-Based Treatment

MBT is a structured manualised psychotherapy for BPD that integrates attachment theory and cognitive theory within a psychodynamic framework (Bateman & Fonagy, 2010). Its primary aim is to restore mentalizing when it is lost (Bateman & Fonagy, 2019). MBT consists of three distinct phases: a group psychoeducation phase, a treatment phase, and an ending phase (Leichsenring et al., 2024). Although BPD was initially considered difficult to treat (Gunderson, 2009), evidence indicates

that MBT is an effective intervention for improving BPD symptoms (Storebø et al., 2020; Vogt & Norman, 2019; Volkert, Hauschild, & Taubner, 2019).

1.4 MBT-I GROUPS

The MBT-psychoeducation programme, known as MBT-Introductory (MBT-I), is the initial stage of MBT, following the assessment phase and preceding the primary treatment. MBT-I aims to ensure that patients start treatment with a clear understanding of its focus, expectations, and potential benefits (Bateman & Fonagy, 2016). Initially, MBT-I was based on the MBT manual by Karterud and Bateman (2011) and was later adapted into a 10–12-week manualised programme by Bateman and Fonagy (2016). Each group session, involving up to ten patients and lasting about 1.5 hours, includes reviewing previous content, discussing homework, introducing new topics, encouraging personalised reflections, and ending with tasks for the next session. In MBT-I, therapists are encouraged to continually adapt to patients' needs, reinforcing the three communication systems to ensure the development of a therapeutic alliance and good treatment outcomes.

The three communication systems were introduced by Bateman et al. (2018) to understand and conceptualise effective psychotherapy in BPD and other psychopathologies. These systems are essential across interventions and describe

the mechanisms through which therapeutic interventions activate, maintain, and foster mentalizing and social learning, ultimately developing epistemic trust and improving patients' social functioning. These systems facilitate self-discovery within the context of relationships with others, remaining central to MBT and other manualised treatments that address the improvement of epistemic stance and learning.

Communication system 1: Teaching and learning content

The first communication system involves the learning and teaching of content. This entails the therapist conveying a model that helps the patient understand their mind in a way that feels relevant to them, providing a sense of being understood and recognised. This therapeutic model requires the therapist's ability to mentalize and communicate it in a manner that resonates with the patient, creating an epistemic match. The therapist's ability to mentalize the patient is a crucial aspect of this system. This communication system is vital during the initial phase of MBT, particularly during the psychoeducation phase, which takes place in group settings. The group setting offers patients the opportunity to rethink themselves, view themselves from a different perspective, and build curiosity about social interactions. Therefore, the capacity of the therapist to introduce mentalizing to patients in a way that feels relevant to them and their perceptions of themselves, and others is fundamental to their engagement in treatment.

Communication system 2: Re-emergence of mentalising

This system occurs when patients regain their openness to social communication in situations previously “blocked” by epistemic disruption. This process is fostered by the therapist's curious and open stance. The re-emergence of mentalization creates a positive feedback loop, where patients' curiosity and interest in social learning and mental states reinforce each other, thereby enhancing their capacity to mentalise. As patients' interest in the clinician’s mind and use of feelings and thoughts increases, their capacity to mentalise is strengthened.

Communication system 3: Applying social learning in the wider environment

When patients are mentalised by the therapist, their capacity to learn is reactivated, releasing them from potential social isolation and improving their relationships outside therapy. This system underscores the importance of patients' ability to understand mental states and learn socially, enhancing their functioning by enabling different interactions with their environment. In MBT-I, this system is crucial for patients to apply what they learn in therapy to their daily lives, thereby enhancing their social interactions.

Research indicates that MBT-I could address some of the complex needs of individuals with BPD. Components of MBT-I have been shown to improve

engagement, enhance understanding, and reduce attachment-related anxiety, thereby decreasing drop-out rates and promoting better therapeutic outcomes **(**Bradley-Scott, 2017; Kvarstein et al., 2014)**.** Studies highlight the positive impact of MBT-I on patients' interpersonal interactions, emotional regulation, and self-reflection (Bradley-Scott, 2017; Ditlefsen et al., 2021). Clinically, these findings are significant because they suggest that MBT-I can enhance patient engagement and expectations for subsequent therapy, possibly improving overall treatment outcomes. This aligns with Kvarstein et al. (2015), who highlighted that MBT-I could contribute to the lower drop-out rates observed in MBT for BPD patients. This is particularly essential for BPD patients, who frequently report higher drop-out rates and less successful treatment outcomes (Arntz et al., 2023; Busmann et al., 2019; de Freixo Ferreira et al., 2023). Further preliminary evidence of the benefits of MBT-I, particularly in decreasing self-harm, is seen through Griffiths et al.'s (2019) adaptation for adolescents, reporting mentalization as a predictor of change. However, MBT-I, its independent benefits, and its impact on patients with BPD has not been systematically researched. More specifically, there has been some initial research on the benefits of MBT-I, however the evidence base is limited, and no previous reports have indicated what specific aspects of MBT-I do patients find most and least beneficial.

1.5 Current study

This study aims to address a critical gap in research by deepening our understanding of the lived experiences of individuals diagnosed with BPD who have participated in MBT-I groups. The novelty of this study lies in its exploration of specific aspects of MBT-I interventions that benefit BPD patients, while also considering the role of ET and therapeutic alliance within the therapy process.

Given the complexity and public implications of BPD, the unmet needs of BPD, the high drop-out rates and the need for increased engagement **(**Kantor et al., 2022; Paris, 2020), understanding the specific benefits and challenges of MBT-I is crucial for informing treatment strategies that better support BPD patients. This study is particularly significant given the tension between the necessity of preparatory interventions like MBT-I and the often impersonal and untherapeutic nature of psychoeducation groups as experienced by patients.

By focusing on the initial phase of MBT and incorporating the voices of patients regarding their experiences and the challenges, the present study aims to elucidate the needs of BPD patients and provide insights into patients experience of the process. By exploring what were the most beneficial aspects of MBT-I, what were less helpful aspects, and what changes has been achieved following participation in an MBT-I group, it seems that the present study could potentially enhance the current understanding of MBT-I and ultimately contribute to the improvement of MBT-I to a more effective and personalised intervention, with fewer drop-out and better therapeutic outcomes.

Research Questions

a) What specific aspects of MBT-I have been perceived as beneficial by the participants?

b) What challenging or less helpful aspects were associated with MBT-I?

c) What changes have been achieved through MBT-I?

2. Methods

2.1 Ethics

This study received ethical approval from the Wales Research Ethics Committee in March 2023 (Appendix B). The approval pertained to amendments to a larger joint study (Appendix A). All prospective participants were provided with a written information sheet (Appendix D) and offered a phone call to address any questions prior to agreeing to participate. A written consent form was signed and obtained from all participants before their participation (Appendix F).

2.2 Quality Assurance

This study adhered to the Consolidated Criteria for Reporting Qualitative Research (Tong, Sainsbury & Craig, 2007, see Appendix K). Specifically, the following procedures were implemented:

a) A reflexive approach was employed to mitigate bias, involving regular self-evaluation of personal biases and consideration of alternative interpretations.

b) Transparency was ensured by openly presenting the research stages and personal perspectives, allowing readers to assess the transferability of findings.

c) A collaborative approach was adopted to prevent any single perspective from unduly influencing the study.

d) The analytical process involved implementation by two researchers and two experienced supervisors, followed by checks for convergence. Different avenues of grouping coding into themes and subthemes were discussed in supervision. The two researchers read and coded extracts of a transcript, which were subsequently discussed and compared to identify and reflect on differences in understanding.

2.3 Recruitment

This study is part of an ongoing larger cross-sectional study investigating social exchanges in BPD and antisocial personality disorder (ASPD), initiated in July 2012.

Recruitment was carried out across six NHS Trusts in London. The research team directly contacted these NHS Trusts and invited them to participate. Patients scheduled to attend the MBT-I groups within these trusts between April 2023 and April 2024 were invited by group facilitators to participate in the study prior to the commencement of the MBT-I sessions. Patients who expressed interest in participation were subsequently contacted by researchers and provided with verbal and written information explaining the research objectives and the process of participating.

Upon obtaining the consent form and scheduling a meeting according to their availability, participants were provided with a Microsoft Teams link to add to their calendars. The interviews were conducted within one week following the completion of the MBT-I. Each interview commenced with an introduction outlining the role of the researcher, emphasising confidentiality, and clarifying that the participants' responses would not be shared with their treatment team in an identifiable manner. Participants were also provided with the opportunity to ask questions.

2.4 Participants

Fifteen participants (2 males, 12 females) were interviewed upon completion of the MBT-I group (Table 1). Fourteen of these interviews were successfully recorded and included in this study. To acknowledge their contribution, a £10 compensation was

offered upon completing the interview. Inclusion criteria encompassed individuals diagnosed with BPD who had completed the MBT-I group and were willing and able to attend the interview. Exclusion criteria included individuals with a history of, or current trauma or neurological disorders, including head injury, epilepsy, and loss of consciousness. Additionally, exclusion criteria included those who lacked proficiency in English, had a learning disability requiring medical treatment or specialist educational support, or did not possess a formal BPD diagnosis.

Table 1

Participants' demographic information

	Pseudonym	Gender	Age	Ethnicity	Employment
1	Kelly	Female	31	Black British – Caribbean	Student
2	Angie	Female	31	Mixed White – Black African	Full-time
3	Jane	Female	26	White British	Full-time
4	Susie	Female	20	Mixed White - Black Caribbean	Part-time
5	Cathy	Female	27	White British	Unemployed
6	Beth	Female	41	White British	Full-time
7	Amy	Female	60	White British	Unemployed
8	Kristy	Female	36	White British	Full-time
9	Betty	Female	23	White British	Full-time
10	Maria	Female	35	White – Any other background	Unemployed

11	Elena	Female	24	Black British – African	Unemployed
12	Clara	Non-binary/Other	24	White – Any other background	Employed
13	Andrew	Male	46	White British	Full-time
14	George	Male	24	White British	Unemployed

Note. All real names that could identify participants have been anonymised and changed to pseudonyms. Employment status has been indicated because several participants have indicated that their employment has affected their ability to attend the intervention.

2.5 MBT-I intervention

The MBT Introductory group (MBT-I) is a psychoeducational programme offered as the pivotal first stage of MBT, occurring after the assessment stage and preceding the primary treatment phase. MBT-I is a highly structured manualised programme developed by Bateman and Fonagy (2016), organised as a 10 to 12-week group psychoeducation programme for up to ten patients, with each session lasting approximately 1.5 hours (Appendix C).

2.6 Design

The development of semi-structured interviews followed a five-phase framework as outlined by Kallio et al. (2016). Adherence to these five phases aimed to ensure trustworthiness and rigorous data collection for this study:

1. *Determining the prerequisites for employing semi-structured interviews:* This initial phase involved identifying areas within MBT-I that needed further research based on previous studies (Turner, 2010).

2. Gathering and applying previous knowledge: In this preparatory phase, a comprehensive review of the literature was undertaken to understand the research context. Such in-depth familiarisation is crucial for developing effective interview questions (Rabionet, 2011).

3. Developing the preliminary interview protocol: Based on insights from Cridland et al. (2015), a series of preliminary questions were formulated. These questions were designed to direct the dialogue towards the core research questions. The interview protocol allowed for the reordering of questions and enabled smooth transitions between questions (Åstedt-Kurki & Heikkinen, 1994). The interview protocol included

primary themes addressing the main research topic, complemented by follow-up questions to clarify these themes further (Turner, 2010).

4. *Conducting a pilot test of the protocol:* This phase involved the empirical testing of the interview protocol to refine and validate its effectiveness. The details of the pilot testing process are elaborated below.

5. *Presenting the finalised semi-structured interview protocol in supervision:* This final phase involved reviewing and reflecting on the pilot test outcomes during supervision. Subsequent revisions were made to finalise the protocol.

2.7 Pilot

Testing the interview protocol was a crucial step in refining the questions to enhance their clarity and relevance. This iterative process was conducted in three stages, as proposed by Barriball & While (1994):

1. *Initial Evaluation:* The research team evaluated the interview protocol, focusing on identifying ambiguities in the questions.

2. *External Review*: An external specialist reviewed the interview protocol, providing valuable suggestions for improving the content of the questions.

3. *Pilot Testing:* The revised interview protocol was pilot tested with study participants. This practical testing phase aimed to assess the questions' effectiveness in eliciting meaningful and comprehensive responses and to obtain direct feedback from patients.

Two pilot interviews were conducted to evaluate the semi-structured interview protocol. The feedback from one participant, Tash, was illustrative: “I think that was pretty much everything I actually like, yeah, I wouldn't have been able to speak about all of that without the questions. So that was a useful guideline.” This feedback indicated the efficacy of the protocol in facilitating comprehensive discussions. Subsequently, the interview protocol (Appendix G) was discussed and amended during supervision sessions held between the pilot interviews and the commencement of the primary research interviews. To ensure methodological rigour, feedback on the interview protocol was provided by three supervisors.

2.8 Data Collection

The interviews were conducted by one interviewer (author) over a 14-month period. Semi-structured, in-depth interviews were conducted to explore the experiences of patients with MBT-I. All 14 interviews were remotely conducted by the researcher NZ via Microsoft Teams, ranging from 45 to 70 minutes. To accommodate participants' potential discomfort with video recording, only audio recordings were

utilised. All interviews were transcribed verbatim. The main interview themes were: “participants' experiences of the MBT-I”, “Sessions”, “impact/changes”, “facilitators”, and “trust”.

2.9 Analysis

The interviews were analysed using reflexive thematic analysis within a hermeneutical-phenomenological epistemology (Friesen et al., 2012; Braun & Clarke, 2022). This approach was selected for its suitability in addressing the research questions related to patients’ experiences of MBT-I and the change processes. Thematic analysis, as employed by Morken et al. (2019) to explore patients’ experiences with MBT, proved similarly effective here. The data was analysed using the software Nvivo (Jackson, Bazeley, & Bazeley, 2019), with a primary focus on identifying patterns of meaning within the dataset.

Through phenomenology, the aim was to explore patients’ concrete experiences, followed by an interpretive examination to understand how participants assign meaning to their experiences (Van Manen, 1997). This interpretive process involved an iterative approach, comprehending both the parts and the whole, while considering preconceptions. Understanding the meaning of participants’ experiences necessitated an element of interpretation and reconstruction. The hermeneutic

approach required a highly reflexive stance towards preconceptions throughout the entire research process (Binder, 2012; Finlay, 2008). Experiences relevant to this research were condensed into "meaning patterns" by comparing narratives from multiple participants. Patterns emerged through convergences and moderate divergences, enriching the thematic understanding. Formulating these "meaning patterns" involved combining hermeneutic interpretation and empathic imagination, grounded in a phenomenological commitment to participants' lived experiences. This was facilitated by routine and ongoing reflections on choices, expectations, actions, and assumptions during the research process (Finlay & Gough, 2003).

Themes were generated through these patterns following the reflexive thematic analysis framework by Braun and Clarke (2022), which guided the identification of patterns in the data through the following six stages:

1. *Data Familiarisation*: The author transcribed all the interviews, made notes, re-read the dataset, and considered recurrent patterns.

2. *Generation of Initial Codes*: The author systematically worked through the dataset, identifying relevant aspects related to the research questions that could inform the development of themes.

3. *Organisation of Codes into Potential Themes*: The author reviewed and analysed the coded data, considering how codes could be merged based on shared meaning to form themes and sub-themes.

4. Review and Refinement of Codes and Themes and Development of a Thematic Map: The author reviewed the themes in supervision to ensure meaningful interpretation of the data addressing the research questions.

5. *Definition and Labelling of Themes:* The author defined the themes, conducting a deep analysis of the data items and identifying extracts to use for the report of the analysis.

6. *Report Production:* The author established the order of the themes to build a coherent narrative, connecting the data in a meaningful and logical manner.

2.10 Reflexivity

Reflexivity is a crucial tool for understanding how the research process is influenced by our preunderstandings (Morrow, 2005). To foster critical reflection on the influence of my own position, perspective, and reality throughout the analysis process as a researcher, I adopted a reflexive approach (Braun and Clarke, 2022).

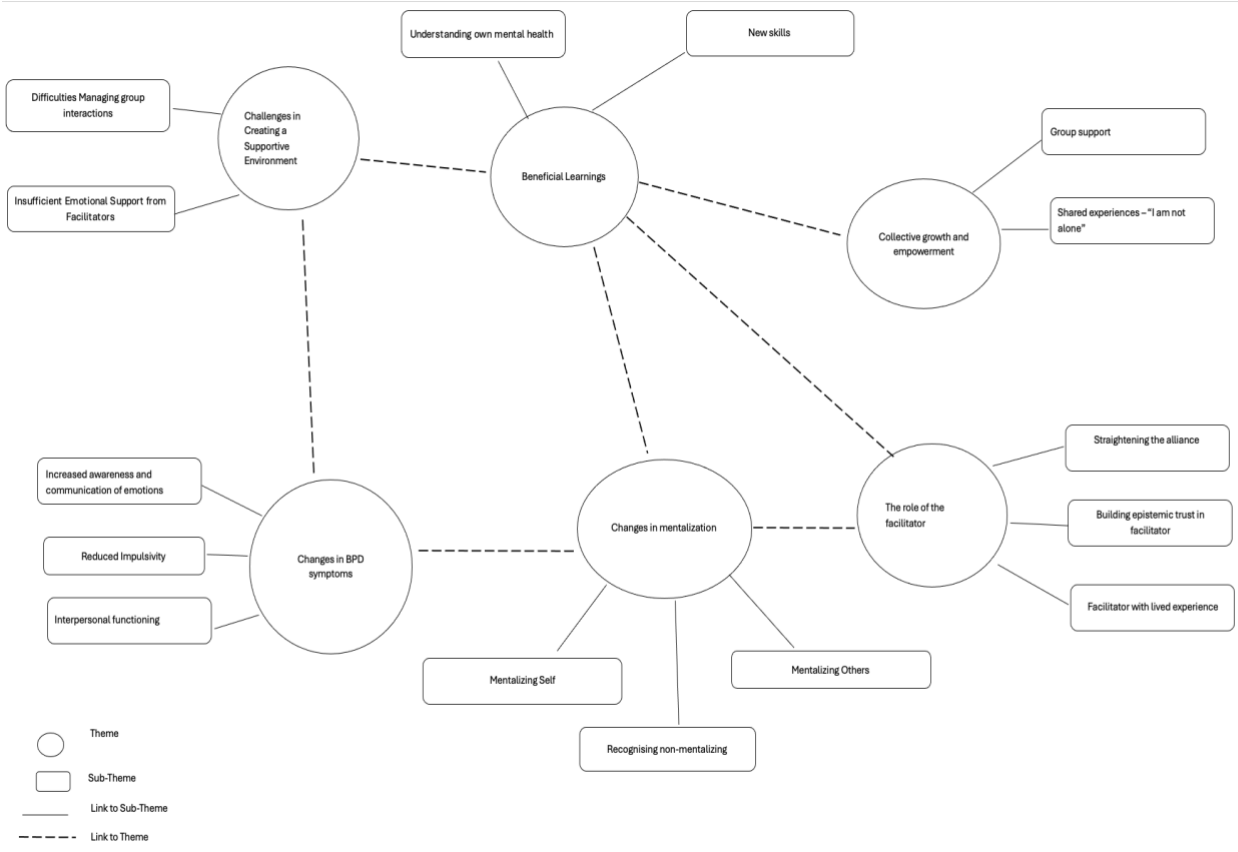
As a female trainee clinical psychologist, I utilised supervision, a research trail, and a reflexive diary to enhance explicit awareness of my own position during the development of the codes and themes. Being female seemed to contribute to building rapport and creating a sense of safety for participants to share their experiences. Several female participants mentioned that they would have felt uncomfortable with a male clinician in the MBT-I groups, highlighting the importance of gender dynamics for some patients in both clinical and research settings. Reflecting on the research process, some participants noted that facilitators in their sessions occasionally misinterpreted their words, which made me aware of the dynamics at play during the interviews. These misinterpretations highlighted the need for active listening and validation of their experiences and perspectives. This awareness strengthened our relationship, as I was able to check in with them at various times to ensure that my understanding of what they shared was accurate and that they felt heard. Overall, this reflection has deepened my understanding of the complexities involved in qualitative interviews and the significant role of effective communication in establishing trust and rapport, ultimately enhancing the richness of the data collected. During the analysis process, I adhered to updated quality standards, including consideration of the 20 questions proposed by Braun and Clarke (2020) for thematic analysis. This approach facilitated the application of subjective skills and prompted reflection on my position

throughout the analytic process. I was not involved in the patients' MBT-I treatment, and therefore, held no authority or power over them.

3. Results

Six themes and twelve subthemes were identified through reflexive thematic analysis (see Figure 1). These themes revealed participants' experiences within the MBT-I groups, their perspectives on the beneficial aspects of the MBT-I, the challenging aspects of MBT-I, observed changes post-MBT-I, and the potential mechanisms through which these changes occurred.

Figure 1. Finalised thematic analysis map demonstrating six themes



3.1 Theme: Beneficial learnings

Participants emphasised the usefulness of the new practical skills acquired through the MBT-I sessions in regulating their emotions. They also noted that the knowledge gained facilitated a deeper understanding of their symptoms and themselves.

Subtheme: "New Skills"

Participants described how the practical skills acquired during the MBT-I sessions were instrumental in enabling them to achieve a state of calmness prior to interpreting situations or responding. These skills created opportunities for awareness of intense emotions and reflection on their emotions while attempting to remain curious rather than jumping to conclusions.

"*It was them teaching us just to calm down and think about our emotions and then respond. Take a break, and then respond…if I don't know what I'm feeling …but my body is feeling in a certain way …then I know how I am feeling…they said there was different temperatures in your body…and just to kind of acknowledge how your body's feeling you react and then match up to the emotion. Think about how you're feeling through your body*" (Kelly).

Participants conveyed that acquiring skills that helped them to pause, allow their emotions to settle, and sit with their emotions has proven beneficial. The process of calming down using MBT-I skills involved practical actions such as taking a break, changing the environment, sitting still, practising breathing techniques, counting, grounding techniques, body awareness, and shifting their focus with an awareness of their emotions.

"*You've got to wait for it to settle down. And yeah, it is learning to let your mind naturally come back down instead of you know doing something stupid like I said, prepping yourself*" (Maria).

This theme elucidated the practical skills that participants acquired through MBT-I, providing concrete examples of their application in real-life scenarios and illustrating the various ways these skills have been beneficial, especially in regulating their emotions.

Subtheme: "Understanding Own Mental Health"

Participants shared beneficial learnings related to their understanding of their own mental health. These insights were acquired through both the psychoeducational content and their interactions with other group members. It seemed that these

learnings helped participants rationalise their symptoms and thinking patterns, subsequently better understanding their behaviours. Jane reflected on her new understanding gained from group members regarding unhelpful behaviours and challenging emotions as symptoms of BPD rather than viewing them as indicative of being “broken”.

“*I think just understanding of how my brain works and how it's a product of my environment and all of the interactions that I've had… It's not me being broken or me being wrong…it’s just me, like, getting a way of thinking to protect my brain from what's happened when I was younger…it was really validating when someone else said something and I'd be like, oh my god, I go through exactly the same and like there's a lot of things that I didn't realise were because of my mental health. I just thought were a fact of life. So, it's definitely helped me understand a lot of my symptoms a lot more….and even recognise that some things even are symptoms*” (Jane).

There was a sense that this new understanding brought a different perspective of themselves, reducing self-judgment. Moreover, this new understanding appeared to enable participants to contextualise their behaviours and emotions within the framework of their experiences rather than perceiving them as personal failures or

inherent flaws. This insight into their mental health contributed to their overall well-being and progress in managing their BPD symptoms.

"*I think it was learning about the brain waves, and about mental health…after that triggering brain cell session and the anxiety depression session to understand what that is, that's when I noticed my mood getting a bit higher when I was doing it*" (George).

A noticeable pattern emerged in how participants' understanding of their symptoms contributed to self-empowerment and self-compassion.

3.2.Theme: Collective growth and empowerment

Subtheme: "Shared Experiences – 'I Am Not Alone'"

Participants emphasised the psychosocial benefits of shared experiences in group settings. Most conveyed a sense of relief and belonging upon realising that their experiences are shared, stating that the main insight they gained from the MBT-I was the reassurance that they are not alone.

"*The fact that we're in the same boat. None of us any better or any worse than the other. All human, those people are in there because they've gone through *** like*

me…at the end of the day they're trying to do the best they can so that they can survive in this world, so we all deserve the same compassion…the main thing I learned is that I'm really not alone" (Angie).

Hearing from others navigating similar experiences contributed to the normalisation of their own challenges, subsequently inducing validation of their experience and feelings. Realising that others encounter similar challenges appears to have shifted their perception from self-blame to understanding the role of potential contributing causes, such as trauma, in their difficulties.

"*Definitely made me think that like, things aren't my fault as much as I thought they were because like being in a group and seeing other people struggle with what I struggle with has been quite validating*" (Jane).

The recognition of shared challenges seemed to reduce feelings of shame and foster self-compassion. By seeing their struggles reflected in others, participants felt less isolated and more understood, leading to a sense of acceptance and safety within the group.

Subtheme: "Group Support"

Most participants stressed the importance of feeling supported by other group members. They shared that the supportive atmosphere and validation from group members were evident through non-verbal cues, such as nodding, and verbal affirmations, such as expressions of agreement and resonance. Moreover, support was shown through helping each other to implement mentalising during sessions and providing encouragement.

"*People sometimes would help me to think about what was happening and why I might have been feeling that way…we mentalized through so many things. I felt like we all helped each other through things. We all genuinely listened to each other. And you could tell there was care in the group. Like if someone got upset, we all genuinely wanted to make sure they were okay afterwards. I think we had a very good group*" (Susie).

This supportive environment seemed to be fostered through empathetic rapport, trust, and a sense of care shared within the group. This collective dynamic enhanced mutual understanding and strengthened the bonds among participants. Additionally, the acknowledgment "we are in this together" (Beth) encapsulates the

sense of collective unity in confronting challenges while seeking treatment and striving to improve their mental health.

One participant vividly described the impact of the support they received from others when they struggled to join the session, being encouraged to attend:

"*I'd see someone from my group, and they go, 'come on, you can do it.' And then we go in together sort of thing*" (Elena).

3.3. Theme: The role of the facilitator

Participants identified specific factors that strengthened their connection with the facilitators, thereby enhancing their alliance and facilitating more effective learning. They described various factors contributing to their trust in the facilitators, emphasising the importance of facilitators with lived experience.

Subtheme: Strengthening the Alliance

Participants reported a positive experience with the facilitators, noting several key factors that fostered rapport and created a sense of a safe and non-judgmental space. Clara, for instance, mentioned, "*Like, I didn't feel like anything that I was doing or anything that I'd done was like, wrong*" *(Clara).*

They felt heard and understood by the facilitators, who demonstrated their support through regular check-ins, detailed explanations when needed, and providing slides for further clarity. Active listening skills and the ability to validate or make an effort to understand participants' experiences, even when the facilitators could not directly relate, were highlighted as significant components in building a therapeutic alliance.

"*I think they would just be good at listening or good at validating. They were supportive. There was one time where I missed a session, I got an email from all of them saying that they missed me in the group and that they were worried and concerned. They seemed really willing to understand and accept what you were saying like…. Say some pretty bonkers and outlandish things that don't really make sense in the real world, but there was never any judgement there … And along with so, when there's no judgement and there's lots of validation, you feel very supported*" (Betty).

Betty's reflection illustrated the critical role of the facilitator in fostering a therapeutic environment that promotes emotional safety, validation, and support. Participants' experiences highlighted the importance of these elements in building an alliance and subsequently trust in the facilitators, which is essential for the effective delivery of psychoeducational interventions like MBT-I.

Subtheme: Building Epistemic Trust in Facilitators

Participants conveyed trust in the facilitators. However, some expressed concerns about facilitators who were not active in the sessions, leading to doubts about their knowledge. These doubts may be related to epistemic vigilance. It appeared that facilitators' active participation during MBT-I was interpreted as a sign of greater knowledge and experience. The facilitators' ability to mentalise themselves and others in the group seemed to be an important indication of their skills and knowledge, contributing to building trust.

"*The main facilitator, he would be like: 'OK guys, I feel like I haven't quite mentalized this right or I haven't explained this right. I don't want to cause anxiety.' Like he'd take time to, almost like, correct himself, he was the only one who did that. That's why I feel like for me it was like that guy and the facilitator with lived experience were the main people who I trusted*" (Elena).

Furthermore, the development of trust in the facilitators seemed to be cultivated by their genuine and non-judgmental approach, professionalism, and the perceived sense of safety they provided.

"*Just gained more trust and like could tell that they cared about us… like making sure that we were there to get better or try to get better. I think the fact that like they could notice if I wasn't OK and then like X would call me after…and I feel like that really helped me trust then, because I was like, OK, you actually do care about me*" (Clara).

The developed trust seemed to facilitate a deeper acceptance of the knowledge gained from the MBT-I group, thereby enhancing epistemic trust.

Subtheme: Facilitator with Lived Experience

Participants conveyed a sense of hope stemming from the presence of facilitators with lived experience. They highlighted the significance of having a facilitator who could relate and empathise with their experience, understanding them on a deeper emotional level.

"*Having the facilitator with lived experience, that was so important to me in going like, 'oh, you get it.' When thinking like how's mentalizing going to help me with these really strong emotions that I can't control… and then with the facilitator with lived experience it felt like I can see how it does have an impact instead of just imagining it or like hoping that it will*" (Clara).

This connection seemed to inspire hope about the treatment's effectiveness and the possibility of life change, as participants could witness the impact of the MBT intervention on the facilitator with lived experience. Participants shared that this profound understanding enabled the facilitators with lived experience to effectively explain and contextualise information, and simplify complex concepts when needed.

"*She obviously has been through the therapy. So, she knew a lot about, she could relate to certain people and certain situations that was really, really good to have that*" (Andrew).

This highlighted the invaluable role of facilitators with lived experiences when working with individuals with BPD. Participants expressed how such facilitators contribute to fostering a supportive and insightful environment, empowering individuals through the ability to relate to their experiences. This appeared to be another beneficial aspect of the MBT-I.

3.4. Theme: Changes in mentalization

Participants reported improvements in their ability to mentalize themselves and others across various contexts. This enhanced capacity was particularly evident during the interview when they discussed interactions with other group members with

empathy and insight. Additionally, participants reflected on instances where they struggled to mentalize effectively.

Subtheme: Mentalizing Self

Participants provided examples of mentalizing themselves both in the group and in their daily lives, illustrating how this process fostered kindness and self-understanding. By engaging in mentalization, participants were able to rationalise their behaviours and feelings, leading to subsequent changes in their actions.

"*I've been really good at not messaging people that I shouldn't be messaging because then I just think like, I've only wanted to do this because I want to get that short amount of validation and I'm only going to feel worse, and it's like being self-aware definitely helps you recognise what you're doing. And like, explain it away instead of thinking like, I think 'this is the right thing to do'. You think like, 'I'm only doing this because this is how I feel, and this is how I think I'll feel afterwards.' And so I have definitely noticed the difference in that sense. It like helps you*" (Jane).

This reflective process, as expressed by Jane, demonstrated how self-awareness assists in recognising and explaining one's behaviours, leading to more informed decision-making. Through the practice of mentalizing, participants reported

increased awareness of their thinking, emotions, and biases, thereby reducing self-judgment.

"*I knew where the emotions were coming from. Like I knew, OK, I'm feeling quite… I'm feeling this way because I miss my ex. I am starting a new relationship. I'm worried about it. And yeah, it's kind of like terrifying. So it's like understanding why those emotions are there*" (Clara).

It appeared that through MBT-I, participants developed the capacity to understand their own thoughts and behaviours, enabling them to consider situations from different perspectives.

Subtheme: Mentalizing Others

Participants provided examples of successfully mentalizing others in emotionally charged situations, which typically would have triggered intense emotions and reactions. This practice facilitated detachment from their negative inner voices and prompted understanding of others' perspectives.

"*I normally get really angry with people just in the queues… and just want to like look for a fight. But recently I've been trying to calm down because like I was rude to someone for no reason, and then it made me feel really bad after…And like normally*

before I wouldn't care. But now I'm like oh I could have ruined her day…you never know what someone's going through or thinking, especially strangers. Like they could have the worst thing going on in their life right now. And the last thing they need is some woman being rude to them for no reason" (Cathy).

Elena provided an example of mentalizing family members in triggering situations, describing how this approach helped her calm down and adopt the other's perspective.

"*You know what, she's (mother) actually really tired and she does want to go to bed, and she did have, like, a full day at work*" (Elena).

It appeared that mentalizing others increased participants' compassion and reduced anger and anxiety related to interactions with strangers. Mentalizing helped them understand alternative explanations for others' behaviours, fostering a more empathetic perspective.

Subtheme: Recognising Non-Mentalizing

Participants demonstrated an awareness of their difficulties in mentalizing, especially during intense emotional situations.

"*I've recognised that my emotions are quite intense at times. And so, I don't really mentalize at those moments*" (Kelly). This reflected an understanding of the need to mentalize, despite being unable to do so in practice. Additionally, some participants expressed struggles with implementing mentalizing and acknowledged a lack of comprehensive understanding of the practical process.

"*I wouldn't say that I understand mentalizing very well. I understand the concept, but the actual tools and how to use it and all of those things, I'm guessing that comes later on. But I've got the curiousness to know that I want to know now*" (Maria).

Maria's curiosity indicates her desire to improve her mentalizing skills. The ability to recognise their own limitations in mentalizing suggests that participants were connected to reality, not in a pretend mode. They were aware of their physical and emotional states, which is crucial for effective mentalizing. Furthermore, participants began noticing when others failed to mentalize.

"*If a colleague would say something in passing about another colleague, and I'm thinking, well, you don't know what that other colleague's going through*" (Beth).

This observation indicated Beth's growing ability to mentalize and recognise the lack of mentalizing in others. This theme underscored reflections and emphasised both the challenges and progress in the participants' mentalizing abilities, highlighting the importance of awareness and continuous learning in the process. Moreover, the extracts underlined the transformative changes in cognitive processes through mentalization.

3.5. Theme: Changes in BPD symptoms

Participants reported personal changes during MBT-I, particularly noticeable from the midpoint in the interviews when they felt more comfortable and open to sharing. This comfort and openness were likely influenced by their trust in me as the interviewer. As the interviews progressed, I noticed that the rapport we developed fostered a safe environment, which likely helped build epistemic trust and express their thoughts and feelings. This shift facilitated deeper engagement and richer narratives. The personal changes reported by participants encompassed increased emotional awareness, improved communication of their emotions with others, enhanced interpersonal relationships, and reduced impulsivity.

Subtheme: Increased Awareness and Communication of Emotions

Participants noted improvements in their awareness and connection to their emotions, which allowed them to reflect and rationalise their emotions in various situations. This heightened awareness enabled them to express their feelings and needs to others. This connection to their emotions seemed to have given participants a voice, empowering them to articulate to others the rationale behind their behaviours and understand themselves better.

"*On a baseline struggle with connecting with my own emotions, but I would say that it's improved. Only yesterday it was telling my family that I felt unstable because I thought it was the fact that we're getting ready to move house. So, like I think I've become more in tune with my own emotions and like my sister's emotion*" (Betty).

This extract illustrated the development of emotional awareness and the ability to communicate emotions, leading to better personal and familial understanding. Additionally, Kristy's experience highlighted how improved communication skills can directly alleviate anxiety and enhance personal interactions.

"*I was worried that if I asked my boss, she would just say yes because I've been off all week because I was unwell… and I was also worried that if I don't say anything, she'll think badly of me. And it was really, it was making me really anxious. But MBT-I made me think, actually, why not just ask and see what the answer is and just sort of ask but also say like I'm going to do this, I hope this is OK and she came back and said, yeah, that was absolutely fine and it alleviated that anxiety straight away*" (Kristy).

Maria's succinct statement emphasises the positive impact of MBT-I on assertiveness and self-advocacy: "*I'm a bit more assertive about my own needs*" (Maria).

An example illustrating assertiveness was provided by Clara: "*We did a check-in at rehearsals and I was like, I'm quite emotional… And I might need some, like moments of just calmness and like I might need to sit out at any point. But just to let you guys know. So I feel like I'm very much less ashamed of leaving the space now*."

Subtheme: Interpersonal Functioning

Participants reported improved interactions with family members and close relationships. They reflected on how their assumptions had been unhelpful and recognised the value of mentalizing in accepting others and being more patient.

Considering others' feelings influenced by their behaviours led to changes in their own behaviours.

"*And instead of, like pushing her away and being like, oh, well, now I'm irritated. I'll be like, oh, that's cool because I knew that she was stressed*" (Betty).

Betty's experience demonstrated how understanding others' stress can mitigate irritation and improve relational dynamics. Cathy's narrative showed increased empathy and consideration for others' perceptions, fostering enhanced communication.

"*But instead of just ignoring her, I think in my head now, like oh, I better reply to her because she doesn't know me. She might think I'm being rude. She might think I'm that, and then that might make her feel a type of way*" (Cathy).

Maria's insights highlighted the importance of self-regulation in response to others' inflexible behaviours, promoting healthier interactions.

"*Now I understand the way that she is and I think to myself, 'Well, she's not going to change the way she thinks or the way she feels, so perhaps I can change the way that I react*'" (Maria).

Subtheme: Reduced Impulsivity

Participants noticed changes in how they handle situations, reporting an increased ability to pause before reacting. This reduction in impulsivity helped them manage anger and improve interactions. The ability to step back allowed them to mentalize and regulate their emotions better, leading to rational responses and improved relationships.

"*I actually got in an argument today with somebody. It was just like a bit of a misunderstanding, but I instantly went to being angry about it. But it's like I could stop myself and come away from the situation. And just actually think. I've been like trying to write things down and actually go over the process of why do I feel so angry and trying to get down just slowly, like trying to see what it's like, you know, how the other person might feel because if they reacted to me that way, you know, like, just trying to flip the situation around… it's given me the opportunity to actually think more carefully about why I might be feeling a certain way and what is the core of that feeling. Yeah, I find this helpful to me because I don't get lost in my heightened emotion*" (Susie).

Susie’s reflection demonstrated the significant impact of MBT-I in helping participants pause, reflect, and understand their emotions, leading to better emotional regulation.

Maria reported that the reduction in her impulsivity had a profound impact on her life and well-being. It demonstrated her ability to make more thoughtful decisions when emotionally charged, leading to noticeable improvements in her overall well-being.

"*Now instead of when I feel overwhelmed going out and getting a round of coke and drinking a load of drinks or whatever, I let the moment pass and then I'm back to normal and I haven't ruined my life and my mental health and my well-being in between*" (Maria).

It appeared that Maria’s enhanced self-regulation has effectively prevented impulsive behaviours that previously resulted in negative consequences, thereby preserving her mental health and well-being.

This theme illustrated the transformative changes in various aspects of participants' BPD symptoms. Their insights and reflections underscore the importance of MBT-I in fostering emotional awareness, improving interpersonal relationships, and promoting self-regulation. These changes collectively contribute to a reduction in BPD symptoms, thereby enhancing the overall quality of life for individuals attending the MBT-I group sessions.

3.6. Challenges in Creating a Supportive Environment

Subtheme: Insufficient Emotional Support from Facilitators

Participants expressed a need for additional emotional support, particularly following the disclosure of personal information. One participant observed that individuals did not attend a group session after sharing deeply personal experiences, attributing this to inadequate support from the facilitators in managing their subsequent emotional struggles.

"*A lot of things have been raised that were very significant for us, probably a lot of shared experiences around things like self-harm and suicide and so forth… and I came back the following week and I know a lot of people didn't come back the following week and the week after they did come back and they also expressed similar concerns*" (Andrew).

Moreover, the absence of additional support was identified as an obstacle in sharing, given the recognition that the space is not therapeutic. The lack of emotional support was seen as a barrier to both expressing and processing emotions.

"*Because things get raised in the group, but we can't go into them because it's not a therapeutic space, it's an educational space…. You can only reveal an incident that's maybe distressed you in the week as an example. So, then things are brought up but not resolved. So, you then have to go away holding that and there's not really anywhere else to go with it*" (Amy).

These extracts illustrated the importance of providing sustained emotional support in group settings for individuals diagnosed with BPD.

Subtheme: Difficulties Managing Group Interaction

Participants expressed that conflicts and disagreements in the group triggered difficult feelings. Some reported feeling nervous and uncomfortable when conflicts arose.

"*There were conflicts within the group and that made me feel really nervous*" (Clara).

Expectations from the facilitators to intervene when group members were disruptive, talking excessively, or not respecting boundaries in sharing were noted.

"*I did think at times I thought the facilitators might say more when people were particularly disruptive, but they would sort of leave it for that time*" (Maria).

These extracts illustrated the complex interpersonal dynamics, particularly in group settings. Effective facilitation plays a pivotal role not only in mitigating conflicts but also in establishing a supportive and emotionally secure environment.

4. Discussion

The present study aimed to qualitatively explore the experiences of MBT-psychoeducation groups for patients with BPD, identifying both beneficial and less helpful aspects of the intervention. Additionally, the study aimed to explore changes observed post-MBT-I and how these changes occurred, a process that seems to remain understudied. Overall, the findings complemented previous research on MBT and MBT-I (Bradley-Scott, 2017; Ditlefsen et al., 2021), highlighting the positive experiences and beneficial processes reported by participants, while adding an understanding of the role of the facilitator and the process of change.

The MBT-I groups were generally described as useful and helpful, with participants noting improvements attributable to the intervention. In line with previous research (Bradley-Scott, 2017; Ditlefsen et al., 2021), the reported beneficial aspects included psychoeducational knowledge, practical skills, group empowerment, and therapeutic alliance. These aspects might have potentially led to positive changes in participants' mentalizing ability, ET, and management of BPD symptoms. Participants noted improved mentalization skills, increased connection with feelings, and decreased impulsivity. Furthermore, participants reported improvements in relationships and an enhanced ability to communicate their emotions.

However, a number of challenges were also identified. Participants reported difficulties with interpersonal interactions within the groups; it is important to acknowledge that these challenges likely varied across different groups. Group dynamics can affect participants' experiences, and the nature of interpersonal difficulties may have impacted the dynamics in each group. Participants also highlighted the need for additional support from the facilitators during the MBT-I group, in between group meetings, and after the group intervention finishes.

4.1 Beneficial aspects of MBT-I

The findings demonstrated that acquiring practical skills through MBT-I sessions helped participants regulate their emotions during challenging times. Participants effectively utilised psychoeducational knowledge on the natural calming of emotions, employing strategies such as sitting with their feelings to allow for emotional stabilisation. Techniques like breathing exercises, counting, body awareness, and shifting focus were identified as beneficial for alleviating emotions and promoting mentalization, thereby maintaining curiosity. These findings align with previous MBT research highlighting participants' experiences of engaging with their emotions in a new constructive way rather than resorting to avoidance behaviours such as substance use to escape from their emotional states (Ditlefsen et al., 2021; Morken et al., 2019). Additionally, participants reported the effectiveness of breathing techniques, grounding, mindfulness, and attention-shifting, paralleling findings from DBT research (Heerebrand et al., 2021).

Furthermore, participants indicated that the MBT-I sessions enriched their understanding of BPD symptoms, fostering self-reflection on the impact of these symptoms on their thoughts, emotions, and behaviours. This introspective process appeared to cultivate self-compassion while reducing self-judgment, a crucial aspect for BPD patients prone to self-criticism, which can deteriorate their mental health

(Donald et al., 2019; Warren, 2015). Bradley-Scott (2017) similarly reported that MBT-I positively impacted self-reflection and understanding of self and others.

4.2 Collective growth and empowerment

Participants frequently expressed a newly recognised feeling encapsulated in the statement "I am not alone." This sentiment underscores the importance of a sense of belonging, normalisation, and validation, especially for BPD patients who often struggle with feelings of loneliness (Liebke et al., 2017). Engaging with similar others in group settings fosters connection and bonding, helping members understand that they are not alone in their struggles (Tan et al., 2018). The current findings highlight the therapeutic value of normalising BPD symptoms, fostering interpersonal learning, group support, and validation through shared experiences. These components have been identified as therapeutic factors that may potentially promote recovery (Hauber et al., 2019).

Within MBT-psychoeducational groups, normalisation has been previously reported as a chief beneficial treatment factor (Koivisto, Melartin, Lindeman, 2021). Participants reported that feelings of self-blame and self-criticism shifted to a more self-compassionate stance following the MBT-I intervention, where they felt that they are not alone and that BPD symptoms are not their fault. A possible hypothesis is that

shared struggles identified in others with BPD contributed to normalisation and a reduction of self-criticism (Ditlefsen et al., 2021).

4.3 The role of the facilitator in ET and engagement

Participants reported that foundational therapeutic skills, including care, warmth, empathy, and creating a safe, non-judgmental space, were essential for them to develop trust in their facilitators and form a stronger therapeutic alliance. Participants also highlighted the significance of facilitators' proficiency in mentalizing, which was reported as another contributor to the development of trust. This trust subsequently facilitated further engagement with the therapeutic process and the information shared by the facilitators. This finding aligns with previous research on the role of ET in enabling the effective transmission of information and knowledge (Li et al., 2023; Nolte et al., 2024).

The development of ET is a critical component of MBT-I. When ET is lacking or absent, the potential for new learning and subsequent change can be significantly impaired (Fonagy, Luyten, & Allison, 2015). Cultivating and improving ET may facilitate social learning and improve the quality of life for BPD patients by enabling the development of interpersonal interactions and the formation of positive social communications. It also facilitates a more beneficial therapeutic prognosis in MBT

(Fonagy & Campbell, 2017). Enhanced trust in others, along with improved mentalization skills, has been associated with a greater decline in BPD symptoms (Bo et al., 2017).

Taking the present findings into account, it seems that the facilitator's role within MBT-I is particularly important. Facilitators have the potential to foster participants' learning and contribute to overall engagement with the intervention through the critical mechanism of ET. Additionally, participants highlighted the value of facilitators with lived experience and how they experienced hope by being able to relate to their facilitator. Individuals with BPD present with significant difficulties in trusting the personal relevance of knowledge and authenticity within an attachment relationship, which may complicate the process of forming an alliance with facilitators who are not able to relate to what patients are sharing (Bo et al., 2017). It therefore seems that being able to relate to and trust the facilitator may increase engagement with the therapeutic process in MBT-I.

4.4 Complexity in psychoeducational processes

Interpersonal challenges, conflicts within the group, and lack of containment between group members were reported to activate intense emotions and lead to disengagement for some participants. MBT group psychotherapy for BPD, where

inherent interpersonal dysfunction is present, can lead to attachment anxiety in individuals with BPD (Bateman, Fonagy & Allen, 2009). This aligns with a study exploring group obstacles in long-term psychoeducational group therapy for BPD patients (Koivisto et al., 2021). Inflexibility and aggression within the group were highlighted as obstacles to the treatment process. This may be related to psychic equivalence, in which participants' uncomfortable feelings prevent them from engaging with alternative perspectives and understanding how this might be an opportunity to mentalize the interpersonal dynamics present in the group setting (Fonagy, Target, & Bateman, 2018).

To address these issues, participants suggested that additional individual support might provide adequate containment and enhance engagement with MBT-I. Support in the form of boundaries from the facilitators on how much is shared, as well as individual emotional support following difficult group interactions or the sharing of personal information, was described as important. This aligns with research highlighting the perceived need for emotional containment in MBT-psychoeducation groups (Bradley-Scott, 2017).

Overall, the current findings suggest that interpersonal challenges, conflicts within the group, and lack of containment between group members can activate

intense emotions and lead to disengagement. It seems that additional individual support might have the potential to mediate challenging group experiences and prevent subsequent disengagement.

4.5 Improvements through MBT-I

Mentalizing difficulties have been systematically associated with affect dysregulation, interpersonal disturbance, and impulsivity in individuals with BPD (Euler et al., 2021; Bateman & Fonagy, 2010). Participants reported improvements in their mentalizing skills in relation to themselves and others. Previous MBT-I research has documented participants' attempts to apply mentalizing in practice following an MBT-I intervention (Bradley-Scott, 2017). Koivisto and colleagues (2021) also reported that long-term psychoeducation can improve mentalization in BPD patients.

When such findings are reported, it is important to consider whether they might be affected by underlying pretend mode states, where the observations reported by participants may not be associated with reality in a flexible way. However, participants were able to provide concrete examples of events where they successfully mentalized themselves and others, as well as instances where they experienced a lack of confidence and inability to mentalize in situations involving close relationships when their attachment was activated. This suggests that the present findings may not be

explained by pretend mode states, but rather indicate a factual improvement in mentalizing skills.

Additionally, the current findings suggest that implementing mentalization, maintaining curiosity, and pausing before responding to situations can lead to an increased ability to regulate emotions and subsequently improve interpersonal functioning. Another factor contributing to the improvement of interpersonal functioning is participants' enhanced awareness of their emotions and improved communication of their feelings and needs to others. This is consistent with previous findings showing that psychoeducation for BPD may result in a decline in impulsivity in patients with BPD and improvements in psychosocial functioning, including decreased disconnection from feelings, development of more adaptive emotional reactions, and reduction in maladaptive ones (Koivisto et al., 2021; Zanarini & Frankenburg, 2008; Zanarini et al., 2017). Research specifically focused on MBT-psychoeducation for BPD has also shown positive effects on impulsivity and relationship management (Ceryn, 2017).

4.6 Clinical Implications

The clinical implications of the present findings are significant for improving the understanding of the benefits of MBT-I for BPD patients and identifying specific MBT-

I components that could be optimised to make it an even more effective and feasible intervention. The findings highlighted the critical role of mentalization skills in improving emotional regulation and reducing impulsivity. Participants reported an increased ability to stay in touch with their feelings and manage impulsive behaviours, further emphasising the importance of integrating mentalization techniques into therapy to foster emotional stability. Techniques such as breathing exercises, grounding, and mindfulness were found to be particularly effective.

The group therapy setting itself was also reported as beneficial by normalising participants' experiences and creating a sense of belonging and validation. The role of facilitators was highlighted as crucial in creating a safe, non-judgmental space and building a therapeutic alliance based on empathy and trust. The study also identified challenges, particularly the lack of support in navigating complex interpersonal dynamics within the group settings. Participants expressed a need for more support in managing conflicts and ensuring emotional containment.

Overall, the present results provide a comprehensive understanding of how MBT-I can be optimised to meet the needs of BPD patients more effectively. By addressing both the beneficial aspects and the challenges identified, facilitators could refine their approaches to deliver more targeted and effective MBT-I interventions. The

clinical significance of the findings suggests that such adaptations of MBT-I could potentially lead to significant improvements in the symptoms and quality of life for individuals with BPD who receive the intervention, enhancing their emotional regulation, interpersonal relationships, and overall mental health.

4.7 Future suggestions

Participants highlighted the need for additional support, particularly in the context of complex group dynamics and emotional containment. A possible future improvement could include the incorporation of individual sessions alongside the psychoeducation groups from the initial stages of MBT-I. Although individual sessions are typically offered during the second phase of MBT, initiating them at the beginning of the psychoeducation phase could provide continuous support to patients as they adjust to group settings. This early intervention might enhance the overall experience, provide a space for containment, and reduce anxiety associated with group dynamics.

Given the high dropout rates in BPD, it seems important to reach out to individuals who discontinued the MBT-I sessions. Understanding the reasons for dropping out could offer valuable insights into potential barriers and areas needing improvement. Future research should prioritise capturing the perspectives of those who left the MBT-I, as their feedback could highlight unaddressed challenges and inform approaches for improvement. While beneficial changes were reported by

participants, the long-term sustainability of the tools and knowledge acquired during MBT-I remains an area necessitating further investigation.

4.8 Reflexivity

Considering wider contexts has been central to the collection, analysis, and interpretation of the data. Participants in this study receive support from the publicly funded National Health Service (NHS). A recent review highlighted that patients often feel their mental health problems are not prioritised in primary care and face difficulties in accessing mental health treatment. The interaction between patients and mental health professionals plays a pivotal role in accessing mental health services (Tunks et al., 2023). Considering such contexts is significant for research exploring the experiences of patients with BPD because the unique characteristics of the healthcare system in the UK, including potential difficulties in accessing mental health support, can impact the epistemic trust and outcomes of therapy. Additionally, the interpersonal functioning difficulties faced by individuals with BPD make such barriers particularly important to consider. Understanding these contextual factors is crucial for ensuring that the current findings are interpreted tentatively and remain relevant to the specific healthcare environment in which the therapy is being implemented.

As the primary researcher, my background in mental health and psychology might have inevitably influenced the interpretation of the findings, despite efforts to

approach the data without biases (Part III). I chose to undertake this research to provide a platform for the voices of individuals with BPD, particularly considering the societal stigma, their unmet needs, and the potentially unheard perspectives that may contribute to the high dropout rates observed in treatment. My aim was to better understand what these individuals perceive as helpful or unhelpful in their care, with the goal of contributing to the existing literature and promoting a more tailored, idiosyncratic approach to treatment. However, my desire to identify beneficial aspects of care may have introduced biases, rooted in the assumption that certain aspects of treatment are indeed helpful, and that research would discover them. This may have influenced my positioning during interviews, the framing of my questions, and, consequently, the responses of the participants. Reflexivity was crucial in acknowledging how my prior assumptions may have shaped both the research process and data collection. To mitigate this, I engaged in individual and supervisory reflexive practices (Binder et al., 2016; Braun & Clarke, 2021; Clarke & Braun, 2021) to remain attuned to the participants' experiences while reflecting on possible blind spots. This required a consistent focus on my own biases and positionality throughout the research process. I regularly engaged in individual reflexive practices, such as journaling and self-questioning, to critically reflect on my personal experiences and assumptions. I participated in supervisory reflexive discussions with my supervisor,

which provided a space to explore potential biases and challenge the interpretations mentioned above.

Additionally, in the initial stages of the project, existing literature on BPD informed my understanding of the disorder and led to an assumption that interactions with BPD individuals would generally reflect those findings. This influenced early data collection, where I was concerned about potentially distressing participants with my questions or making them feel rushed or unheard during interviews. However, my yearlong placement in a personality disorder service, along with guidance from experienced clinicians, provided new insights. By observing and interacting with BPD patients, I learned to acknowledge participants' experiences while moving forwards collaboratively in interviews. This balanced approach potentially ensured participants felt validated, while also allowing for efficient data collection, thus overcoming my initial concerns about causing distress.

4.9 Limitations

While this research incorporated a more diverse range of voices in terms of race and gender compared to previous studies, which predominantly included white females, it still featured a high proportion of white female participants, limiting the generalisability of the findings. Future research should strive to include more ethnically and gender-diverse samples to enhance the applicability and relevance of the results.

A key limitation of our study is the potential bias stemming from self-selection among participants who voluntarily agreed to take part. It is important to consider whether these participants accurately represent the overall sample, as this impacts the generalisability of our findings to the broader population.

Additionally, there may be potential bias in recruitment, as this study primarily involved individuals with BPD who have access to treatment. This study does not capture the experiences of those outside the NHS system, potentially excluding individuals who are isolated or have difficulties accessing therapy. The hierarchical power dynamics in the NHS patient-therapist system, combined with potential barriers in accessing therapy, may have influenced participants' responses during the interviews. Participants knew they would continue with MBT after completing the psychoeducation part. Despite assurances at the beginning of each interview that their responses would not affect their treatment in any way and that confidentiality was emphasised, this dynamic could still influence the responses of some participants. This is particularly relevant for individuals with BPD, who may exhibit heightened epistemic vigilance, reducing their trust.

While measures were implemented to mitigate these influences, such as emphasising confidentiality, the hierarchical nature of the healthcare system and the

unique trust difficulties associated with BPD may still have affected participants' responses. Reflecting on these dynamics is critical for understanding the nuanced ways in which the structure of the healthcare system and the characteristics of BPD can impact the research outcomes.

4.10 Suggested Adaptations to MBT-I

- Incorporation of individual sessions from the start of the MBT-I phase, rather waiting until the second phase, to provide continuous support and emotional containment.
- Increased facilitator support and check-ins during and after disagreements within group settings to help manage complex interpersonal dynamics.
- Active participation from facilitators in managing group interactions, particularly during challenging moments.
- Utilisation of practical techniques such as grounding exercises, body awareness, and breathing techniques to help participants manage anxiety and emotional responses.

5. Conclusions

This study provides valuable insights into the experiences of MBT-I psychoeducation groups for BPD patients, highlighting beneficial aspects, areas

requiring improvement, and potential changes through MBT-I. The group setting, facilitators, and the beneficial tools and knowledge contributed to self-understanding and emotional stabilisation. Notable improvements were observed in emotional regulation, interpersonal relationships, and reduced impulsivity, attributed to the application of mentalization techniques. Importantly, these findings indicate that MBT-I can enhance engagement and therapeutic outcomes for BPD patients. By improving mentalization skills, emotional regulation, and fostering interpersonal relationships, MBT-I shows promise in addressing part of the complex needs of individuals with BPD, thereby potentially improving their overall therapy experience and outcomes. Addressing participants' concerns regarding the lack of support and containment from facilitators could further enhance their experience and overall therapeutic outcomes.

6. References

Álvarez-Tomás, I., Soler, J., Schmidt, C., & Pascual, J. C. (2024). Physical health, primary care utilization and long-term quality of life in borderline personality disorder: A 10-year follow-up study in a Spanish sample. *Journal of Psychosomatic Research*, 111623.

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in clinical practice*. American Psychiatric Pub.

Arntz, A., Mensink, K., Cox, W. R., Verhoef, R. E., van Emmerik, A. A., Rameckers, S. A., ... & Grasman, R. P. (2023). Dropout from psychological treatment for borderline personality disorder: a multilevel survival meta-analysis. *Psychological Medicine*, *53*(3), 668-686.

Åstedt-Kurki, P., & Heikkinen, R. L. (1994). Two approaches to the study of experiences of health and old age: the thematic interview and the narrative method. Journal of advanced nursing, 20(3), 418-421.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, 5th edn. American Psychiatric Press: Washington, DC.

Barriball, K. L., & While, A. (1994). Collecting data using a semi-structured interview: a discussion paper. Journal of Advanced Nursing-Institutional Subscription, 19(2), 328-335.

Bateman, A., & Fonagy, P. (2006). Mentalizing and borderline personality disorder. *Handbook of mentalization-based treatment*, 183-200.

Bateman, A. W., & Fonagy, P. (Eds.). (2019). *Handbook of mentalizing in mental health practice*. American Psychiatric Pub.

Bateman, A., & Fonagy, P. (Eds.). (2012). Handbook of mentalizing in mental health practice. American Psychiatric Publishing.

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World psychiatry*, *9*(1), 11.

Bateman, A., Fonagy, P. & Allen, J. (2009). Theory and Practice of Mentalization-Based Therapy. In Gabbard, Glen (ED) Textbook of psychotherapies treatments (pp.757-780). American Psychiatric publishing Inc:Arlington, VA.

Bateman, A., Campbell, C., Luyten, P., & Fonagy, P. (2018). A mentalization-based approach to common factors in the treatment of borderline personality disorder. Current opinion in psychology, 21, 44-49.

Bender, D. S., Dolan, R. T., Skodol, A. E., Sanislow, C. A., Dyck, I. R., McGlashan, T. H., ... & Gunderson, J. G. (2001). Treatment utilization by patients with personality disorders. *American Journal of psychiatry*, *158*(2), 295-302.

Binder, P. E., Holgersen, H., & Moltu, C. (2012). Staying close and reflexive: An explorative and reflexive approach to qualitative research on psychotherapy. *Nordic Psychology*, *64*(2), 103-117.

Binder, P. E., Schanche, E., Holgersen, H., Nielsen, G. H., Hjeltnes, A., Stige, S. H., ... & Moltu, C. (2016). Why do we need qualitative research on psychological treatments? The case for discovery, reflexivity, critique, receptivity, and evocation. *Scandinavian Psychologist*, *3*.

Bo, S., Sharp, C., Beck, E., Pedersen, J., Gondan, M., & Simonsen, E. (2017). First empirical evaluation of outcomes for mentalization-based group therapy for adolescents with BPD. *Personality Disorders: Theory, Research, and Treatment*, *8*(4), 396.

Bradley-Scott, C. C. (2017). *Exploring mentalization-based psychoeducation groups for people with borderline personality disorder*. Canterbury Christ Church University (United Kingdom).

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis?. *Qualitative research in psychology*, *18*(3), 328-352.

Braun, V., & Clarke, V. (2022). Thematic analysis: a practical guide.

Busmann, M., Wrege, J., Meyer, A. H., Ritzler, F., Schmidlin, M., Lang, U. E., ... & Euler, S. (2019). Alternative Model of Personality Disorders (DSM-5) predicts dropout in inpatient psychotherapy for patients with personality disorder. *Frontiers in psychology*, *10*, 952.

Byrne, D. (2022). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & quantity*, *56*(3), 1391-1412.

Campbell, C., Tanzer, M., Saunders, R., Booker, T., Allison, E., Li, E., ... & Fonagy, P. (2021). Development and validation of a self-report measure of epistemic trust. *PloS one*, *16*(4), e0250264.

Cridland, E. K., Jones, S. C., Caputi, P., & Magee, C. A. (2015). Qualitative research with families living with autism spectrum disorder: Recommendations for conducting semistructured interviews. Journal of Intellectual and Developmental Disability, 40(1), 78-91.

de Freixo Ferreira, L., Guerra, C., & Vieira-Coelho, M. A. (2023). Predictors of psychotherapy dropout in patients with borderline personality disorder: A systematic review. *Clinical Psychology & Psychotherapy*, *30*(6), 1324-1337.

Ditlefsen, I. T., Nissen-Lie, H. A., Andenæs, A., Normann-Eide, E., Johansen, M. S., & Kvarstein, E. H. (2021). “Yes, there is actually hope!”—A qualitative investigation of how patients experience mentalization-based psychoeducation tailored for borderline personality disorder. *Journal of Psychotherapy Integration*, *31*(3), 257.

Donald, F., Lawrence, K. A., Broadbear, J. H., & Rao, S. (2019). An exploration of self-compassion and self-criticism in the context of personal recovery from borderline personality disorder. Australasian Psychiatry, 27(1), 56-59.

Euler, S., Nolte, T., Constantinou, M., Griem, J., Montague, P. R., Fonagy, P., & Personality and Mood Disorders Research Network. (2021). Interpersonal problems in borderline personality disorder: associations with mentalizing, emotion regulation, and impulsiveness. *Journal of Personality Disorders*, *35*(2), 177-193.

Finlay, L., & Gough, B. (Eds.). (2008). *Reflexivity: A practical guide for researchers in health and social sciences*. John Wiley & Sons.

Fisher, S., Zilcha-Mano, S., & Fonagy, P. (2022). Conceptualizing epistemic trust in psychotherapy: A triadic model. *Psychotherapy Bulletin*, *57*(2), 29-35.

Fonagy, P., & Allison, E. (2023). Beyond mentalizing: Epistemic trust and the transmission of culture. *The Psychoanalytic Quarterly*, *92*(4), 599-640.

Fonagy, P., & Bateman, A. W. (2007). Mentalizing and borderline personality disorder. Journal of Mental Health, 16(1), 83-101.

Fonagy, P., Campbell, C., Constantinou, M., Higgitt, A., Allison, E., & Luyten, P. (2022). Culture and psychopathology: An attempt at reconsidering the role of social learning. *Development and Psychopathology*, *34*(4), 1205-1220.

Fonagy, P., Gergely, G., & Jurist, E. L. (2018). *Affect regulation, mentalization and the development of the self*. Routledge.

Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and psychopathology*, *21*(4), 1355-1381.

Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of personality disorders*, *29*(5), 575-609.

Fonagy, P., Target, M., & Bateman, A. (2018). The mentalization based approach to psychotherapy for borderline personality disorder. In *The psychoanalytic therapy of severe disturbance* (pp. 35-80). Routledge.

Friesen, N., Henriksson, C., & Saevi, T. (2012). Hermeneutic phenomenology in education. Method and practice. Rotterdam: Sense Publishers.

Griffiths, H., Duffy, F., Duffy, L., Brown, S., Hockaday, H., Eliasson, E., ... & Schwannauer, M. (2019). Efficacy of Mentalization-based group therapy for adolescents: the results of a pilot randomised controlled trial. *BMC psychiatry*, *19*, 1-13.

Gunderson, J. G. (2009). Borderline personality disorder: ontogeny of a diagnosis. *American Journal of Psychiatry*, *166*(5), 530-539.

Hauber, K., Boon, A. E., & Vermeiren, R. (2019). Therapeutic factors that promote recovery in high-risk adolescents intensive group psychotherapeutic MBT programme. *Child and adolescent psychiatry and mental health*, *13*, 1-10.

Heerebrand, S. L., Bray, J., Ulbrich, C., Roberts, R. M., & Edwards, S. (2021). Effectiveness of dialectical behavior therapy skills training group for adults with borderline personality disorder. *Journal of clinical psychology*, *77*(7), 1573-1590.

Jackson, K., Bazeley, P., & Bazeley, P. (2019). *Qualitative data analysis with NVivo*. Sage.

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. Journal of advanced nursing, 72(12), 2954-2965.

Karterud, S., & Bateman, A. (2011). *Manual for mentaliseringsbasert psykoedukativ gruppeterapi (MBT-I)*. Gyldendal akademisk.

Knapen, S., Hutsebaut, J., van Diemen, R., & Beekman, A. (2020). Epistemic trust as a psycho-marker for outcome in psychosocial interventions. *Journal of Infant, Child, and Adolescent Psychotherapy*, *19*(4), 417-426.

Kvarstein, E. H., Pedersen, G., Urnes, Ø., Hummelen, B., Wilberg, T., & Karterud, S. (2015). Changing from a traditional psychodynamic treatment programme to

mentalization-based treatment for patients with borderline personality disorder–Does it make a difference?. *Psychology and Psychotherapy: Theory, Research and Practice*, *88*(1), 71-86.

Lazarus, S. A., Cheavens, J. S., Festa, F., & Rosenthal, M. Z. (2014). Interpersonal functioning in borderline personality disorder: A systematic review of behavioral and laboratory-based assessments. *Clinical psychology review*, *34*(3), 193-205.

Leichsenring, F., Fonagy, P., Heim, N., Kernberg, O. F., Leweke, F., Luyten, P., ... & Steinert, C. (2024). Borderline personality disorder: a comprehensive review of diagnosis and clinical presentation, etiology, treatment, and current controversies. *World Psychiatry*, *23*(1), 4-25.

Leichsenring, F., Heim, N., Leweke, F., Spitzer, C., Steinert, C., & Kernberg, O. F. (2023). Borderline personality disorder: a review. *JAMA*, *329*(8), 670-679.

Li, E., Campbell, C., Midgley, N., & Luyten, P. (2023). Epistemic trust: a comprehensive review of empirical insights and implications for developmental psychopathology. *Research in Psychotherapy: Psychopathology, Process, and Outcome*, *26*(3).

Lis, S., & Bohus, M. (2013). Social interaction in borderline personality disorder. *Current psychiatry reports*, *15*, 1-7.

Liebke, L., Bungert, M., Thome, J., Hauschild, S., Gescher, D. M., Schmahl, C., ... & Lis, S. (2017). Loneliness, social networks, and social functioning in borderline

personality disorder. *Personality Disorders: Theory, Research, and Treatment*, *8*(4), 349.

Luyten, P., Campbell, C., & Fonagy, P. (2020). Borderline personality disorder, complex trauma, and problems with self and identity: A social-communicative approach. *Journal of personality*, *88*(1), 88-105.

Luyten, P., & Fonagy, P. (2019). Mentalizing and trauma. *Handbook of mentalizing in mental health practice*, *2*, 79-99.

Mascaro, O., & Sperber, D. (2009). The moral, epistemic, and mindreading components of children's vigilance towards deception. *Cognition*, *112*(3), 367-380.

Morken, K. T., Binder, P. E., Arefjord, N., & Karterud, S. (2019). Juggling thoughts and feelings: How do female patients with borderline symptomology and substance use disorder experience change in mentalization-based treatment?. *Psychotherapy research*, *29*(2), 251-266.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. Journal of counseling psychology, 52(2), 250.

Nolte, T., Hutsebaut, J., Sharp, C., Campbell, C., Fonagy, P., & Bateman, A. (2023). The role of epistemic trust in mentalization-based treatment of borderline psychopathology. *Journal of Personality Disorders*, *37*(5), 633-659.

Paris, J. (2009). The treatment of borderline personality disorder: implications of research on diagnosis, etiology, and outcome. *Annual Review of Clinical Psychology*, *5*, 277-290.

Rabionet, S. E. (2011). How I learned to design and conduct semi-structured interviews: an ongoing and continuous journey. Qualitative report, 16(2), 563-566.

Storebø, O. J., Stoffers-Winterling, J. M., Völlm, B. A., Kongerslev, M. T., Mattivi, J. T., Jørgensen, M. S., Faltinsen, M. S., , E., Todorovac, A., Sales, C.P., Callesen, H.E., Lieb, K & Simonsen, E. (2020). Psychological therapies for people with borderline personality disorder. *The Cochrane database of systematic reviews*, *2020*(5).

Tan, Y. M., Lee, C. W., Averbeck, L. E., Brand-de Wilde, O., Farrell, J., Fassbinder, E., ... & Arntz, A. (2018). Schema therapy for borderline personality disorder: A qualitative study of patients' perceptions. *PloS one*, *13*(11), e0206039.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International journal for quality in health care*, *19*(6), 349-357.

Tunks, A., Berry, C., Strauss, C., Nyikavaranda, P., & Ford, E. (2023). Patients' perspectives of barriers and facilitators to accessing support through primary

care for common mental health problems in England: A systematic review. *Journal of Affective Disorders*.

Turner III, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. The qualitative report, 15(3), 754.

Van Manen, M. (2016). *Researching lived experience: Human science for an action sensitive pedagogy*. Routledge.

Vogt, K. S., & Norman, P. (2019). Is mentalization-based therapy effective in treating the symptoms of borderline personality disorder? A systematic review. *Psychology and Psychotherapy: Theory, Research and Practice*, *92*(4), 441-464.

Volkert, J., Hauschild, S., & Taubner, S. (2019). Mentalization-based treatment for personality disorders: efficacy, effectiveness, and new developments. *Current Psychiatry Reports*, *21*, 1-12.

Warren, R. (2015). Emotion regulation in borderline personality disorder: The role of self-criticism, shame, and self-compassion.

Winsper, C., Bilgin, A., Thompson, A., Marwaha, S., Chanen, A. M., Singh, S. P., Wang, A., & Furtado, V. (2020). The prevalence of personality disorders in the community: a global systematic review and meta-analysis. *The British Journal of Psychiatry*, *216*(2), 69-78.

Part III: Critical appraisal

This critical appraisal encompasses reflections on the process of conducting the research outlined in Part II. In qualitative research, it is crucial to consider the researcher's impact and influence during all stages of the project. Braun & Clarke, (2022) emphasise the significant role of the researcher, highlighting the importance of utilising their subjectivity and reflexive engagement as a tool for the analysis. Additionally, the interaction and relationship between participants and the researcher significantly shape the data. Finley (2002) illustrates this dynamic succinctly: "a different relationship will unfold a different story". This underscores the necessity of acknowledging and navigating the interpersonal nuances that impact the research process.

This appraisal considers two types of reflexivity. Personal reflexivity involves reflections on how my own beliefs, values, and experiences and position have influences the research and how the research has impacted me as the researcher. Epistemological reflexivity, on the other hand, involves a critical consideration of how the methods and research questions have impacted the research and my interpretation of the data (Willig, 2013).

Initially, I will utilise personal reflexivity to reflect on my role and impact in the research process and how the research has affected me as a trainee clinical psychologist, researcher, and individual. Secondly, I will engage in epistemological reflexivity to reflect on how the interview process may have influenced the findings.

Finally, I will provide reflections on the nature of borderline personality disorder (BPD) and the diagnostic system.

1. Personal Reflexivity

Engaging in reflexivity provides an opportunity for the “bracketing” of our personal perspective (Fisher, 2009), identifying and placing them aside to be able to remain curious and open to possibilities of the data being different to our own expectations. However, it can be impossible to fully bracket our beliefs. Therefore, Finley (2008), proposes an approach compared to a “dance”, where the researcher navigates the tension between their beliefs and bracketing, using this dynamic as a valuable source of insight.

In light of this, it is important to consider aspects of my personal position and identities that might have influenced the research process. Thus, I will consider and reflect on my impact 1) as a female researcher 2) as an insider-outsider and power dynamics; 3) as a trainee clinical psychologist. Thereafter, I will engage in reflections on the impact of this research on myself, and how this might have impacted the participants.

Reflecting on my experience as a female researcher, an insider-outsider, and a trainee clinical psychologist, I found that my identity significantly influenced the research process and the interactions with participants. In particular, being female appeared to play a crucial role in building rapport and ensuring participants felt safe to share their experiences. Some female participants expressed that they would have felt uncomfortable with a male clinician withing the MBT-I groups, highlighting the importance of gender dynamics in research and clinical settings. This was especially relevant in my role as a trainee clinical psychologist, where power dynamics and alliance needed careful consideration.

During the interviews, the logistical aspects such as timings and flexibility presented both challenges and opportunities. I often found myself chasing participants, explaining the study in detail, and accommodating their schedules, sometimes waiting for half an hour on the Teams link only to reschedule later. This flexibility, while demanding, seemed to foster a sense of compassion and understanding, which was instrumental in collecting data from all participants. Reflecting on this process, it was important to balance this flexibility with the need to collect data efficiently, ensuring that the research remained on track.

Prior to the main phase of data collection, I interviewed all participants before they started the group, which helped to establish initial rapport. Although I did not use this preliminary data due to time constraints and the scope of my thesis, this early interaction was beneficial. It allowed me to build rapport and emphasise the importance of their voices and experiences in the study, encouraging their continued participation. Being aware of the power I held as a researcher, and how this could influence or add pressure to participants engagement, I took steps to confirm with them their inclination to proceed with the second phase of the project. To respect their voices and comfort, I ensured that I create space for them to express any disinterest or hesitation regarding further participation.

Reflecting on the power dynamics inherent in the research process, my position as a researcher along with my research context within a powerful institution, created an inevitable power imbalance with the participants, who were positioned as patients. This dynamic influenced various aspects of the research. As a representative of a valued academic institution, my role carried an implicit authority which could have impacted how participants engaged with the study. They might have felt a sense of obligation to participate or to respond in ways they perceived as favourable or expected. This power differential required careful navigation to ensure that participants felt genuinely heard and respected, rather than pressured or

patronised. I strived to remain aware of this and manage potential imbalance by adopting a compassionate and flexible approach, fostering an environment where participants could share their experiences openly and without fear of judgment. This sensitivity to power dynamics was crucial in ensuring that the research process was ethically thorough, and that the data collected truly reflected the participants' authentic voices and experiences.

Interview process

I initially approached the interviews with a strong therapeutic mindset, “wearing” the psychology hat. My first participants had reported feeling unheard in previous settings, which made me particularly cautious not to replicate this experience. I was deeply committed to providing participants with space where they could express themselves. This approach, however, led to longer interviews as I summarised and reflected back their thoughts to ensure they felt understood. Additionally, some participants mentioned that facilitators in their therapy sessions occasionally misinterpreted their words, which made me mindful of checking and confirming their meanings. Through the process, I realised that it was essential to balance thoroughness with efficiency, particularly given the limited time for analysis and transcription. Consequently, I started focusing towards conducting more succinct interviews, where the emphasis was on gathering relevant data.

Reflecting on my confidence in conducting concise interviews, my yearlong placement working with individuals diagnosed with BPD has been very helpful in challenging my own biases. For instance, during my first interviews my lack of experience with BPD patients made me hesitant to guide participants back to the research questions, fearing that interruptions might upset or invalidate them. However, I learned that explaining the necessity of occasional interruptions to participants may be sufficient to feel heard. Furthermore, at the end of each interview, I asked if there was anything I had missed or if participant had additional insights to share. I believe that this approach not only made the interview process more efficient, but also considered the importance of validating participants "experiences".

Analysis of Data

A critical element in conducting reflexive thematic analysis involves identifying and acknowledging my personal context and epistemological stance (Braun & Clarke, 2022). I approached the research process through a critical realist stance. As proposed by Willig (1999), critical realism suggests that human knowledge can only capture a limited part of the greater reality. It proposes that we can attempt to understand the real social world through this knowledge, however it can be further or closer to reality. This approach seemed to fit the purpose of my research, enabling

the conceptualisation of patterns across participants' individual accounts and their common experiences. The approach of the research questions involved semantic and inductive perspective enabling the exploration of patients experiences within the MBT-I while maintaining the connection to their meanings and reality. My position moved along the semantic-latent and inductive-deductive approach during the research process.

2. Epistemological Reflexivity

Epistemological reflexivity invites the researcher to reflect on their assumptions during the research process and the impact this might have on their understating and interpretation of the data (Willig, 2013). My reflections are related to the process of interviewing participants.

Assumptions

From the initial stages of this project, existing literature significantly informed my understanding of BPD. According to the DSM-5, BPD is characterised by intense emotions, impulsivity, poor self-image, and unstable interpersonal relationships (APA, 2013). Individuals with BPD may go to considerable lengths to prevent abandonment, express disproportionate anger, experience persistent feelings of emptiness, and engage in repeated self-harm or suicide attempts (Leichsenring et al., 2024).

Based on this information, I initially assumed that these findings broadly represented any interactions with individuals diagnosed with BPD. This assumption influenced the early stages of data collection, which I approached with apprehension. I was concerned about causing distress to participants by moving from one question to another, particularly when they would refer to difficult experience. My assumption was that the interview might feel rushed, and participants might feel invalidated, unheard, or upset.

However, my placement in a personality disorder service provided me with valuable opportunities to observe experienced clinicians and contribute to BPD assessment. Learning from my interactions with BPD patients in the service and utilising supervision to reflect on my assumptions helped me refine my approach. I learned that acknowledging participants' experiences while mutually agreeing to proceed with subsequent interview questions for the sake of time was an effective approach to move forward in a collaborative manner. This balanced approach allowed for a validating and efficient interview process ensuring comprehensive data collection, while challenging my initial concerns and assumptions about participants' distress.

3. Future Directions

Reflecting on this process, it is evident that bridging the critical research gap by equally incorporating lived experiences alongside research expertise is essential

for addressing the needs of the populations we aim to serve and improving treatment outcomes. Based on this reflection, a significant change in my study would involve more comprehensive inclusion of participants at all stages of the research process. While I attempted this by piloting the first two interviews and collecting feedback from participants on potential addictions or overlooked aspect, further steps would be beneficial. For instance, involving participants in the initial design of the interview questions would enhance the relevance and depth of my study.

Additionally, at the end of each interview, I asked participants if there was anything they felt was missing or if they had additional insights. Moving forward, an important next step would be to share the study's finding with the participants and invite them to review and comment in the results. This iterative feedback process would ensure that the research remains relevant and truly reflective of the participants' experiences.

4. Broader reflections on BPD

BPD is a diagnosis that has been described as stigmatising and problematic within the traditional diagnostic system. This diagnosis often brings significant biases, leading to detrimental impact on those labelled with BPD, which may prompt service users to push back against the diagnostic label. People with BPD report significant problems accessing consistent and effective care and feeling

misunderstood by professionals with the healthcare (Lawn & McMahon, 2015). This may be linked to clinicians stigmatising biases and attitudes, which can affect their perceptions and interaction with individuals diagnosed with BPD.

The functional psychiatric diagnostic framework claims to identify patterns of distress and impairment in functioning (Garland & Miller, 2020). However, this model often neglects the nuanced personal stories behind these patterns failing to support individuals in sharing their experiences. Furthermore, this diagnostic approach demonstrates limitations in its consideration of cultural context, which can be particularly problematic in diverse settings, such as the NHS in London. Although the DSM-V has made considerable attempts to incorporate cultural concepts, such as Cultural Formulation Interview (Aggarwal & Lewis-Fernández, 2015; Jarvis et al., 2020), and specific guidelines for integrating cultural considerations into diagnosis (APA, 2013; Devgun, 2023), these efforts can be insufficient in fully addressing the nuances of cultural diversity. Similarly, the ICD-11 Personality Disorder model acknowledges the important role of cultural factors in the development of personality disorders, which is useful in some contexts; however, it does not fully account for the cultural factors present in ethnically diverse countries such as Peru (Hualparuca-Olivera, 2022).

The DSM and ICD provide a framework for diagnosis that is internationally recognised, however it often lacks sensitivity to cultural variability in the manifestation and interpretation of psychiatric symptoms. This can lead to clinical practices that unintentionally perpetuate cultural biases, thereby compromising the treatment within diverse patient population. These implications underscore the necessity for more culturally attuned approach that incorporate individual and cultural differences and their personal story, ultimately enhancing the quality of care.

The Power Threat Framework (PTMF), by Johnstone & Boyle (2018), provides an alternative nondiagnostic conceptual system that seeks to understand and address the symptoms through a conceptual system integrating biological, psychological, and social factors. PTFM focuses on understanding what has happened to the individual, exploring how power operates in their life, acknowledging how this can lead to distress. This framework shifts the focus from labelling a diagnosis like BPD, which can be disempowering and may impose ideological power creating additional threats to the individual's body, sense of security, work, social life. Instead, PTFM focuses on how individuals with BPD interpret their experiences and the meanings they assign to their story, incorporating experiences and feelings influenced by social norms and stigma. This framework includes approaching

psychiatric symptoms as understandable responses to adverse environment, also perceived as coping mechanisms and valid reactions to threats.

Upon reflecting on my positioning and experiences within my current placement at a personality disorder service, I have noticed that the conventional diagnostic framework may often fail to account for cultural considerations. In contrast, the PTMF can empower individuals to share their stories potentially in a less stigmatising and pathologizing manner. This reflection has led me to consider how the PTMF principles, with its focus on social justice and power, can provide a more holistic perspective that respects cultural context and embraces individual differences.

Reframing the “symptoms” as threat responses can provide an empowering and compassionate alternative to the stigmatising diagnostic labels of the traditional psychiatric approach. This perspective acknowledges the individual’s strengths and adaptive coping mechanisms, shifting the focus from pathologizing what is perceived as “wrong” with the individual to empowering and understanding their lived experiences and the meanings they assign to them. By prioritising the individual’s socio-cultural context and their personal narrative, this approach can foster a more inclusive and compassionate approach of mental health care.

5. References

Aggarwal, N. K., & Lewis-Fernández, R. (2015). An introduction to the cultural formulation interview. *Focus*, *13*(4), 426-431.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, 5th edn. American Psychiatric Press: Washington, DC.

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis?. *Qualitative research in psychology*, *18*(3), 328-352.

Braun, V., & Clarke, V. (2022). Thematic analysis: a practical guide.

Devgun, A. (2023). Cultural Competence in Mental Health Diagnosis: The DSM and its Global Applicability. *Available at SSRN 4575474*.

Finlay, L. (2002). “Outing” the researcher: The provenance, process, and practice of reflexivity. Qualitative health research, 12(4), 531-545.

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the" phenomenological psychological attitude". Journal of phenomenological psychology, 39(1), 1-32.

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. Psychotherapy Research, 19(4-5), 583-590.

Garland, J., & Miller, S. (2020). Borderline personality disorder: part 1–assessment and diagnosis. BJPsych Advances, 26(3), 159-172.

Hualparuca-Olivera, L. (2022). Cultural lenses of the utility of the ICD-11-PD model: integrating the Peruvian context. *Frontiers in Psychiatry*, *13*, 1016471.

Jarvis, G. E., Kirmayer, L. J., Gómez-Carrillo, A., Aggarwal, N. K., & Lewis-Fernández, R. (2020). Update on the cultural formulation interview. *Focus*, *18*(1), 40-46.

Johnstone, L., & Boyle, M. (2018). The power threat meaning framework: An alternative nondiagnostic conceptual system. *Journal of Humanistic Psychology*, 0022167818793289.

Lawn, S., & McMahon, J. (2015). Experiences of care by A ustralians with a diagnosis of borderline personality disorder. Journal of Psychiatric and Mental Health Nursing, 22(7), 510-521.

Leichsenring, F., Fonagy, P., Heim, N., Kernberg, O. F., Leweke, F., Luyten, P., ... & Steinert, C. (2024). Borderline personality disorder: a comprehensive review of diagnosis and clinical presentation, etiology, treatment, and current controversies. *World Psychiatry*, *23*(1), 4-25.

Willig, C. (1999) 'Beyond appearances: A critical realist approach to social constructionist work', in Nightingale, D.and Cromby, J. (eds.), Social Constructionist Psychology, Buckingham, Open University Pres

Willig, C. (2013). *EBOOK: introducing qualitative research in psychology*. McGraw-hill education (UK).

7. Appendices

Appendix A: Outline of joint study

The data collection was conducted jointly. Subsequently, we each independently pursued on our own questions, analyses and write-ups.

My contribution focused on qualitatively exploring the experiences of patients in MBT-I groups. The other two projects, titled “Development and validation of a self-reported measure of learning following psychoeducation in Mentalization Based Therapy (MBT)”, conducted by Jane Teo and “The role of initial levels of epistemic trust in Mentalization-Based Psychoeducational groups for borderline personality disorder”, conducted by Sabrina Monteregge, utilised quantitative methods.

I conducted the interviews and the analysis independently.

Appendix B: Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Wales Research Ethics Committee 3
Cardiff

Mailing address:
Health and Care Research Wales
Castlebridge 4
15-19 Cowbridge Road East
Cardiff, CF11 9AB

Email: Wales.REC3@wales.nhs.uk
Website: www.hra.nhs.uk

15 March 2023

Professor Peter Fonagy
HoD, Department of Clinical,
Educational and Health Psychology
UCL
Gower Street
London
WC1N 3BG

Dear Professor Fonagy

Study title:	**Probing Social Exchanges – A Computational Neuroscience Approach to the Understanding of Borderline and Anti-Social Personality Disorder**
REC reference:	**12/WA/0283**
Amendment number:	**Substantial Amendment 14**
Amendment date:	**27 January 2023**
IRAS project ID:	**103075**

The above amendment was reviewed at the meeting of the Sub-Committee held on 13 March 2023 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Completed Amendment Tool [Substantial Amendment 14_authorized amendment tool]	1	27 January 2023
GP/consultant information sheets or letters [Clinician information sheet, remote study (clean)]	3.1	27 January 2023
GP/consultant information sheets or letters [Clinician information sheet, remote study (tracked changes)]	3.1	27 January 2023

GP/consultant information sheets or letters [Clinician information sheet, remote study, MBTi stream (tracked changes)]	3.2	27 January 2023
GP/consultant information sheets or letters [Clinician information sheet, remote study, MBTi stream (clean)]	3.2	27 January 2023
Letter from sponsor [Sponsorship approval]	1	01 March 2023
Participant consent form [Participant consent form, remote study (clean)]	1.5.1	27 March 2023
Participant consent form [Participant consent form, remote study (tracked changes)]	1.5.1	27 March 2023
Participant consent form [Participant consent form, remote study, MBTi stream (clean)]	1.5.2	27 January 2023
Participant consent form [Participant consent form, remote study, MBTi stream (tracked changes)]	1.5.2	27 January 2023
Participant information sheet (PIS) [Participant information sheet, remote study (clean)]	1.8.1	27 January 2023
Participant information sheet (PIS) [Participant information sheet, remote study (tracked changes)]	1.8.1	27 January 2023
Participant information sheet (PIS) [Participant information sheet, remote study, MBTi stream (clean)]	1.8.2	27 January 2023
Participant information sheet (PIS) [Participant information sheet, remote study, MBTi stream (tracked changes)]	1.8.2	27 January 2023
Research protocol or project proposal [Research protocol (clean)]	1.11.1	27 January 2023
Research protocol or project proposal [Research protocol (tracked changes)]	1.11.1	27 January 2023

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

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.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS Project ID - 103075:	Please quote this number on all correspondence

Yours sincerely

[redacted]

PP Miss Joanne Love
Dr Kath Clarke
Chair

E-mail: Wales.REC3@wales.nhs.uk

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Dr David Wilson*
Julia Griem

Appendix C: MBT-I outline

Principles

Aims

1. Open epistemic trust by providing information and experience.
2. Create a framework through which the patient begins to reflect on themselves using a new perspective.
3. Stimulate a subjective experience that this treatment has something for me as an individual, is for me, and about me.
4. Inform the joint formulation and prepare for next phase of treatment.

Format

The programme may be delivered over 8-12 sessions depending on service requirements. For the research project, we are aiming for ten sessions

1. Review of Homework and previous session
2. Information/Psychoeducation/Leaflets of Topic
3. Exercises illustrating topic
4. Personalisation - Examples from group from their own experience
5. Link to patient problems

6. Summary and Homework

Didactics

Slides, role plays (between clinicians and between patients), exercises, working in pairs, videos e.g. Guardian ad, leaflets, expert by experience input if possible.

Homework (plus reporting back at beginning of next): “Have a think over the week and see what you observe in relation to the topic” – give homework individually to each patient as this is more likely to make them feel it is worth doing as it is for them e.g. ‘Sarah you mentioned your family don’t mentalize much. Perhaps see if you can notice a moment when they actually do and write it down’; ‘John you said that your boss never takes you into account or thinks about how you are – can you see if you notice a time when he does listen to you or takes into account how you feel’.

Content

Session 1 Mentalizing

Mentalizing, Poles/Dimensions, social mentalizing modes etc., misunderstandings, not knowing stance

Session 2 Ineffective mentalizing

What does ineffective MZ look like - pre-mentalizing modes, hypermentalizing. Use every day examples and process in the group of mentalizing, get people to

personalize (this is me when I'm in one of these modes), what are the consequences of low MZ, emotional arousal on mentalizing,

Session 3 Emotions

What are the basic emotions (life requirements "to survive"), get patients to consider those in themselves, examples, chart to be shown, degrees of emotional intensities, social emotions (required for creating social cohesion/cultural agreement: jealousy, shame etc., positive and negative ones).

Session 4 Regulating emotions

Registering and regulating emotions, some info on mindfulness (e.g. headspace clips), body as source of experiencing a feeling (perhaps use outline of body to map emotions and where they are 'located'); emotions becoming too intense or too suppressed (patients who avoid).

Session 5 (for research study move to 7th and 8th session) Attachment

Attachment definitions and strategies.

Use questionnaires for people to find themselves, centralized vs diffused relationships, attachment and therapy, still face paradigm, group activity. Try to help

each patient identify the common attachment strategies that are activated in their relationships

Session 6 Attachment continued

Session 7 - BPD

What's PD/EUPD/BPD? Take a dimensional approach using mentalizing as the primary dimension. Chart the Symptoms, Interpersonal problems, Emotional roller coaster, Impulsivity to vulnerabilities in MZ. Diagnosis as something that can change, PDs can be treated

Some services discuss the categorical diagnosis – BPD/ASPD/NPD. Provide web links that give accurate and compassionate information.

Session 8 and 9 (maybe include expert by experience here if possible)

MBT, what it's like doing MBT programme, going into a group, problems with treatment etc.

Session 10 Varied content depending on patient population - Summary session and/or:

Anxiety and depression and/or trauma and self-harm

Discussion of attachment trauma may be triggering and has to be done carefully – consider introducing it generally e.g. in terms of past experience still being felt in present life in all sorts of ways; link to avoidance and emotional turmoil; dissociation in minor and major forms may need emphasis and discussion on how to manage it; return to earlier discussions about body and difficulties in representing bodily experience; self harm and how to manage it.

Appendix D: Participant Information Sheet

Personality Disorders – a Computational

Psychiatry Approach

Understanding the Social Brain in Healthy Volunteers and People with Psychological Difficulties- Reduced Online Study, MBT-I stream

This study has been approved by the Research Ethics Committee for Wales (Project ID Number): 12/WA/0283.

We would like to invite you to participate in this research project.

You are being invited to take part in a research study. You should only participate if you want to. Before you decide whether to take part, this sheet will give you some more information about why the study is being carried out, what you would be asked to do if you decide to take part, and how the study will be conducted. Please take some time to read this sheet, and to discuss it with other people if you wish. You are also very welcome to ask any further questions about the study, or if you find anything on this sheet unclear.

Why is this study being done?

With the proposed project we plan to investigate the social brain and social behaviour of people suffering from personality disorders or similar traits and compare them with

healthy control participants. Only little is known about the neurobiology and cognition of Borderline and Antisocial Personality Disorders and how patients experience themselves in their social world and groups (including therapy groups). Our study design will address some of these. This will hopefully allow us to gain a better understanding of the disorders and to develop more informed and effective treatments from which clients will benefit.

Why have you been invited to take part?

You have been invited to take part in the study because you have recently been assessed by a clinician at one of the clinical or probation services currently collaborating with the research team.

Do I have to take part?

No. Taking part in the study is entirely voluntary. It is your choice whether or not you would like to participate. Deciding not to take part in the study will not affect the care you receive from services either now or in the future. If you do decide to participate, you will be given this information sheet to keep, and you will later be asked to fill in an online consent form stating that you wish to take part. If you do give consent to take part in the study, you are still free to leave the study at any point, without giving a reason. This will not affect the care you are currently receiving, or will receive in the

future. If you leave, any information that we have already collected from you will be destroyed.

What will happen if I decide to take part?

This study is currently an online study, meaning you do not have to travel anywhere if you don't want to and can complete all tasks from home. However, if you prefer, and as long as the guidelines permit, we can arrange for you to visit our research centre and complete the study in person. If you wish to take part in the study, then you can get in touch with the research team or provide your contact details so that we can arrange a time to discuss the study in more detail. If you agree to participate in this study, you will be asked to complete the following components:

Study Overview:

- An online consent form. If you agree to participate, the first step will be to log into your POD account and complete a consent form that states you have understood all the information about the study, have had a chance to ask questions and are happy to participate. The researcher will send you your unique, anonymized POD login details. If you decide to attend the study in person, you will complete this consent form on paper and we will ask you to provide signed consent if you are happy to participate.

- Self-report questionnaires asking about personality/character traits, childhood and upbringing experiences, other life experiences, your general mental and physical health, as well as your experience of the psychoeducational MBT-I group offered by your service (in case this is part of your treatment)
    - A description of each questionnaire can be found at the end of this information sheet. If you are interested, you can have a look through this to decide if you are happy with these questionnaires or if you have any questions you would like to ask the research team. In case there are questionnaires you would prefer not to answer, that is okay. You can still participate and let the researcher know which questionnaire you would like to skip.
    - These questionnaires will be made available to you on POD. The researcher will control the number of questionnaires that are available to you so that you do not become overwhelmed. Once you complete the first part of the questionnaires, the researcher will make the next part available.
    - Altogether, the questionnaires should take about 2-3 hours. You do not have to complete them all at once, you can split this up in any way that is convenient for you. All questionnaires should be completed within 2

weeks of starting the study (and a few will be done during and after the MBT-I group is completed).

- The Trust game, the Dancing game, the Two or Multiple Partners Social Exchange game, and the Intentions task
    - You will play these four online games on a computer or laptop. If this is not available to you, please let the researcher know.
    - For all games, the instructions will be sent to you by the researcher and you will have an opportunity to discuss these. It is important that you understand the instructions.
    - For all games, you will be responding to written cues on the screen using a keyboard and a mouse. You will be playing with virtual partners. The games are similar to simple computer games.
    - The Trust and the Dancing game should take about 20 minutes to play, and the Two or Multiple Partners Social Exchange game and the Intentions task should take about 30 minutes.
- MBT-I evaluation interview
    - In case this is part of your treatment, you might get invited to complete two brief interviews of ca. 20 minutes each, with a researcher via video

call, to discuss your experience of the group and what you feel you have learned from it. This will not affect your treatment.

- If you decide to attend in person, the questionnaires, games, and interview will still be done in the same way as described above.

- Study completion & debriefing. Once you have completed the study, or in case you decide to withdraw at any point, the researcher will provide you with some debriefing information. The researcher will also ask you to provide your bank account details so that an online bank transfer for your participation payment can be made.

All identifiable information will be removed prior to you completing the study.

No part of the study is compulsory and there will be separate consent sections for each part of the study.

We do encourage you to discuss these details with the research team in order to make sure that you fully understand them and that your concerns and questions can be addressed.

What are the possible disadvantages and risks of taking part?

There are no major risks in participating. Some people may find it upsetting to answer questions about their personal experiences. At the end of this information sheet you will find a description of all the questionnaires. These descriptions can help you decide whether you would like to participate in this study. Of course, if you decide to participate, you can skip a questionnaire or a specific question in case you are worried that it might be upsetting. Please feel free to discuss this with the researcher at any point. We will support you if you become upset. A specific Risk and Safety protocol for this study has been developed. You will be given time at the end of the study (or at the moment of study withdrawal) to be fully debriefed with a member of the research team and provided with information on crisis phone numbers. The debriefing sheet also contains a self-guided relaxation exercise and some mindfulness techniques. Your personal therapist or probation officer will also be aware of your participation in the study and able to support you should you find discussing your experiences difficult. Should you feel overwhelmed or acutely distressed during or at the end of the assessments, we you will be appropriately looked after by an experienced clinician. You can also contact the Samaritans help line for free from any phone by dialling 116 123.

What are the possible benefits of taking part?

You may find it interesting to complete these tasks and the information gathered during this study will also help to inform our understanding of treatment for Personality

Disorders, which will hopefully be a step towards helping improve interventions in the future.

Will I be paid for taking part in the study?

As an acknowledgement of your time, we will be offering you £30 for completing the self-report questionnaires and £10 for each of the four computer games. Therefore, the reimbursement for completing the full study will be £70, and an additional £20 will be paid for your participation in the MBT-I evaluation component. This will be paid to you via an online bank transfer at the end of the study. In case you decide to withdraw or drop out of the study, you will be reimbursed for your time spent on anything completed so far. If you decide to attend the research appointment in person, you will be reimbursed for your travel costs as long as you can provide a receipt for them.

Who will know you are taking part in the study?

We will inform your personal therapist or probation officer if you have been recruited via these services. We may inform your GP of your participation in this study, but information collected during all stages of the study will be kept strictly confidential. All information will only be viewed by members of the research teams at University College London and Virginia Tech University in the US. However, if through the course of the study it was found that you are at immediate risk of harm to yourself or others,

this information will be shared with your therapist or GP and, if necessary, emergency services.

Your consent form will be kept in a separate location from all your other data, ensuring that this remains anonymous. All data will be stored in secure locations whereby a participant ID will be assigned to your data, non-identifiable personal information and the results of your tasks will be recorded on computers or flash drives which are password protected.

The data from this study will be stored in accordance with the UCL and NHS Data Protection and Records Management policies.

Your study data and any information will be treated as strictly confidential and handled in accordance with the provisions of the UK General Data Protection Regulation (UK GDPR).

Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any ensuing reports or publications.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

What will happen to the results of the research study?

The results will be written up in the form of reports to be submitted to scientific journals or presented at conferences. You will not be identifiable from these results. On completion and if you request it you will be sent a report of the study.

What if there is a problem?

Every care will be taken in the course of this study. However, in the unlikely event that you are injured by taking part, compensation may be available.

If you suspect that the injury is the result of the Sponsor's (University College London) negligence then you may be able to claim compensation. After discussing with your research doctor, please make the claim in writing to Dr. Janet Feigenbaum or Dr Tobias Nolte on behalf of the Chief Investigators (Profs Read Montague and Peter Fonagy) who are based at University College London. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to

your participation in the research, National Health Service or UCL complaints mechanisms are available to you. Please ask your research doctor if you would like more information on this. In the unlikely event that you are harmed by taking part in this study, compensation may be available to you. If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to claim compensation. After discussing with your research doctor, please make the claim in writing to the Prof Fonagy who is the Chief Investigator for the research and is based at UCL, Research Department of Clinical, Educational and Health Psychology, 1-19 Torrington Place, London, WC1E 7HB. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this

Who has reviewed this study?

This study has been reviewed by the **REC for Wales 12/WA/0283**

Contact Details

If you wish to contact the research team to discuss any of the information further or any concerns you have about the study, then please do so by getting in touch with the members of the research team listed below:

If you feel that we have not addressed your questions adequately or if you have any concerns about the conduct of the research team, then please contact my supervisor

Dr. Janet Feigenbaum (Strategic and Clinical Lead for Personality Disorder Services, North East London NHS Foundation Trust and Senior Lecturer, Research Department of Clinical, Educational and Health Psychology, UCL) on 07957 919 961or by email at janet.feigenbaum@nhs.net.

Janet Feigenbaum, PhD

Research Department of Clinical, Educational and Health Psychology

General Office, Room 436, 4th Floor

1-19 Torrington Place, London, WC1E 7HB

Tobias Nolte MD

Wellcome Trust Centre for Neuroimaging & Research Department of Clinical, Educational and Health Psychology

12 Queen Square

London

WC1N 3BG

Tobias.nolte@annafreud.org

Thank you very much for taking the time to read this information sheet.

Appendix E: Questionnaire Descriptions

The below provides a description of the questionnaires which make up the baseline and follow-up parts of this research study. If, based on this description, you are concerned that a specific questionnaire might make you feel upset, please let your researcher know and this questionnaire can then be skipped. We do not want to make you feel upset in any way. In case you decide to go ahead with all questionnaires and unexpectedly find that a question is upsetting you, then the questionnaire can be abandoned at that stage as well.

Questionnaire	Brief Description
BASELINE STUDY (you complete these once)	
Brief Symptom Inventory (BSI)	This questionnaire contains a list of problems people sometimes report, including both physical and mental health symptoms. Examples include “Nervousness or shakiness inside” and “Feeling hopeless about the future”. It asks you to indicate how much each of these problems has caused you distress in the past 7 days on a scale from Not at All to Extremely.
Antisocial Process Screening Device (APSD)	This questionnaire is a screening questionnaire for the presence of antisocial, impulsive or self-enhancing behaviours. Examples include “You lie easily and skilfully” and “You do risky and dangerous things”. It asks you to choose how much these items describe you on a scale from Not at all true to Definitely true.
Personality Assessment Inventory – Borderline subscale (PAI-BOR)	This questionnaire assesses four domains of personality: affective instability, identity problems, interpersonal problems, and self-harm. Examples include “My mood can shift quite easily” and “I can’t handle separation from those close to me very well”. It asks you to choose how true each statement is for you, on a scale from False to Very True.
Inventory of Interpersonal Problems (IIP32)	This questionnaire is focused on your interpersonal relationships, or your relationships with other people. It will ask about recent experiences with other people and whether you have had any

	difficulties relating to other people. Examples include “It is hard for me to confront people with problems that come up” and “I am overly generous to other people”. You will answer the questions on a scale from Not at all to Extremely.
Self-Report Psychopathy Scale (Levenson SRPS)	This questionnaire will ask you about your empathy levels and your emotions towards other people. It will also ask you about your lifestyle preferences. Examples include “For me, what’s right is whatever I can get away with” and “Love is overrated”. You will be asked to answer on a scale from Strongly Disagree to Strongly Agree.
Beck Depression Inventory (BDI-II)	This questionnaire will ask you about the presence and severity of depression symptoms. Examples include “Loss of pleasure” and “Crying”, and you will be asked to answer how often individual symptoms occurred within the past 14 days.
Assessment of significant losses	This questionnaire will ask you if you have experienced any significant losses and/or separations of meaningful individuals during your childhood (from parents/siblings/close family members/close friends).
Schizotypal personality questionnaire (SPQ)	This questionnaire will ask you about a list of experiences some people sometimes have. Some of these experiences may be rather

	unusual. Examples include “Have you had experiences with the supernatural?” and “Some people think that I am a bizarre person”. You will be asked to choose between Yes and No for each item.
Drug & Alcohol Use Questionnaire (DASI)	This questionnaire will ask you about your use of alcohol, nicotine and other substances. It will also ask you about the presence of a history of self-harm. The items will be answered on a scale from Never to Every day or nearly every day.
Standardized Assessment of Personality, Abbreviated Scale (SAPAS)	This short questionnaire will ask you about some common personality traits and preferences. An example includes “In general, do you trust other people”. You are asked to choose from Yes or No, based on what is mostly true for yourself.
Childhood Trauma Questionnaire (CTQ)	This questionnaire will ask you about your childhood experiences, and whether there were any occurrences of trauma, including physical, sexual and emotional. Examples include “People in my family said hurtful or insulting things to me” and “Someone tried to touch me in a sexual way or tried to make me touch them”. You will be asked to answer on a scale from Never True to Very Often True.

Dissociative Experience Scale (DES)	This questionnaire will ask you about every-day experiences you might have had in your life, specifically focusing on your memory, your identity, your awareness and your thoughts. Examples include "Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation)" and "Some people sometimes have the experience of feeling that their body does not belong to them". You will be asked to answer on a scale of 0% to 100%, depending on how often you have these experiences.
PTSD Checklist (PCL-S)	This questionnaire will ask you about the presence of an unusually stressful or traumatic experience in your life in the past 4 weeks, and if this is not the case, you can also consider an experience from any time in the past. You will be asked to indicate how much this experience is affecting various parts of your thoughts, feelings and behaviours today. Examples include "Repeated, disturbing dreams of stressful experience" and "Trouble falling or staying asleep". You will be asked to answer on a scale from Not at All to Extremely.
Paranoid Thoughts Scale (GPTS)	This questionnaire asks you about thoughts and feelings you may have had towards others in the past month. Examples include

	"People talking about me behind my back" and "I was sure someone wanted to harm me". You will be asked to answer on a scale from Not at all to Totally.
Barratt Impulsiveness Scale (BIS-11)	This questionnaire will ask you about your planning and decision-making preferences and whether you have impulsive or non-impulsive tendencies. Examples include "I do things without thinking" and "I am restless at the theatre or in lectures". You will be asked to answer on a scale from Never to Almost Always/Always.
Other As Shamer (OAS)	This questionnaire explores your expectations and thoughts about how others see or judge you. You will be asked to respond to statements describing feelings or experiences about how you may feel other people see you. Examples include "I think that other people look down on me" and "Others see me as fragile". You will answer on a scale from Never to Almost Always.
Reflective Functioning Questionnaire (RFQ)	This questionnaire will ask you about your own thoughts and feelings as well as how you think about others' thoughts and feelings. Examples include "I don't always know why I do what I do" and "My intuition about a person is hardly ever wrong". You will be answering on a scale from Strongly disagree to Strongly agree.

Experiences in Close Relationships (ECR-R)	This questionnaire assesses your attachment preferences when you are in a close or romantic relationship. It can also be answered based on imagining yourself in a close relationship, if you are currently not in one. Examples include “I rarely worry about my partner leaving me” and “I don’t feel comfortable opening up to a romantic partner”. You will be asked to answer on a scale from Strongly disagree to Strongly agree.
The OPD system questionnaire (OPD-SQ)	This questionnaire assesses your personality structure. You will be shown a series of character description of people and be asked to indicate how much these statements reflect you. Examples include “I find it difficult to be aware of my feelings” and “I find it easy to get into contact with other people”. You will be answering on a scale from Fully disagree to Fully agree.
Agency questionnaire (AFI)	This questionnaire measures your sense of authorship/self-congruence, your sense of control over your actions and your interest taking. Examples include “I strongly identify with the things that I do” and “I often pressure myself”. You will be asked to answer on a scale from Not at all true to Completely true.

Difficulties in Emotion Regulation Scale (DERS)	This questionnaire is about any difficulties in emotion regulation, including awareness and understanding of emotions, acceptance of emotions, the ability to engage in goal-directed behaviour and refrain from impulsive behaviour when experiencing negative emotions. Examples include “I care about what I am feeling” and “When I’m upset, I feel weak”. You will answer on a scale from Almost Never to Almost Always.
Personality Assessment Inventory – Antisocial Subscale (PAI-AS)	This questionnaire assesses the tendency for impulsive and antisocial behaviour, as well as thoughts and emotions about others. Examples include “I like to drive fast” and “I’ve done some things which aren’t exactly legal”. You will be asked to answer on a scale from False to Very True.
Empathy Quotient (EQ)	This questionnaire focuses on the affective and cognitive components of empathy. Examples include “I really enjoy caring for other people” and “Seeing people cry doesn’t usually upset me”. You will answer on a scale from Strongly Agree to Strongly Disagree.
Life History of Aggression (LHA)	This questionnaire will ask about the presence, frequency and severity of a range of aggressive behaviours throughout the lifetime. Examples include “Get into verbal fights or arguments with

	other people" and "Had difficulties with the law or police which resulted in a warning". You will be asked to indicate how often these behaviours have happened on a scale from Never to Happened so many times I can't count.
Eating Questionnaire	This questionnaire will measure your view of your eating and exercise habits as well as your view of your own body. Examples include "How often have you had a definite desire to have a totally flat stomach" and "Have you had a strong desire to lose weight". You will be asked to answer on a scale from Never to Every Day.
Pathological Narcissism Inventory (PNI)	This questionnaire will ask about your view of yourself and your rights. Examples include "I get mad when people don't notice all that I do for them" and "Everybody likes to hear my stories". You will be asked to answer on a scale from Not at all like me to Very much like me.
Depressive Experiences Questionnaire (DEQ)	This questionnaire will ask you about experiences with depressive symptoms, self-esteem and self-criticism, and your dependency on others. Examples include "I feel I am always making full use of my potential" and "Often I feel I have disappointed others". You will be asked to answer on a scale from Strongly Agree to Strongly Disagree.

Epistemic Trust Scale (ETS)	This questionnaire asks you to reflect on your trust levels and potential relationships with others that you know (e.g. friends/family), as well as with a psychotherapist. If you are not currently working with a psychotherapist, you can answer this hypothetically. Examples include “I would be very likely to take the advice of a psychotherapist” and “I love learning from new people”. You will be answering on a scale from Strongly Agree to Strongly Disagree.
Additional Epistemic Trust Scale	This questionnaire is very similar to the above ETS but it adds other questions that expand on the above by asking about more generic situations. Examples include “I often feel that people do not understand what I want or need” and “I have often taken bad advice from the wrong people”. You will be asked to answer on a scale from Strongly Disagree to Strongly Agree.
Bullying Experiences Questionnaire (BEQ)	This questionnaire asks about the presence, frequency and severity of bullying experiences in childhood and adolescence. These experiences can range from interpersonal bullying to cyberbullying, with or without physical elements. You will be asked to answer whether you had an experience of a particular type of bullying, and if you have, further questions about the impact of this

	bullying experience will be asked. Examples include “I was excluded from social events” and “I was touched in a way that made me feel uncomfortable”.
Mentalization Questionnaire (MZQ)	This questionnaire assesses different elements of mentalizing or thinking about your own feelings and other people’s feelings. Examples include “Talking about feelings would mean they become more and more powerful”. You will be answering on a scale from I Disagree to I Agree.
Experience of Time Alone Scale (ETAS)	This questionnaire measures your experience of and reaction to spending time alone and loneliness. Examples include “When I am alone, I enjoy pampering and doing nice things for myself” and “I feel hopeless about my future when I am alone”. You will be asked to answer on a scale from Not at all to A great deal.
Personality Inventory for DSM-5, Brief (PID-5-BF)	This questionnaire will ask more questions about your personality traits and characteristics and what you are usually like as a person. Examples include “I worry about almost everything” and “I am easily distracted”. You will be asked to answer on a scale from Very False/Often False to Very True/Often True.

Certainty about Mental States Questionnaire (CAMSQ)	This questionnaire will ask you to reflect on your own thoughts, feelings and behaviours. Examples include “I understand why certain things make me happy” and “I know how a person feels when I look at their face”. You will be asked to answer on a scale from Never to Always.
Shame and Ashamedness Scale (SAS)	This questionnaire will ask you to think about how you experience yourself versus how you think other people experience you. Examples include “I think other people can notice my flaws” and “I get very self-conscious when I am around other people”. You will be asked to answer on a scale from Not at all to A lot.
MBT-I Attitudes and Knowledge Questionnaire	This questionnaire will ask you to think about your understanding of, attitudes towards and skills surrounding the BPD diagnosis and the MBT-I psychoeducational group. You will be asked to answer on a scale from Strongly Disagree to Strongly Agree.
Helping Alliance Questionnaire Revised (HAQ-II)	This questionnaires will ask you to reflect about your relationship with the MBT-I group facilitator. Examples include “I like the facilitator as a person” and “The facilitator and I have meaningful exchanges”. You will be asked to answer on a scale from Strongly Disagree to Strongly Agree.

It is important to keep in mind that all questionnaires are answered on scales. Therefore, some items may not apply to you at all, or you do not experience certain things a lot, and other items might apply to you a lot, or you experience certain things often. This will vary for every person. The questionnaires cover a wide range of topics. It is also important to know that they are not used for any diagnostic purpose, nor can we make any clinically relevant judgments based on your responses. They simply provide an overview of yourself based on your answers. All your answers will be kept strictly anonymously and confidentially.

Once you start working through these questionnaires, we will make them available to you in smaller portions so that it is not overwhelming. We also encourage you to take as many breaks as you'd like so that you do not feel fatigued or stressed.

Appendix F: Consent Form

Personality Disorders – a Computational Psychiatry Approach

Consent Form

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Project Title:

Understanding the Social Brain in Healthy Volunteers and People with Psychological Difficulties. – Reduced Online Study

This study has been approved by the Research Ethics Committee for Wales (Project ID): 12/WA/0283.

Thank you for your interest in taking part in this research. Before you agree to take part, the person organising the research must explain the project to you.

If you have any questions arising from the Information Sheet (version 1.8.2, dated 27/01/2023) or explanation already given to you, please ask the researcher before you to decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please tick the following statements if you agree with them:

1. I have read the notes written above and the Information sheet dated 27/01/2023, version 1.8.2, and understand what the study involves and what is expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction.
2. I understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately.
3. I understand that this study is an online study and that I will be contacted by the researcher via telephone, email or text message. I understand that I will be responsible for completing the study according to the instructions of the researcher.
4. I agree to participate in the components listed in the study overview of the information sheet.
    a. Self-report questionnaires

b. Behavioural tasks

c. MBT-I evaluation component

5. In case I get invited to complete the MBT-I evaluation interview, which forms part of the MBT-I evaluation component, I understand that this will be completed via video call. It has been made clear to me that my participation (or my wish not to participate) in this interview will not affect my treatment in any way. I understand that this interview on my experience of the psychoeducation group will be recorded on safe devices and only be used for research purposes. I understand that it will be transcribed in an anonymized way, stored encrypted and securely, and that the audio recording will be deleted.
6. I consent to the processing of my personal information for the purposes of this research study.
7. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the UK General Data Protection Regulation (UK GDPR).
8. I agree that my anonymous data may be used by others for future research. I am assured that the confidentiality of my personal data will be upheld through the anonymous identifiers.

9. I understand that the information I have submitted will be published as a report and that I can request a copy. Confidentiality and anonymity will be maintained, and it will not be possible to identify me from any publications.
10. I agree that some of the study data will be shared with the collaborating laboratory at Virginia Tech University in the USA and SOMA Analytics. I understand that data shared with Virginia Tech University would no longer be subject to EEA data protection laws but that this data will be anonymised and no identifiable personal information will be shared or transferred.
11. I understand that relevant sections of my medical notes and data collected during my clinical assessment (including the clinical outcome data) and during the study from me may be looked at by individuals from the research team, my clinician, or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.
12. I agree that the research team might re-contact me in case that additional data has to be obtained.
13. I agree that I can be contacted after the end of this study about possible future research and follow-up with the research team and related groups.
14. I agree that my GP can be told that I am participating in this study.

    GP name:

GP surgery:

GP address:

15. I agree that the research project named above has explained to me to my satisfaction and I agree to take part in this study.

Thank you for your help.

By completing and returning this form, you are giving us your consent that the personal information you provide will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

Appendix G: Interview Protocol

General intro:

Over the next half hour, I will be asking you some questions about your recent experiences in relation to MBT-I – the psychoeducational groups that form the first step of your MBT treatment at the service. We will also cover some questions around what trusting others is like for you and how you feel trust is formed. It is very important that you take your time when answering, what I am interested in is really your own personal perspective.

I have no role in the treatment team. Your answers to my questions will be totally confidential and will not be shared with the treatment team in any way where you could be identified. So this conversation is confidential. Please remember that your answers are for research purposes – they will not affect the treatment you are receiving in any way and also you can stop the interview at any time without being required to justify it.

Post-treatment:

1. What was MBT-I like for you?

2. Has the MBT-I impacted your understanding of your own mental health.

- Examples?

3. Has anything changed since doing MBT-I , have you noticed anything different?
    - Can you give me some examples of changes that you might have noticed in your day to day?
    - During/after which sessions you noticed the change?
    - Are you able to identify what it was about these sessions that led to these changes.

4. Could you tell me in your own words how you understand the concept of “mentalizing”?

Do you think it is important to you?

Yes: Can you tell me more, why?

No: Can you tell me more, why not?

5. Have you noticed changes in your mentalizing since the MBT-I ?
    - Examples?

- Is there any impact on how you think and feel about yourself from what you have learned about mentalizing?

6. Has what you learned about mentalizing had any impact on your relationships? Examples? How?

7. Do you think what you have learned about mentalizing and applying it in your life has influenced others to mentalize differently in relation to you?
    - Examples?

8. As a result of learning about mentalizing, have you become more aware of other people mentalizing?

9. Could you share any thoughts/emotions you had before the weekly meetings of the MBT-I ?

    a. Why do you think you felt that way?

10. Have there been moments during the meetings when you found yourself having strong emotions?

- Can you tell me a bit more?
- Where do you think those came from?

11. Can you think of insights or understanding you have gained from the MBT-I that you found helpful?
    - Examples of particular exercises/ techniques?
    - How do you think these things helped you?
    - Have you applied any of the things you have learned in your day-to-day life?

12. Are there any aspects of the MBT-I that you found unhelpful or challenging?
    - Examples
    - Why do you think these were challenging?

13. Did you feel like you could fully share your thoughts and emotions in the sessions?
    - What do you think made that possible/impossible?
    - Can you give me some examples?

14. Did you have a chance to practice mentalizing in the group?

- Any examples?
- How did you experience attempting to mentalize others or being mentalized by others within the group?

15. How did you experience the group facilitator/s?

How do you feel your relationship with them developed?

- How did you work out whether or not they we're "getting you"?
- Overall, to what extent did you experience your group facilitator as knowledgeable?

16. Did the facilitator of the group explain mentalizing clearly?
    - What were the techniques you can recall?

17. What did the group facilitator do to make it easier for you to understand mentalizing?
    - Are there any aspects of the teaching approach that you find helpful?

18. Did the facilitator of the group show mentalizing in their interactions with you and others? Examples?

19. Did you feel supported by the group facilitator?
    - Examples?
    - Were you supported if you had difficulties understanding mentalizing?
    - What showed you that they were or weren't supportive?

20. Were you able to build trust with the facilitators?
    - If yes/no: what helped you with that/why was it difficult?
    - What would have made it easier?

21. How did you experience the other group members?

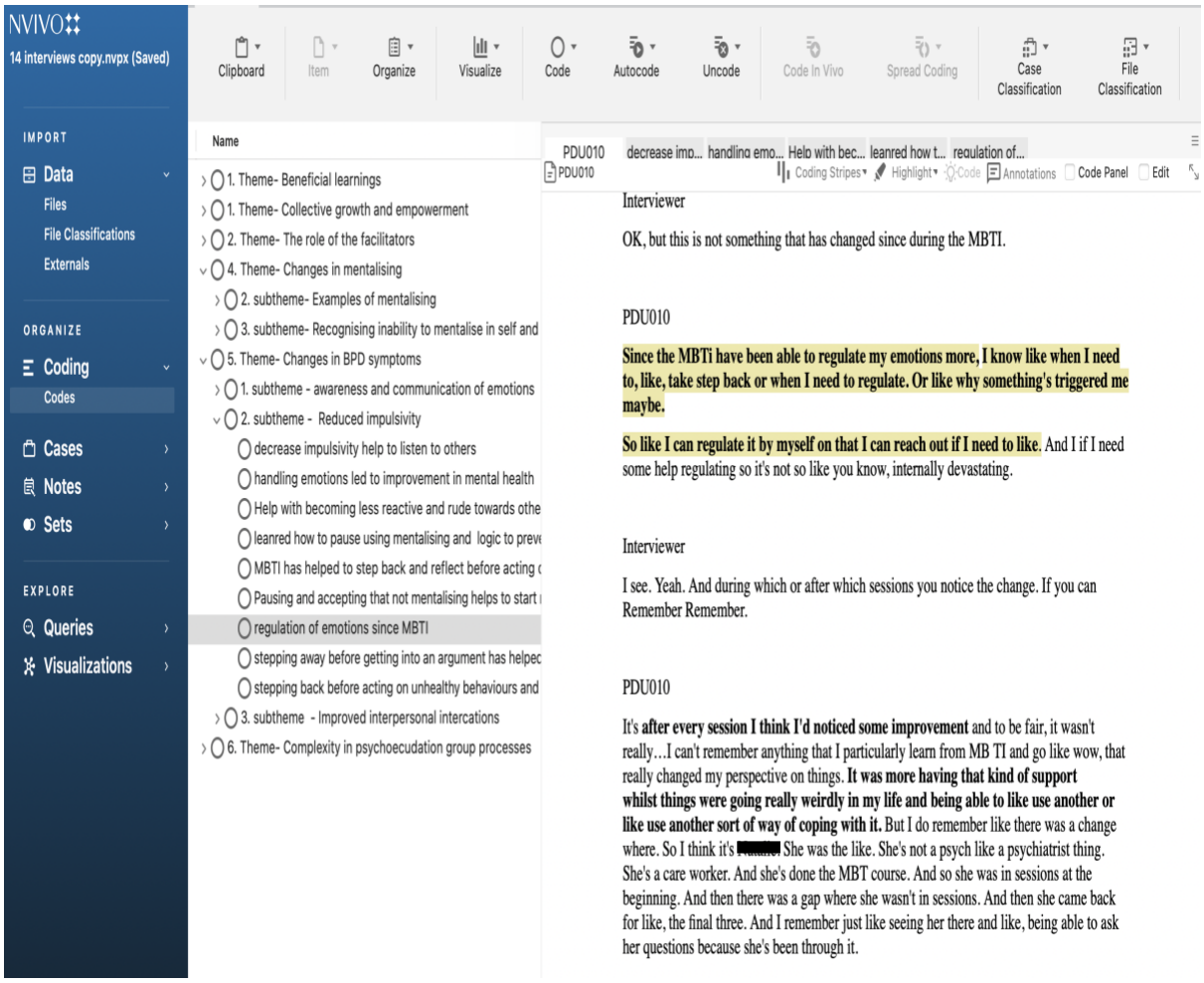
    Overall, to what extent did you feel that your group members understood you?

    How did you work out whether or not they we're "getting you"?

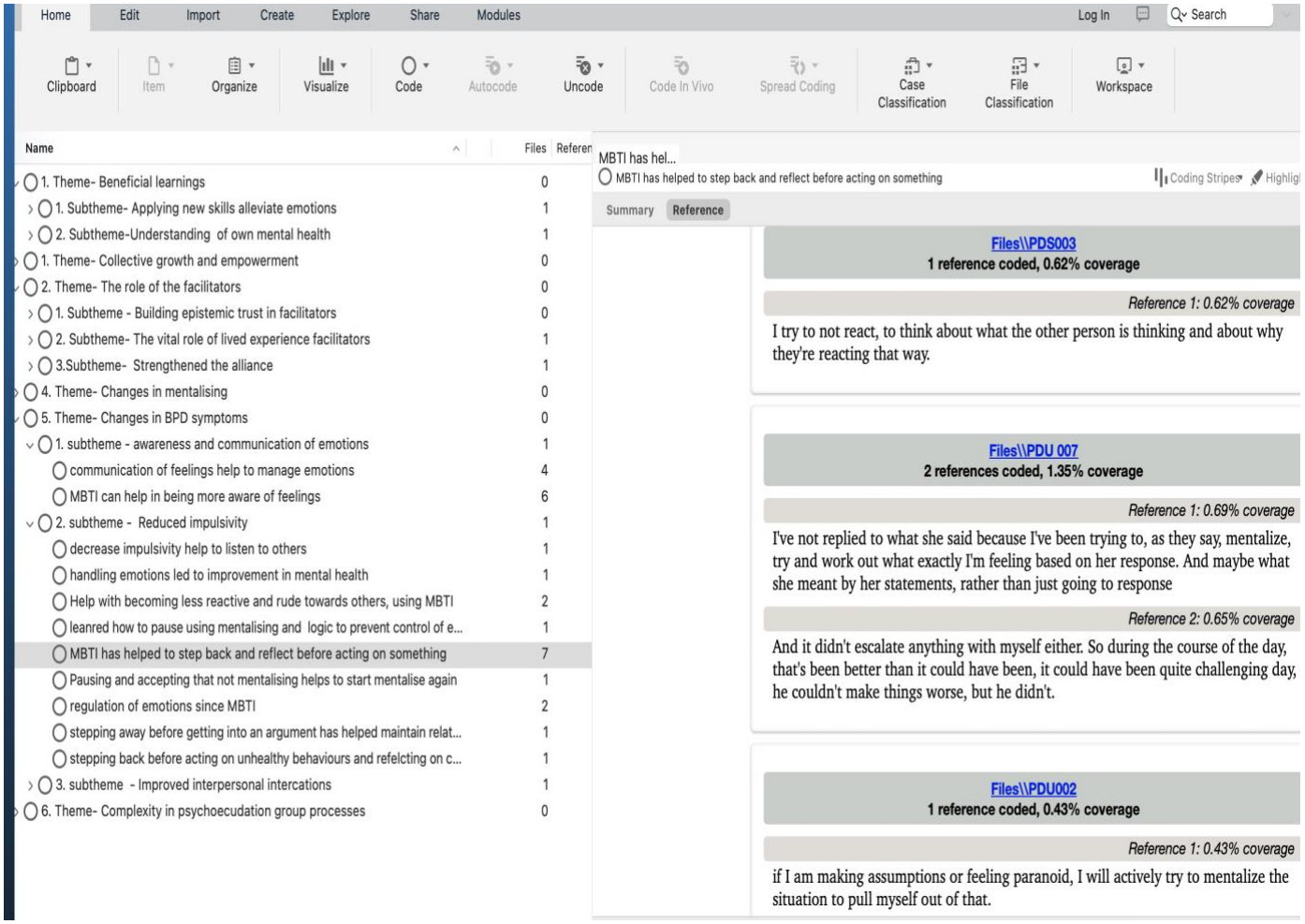
    Did you learn anything from the other group members?

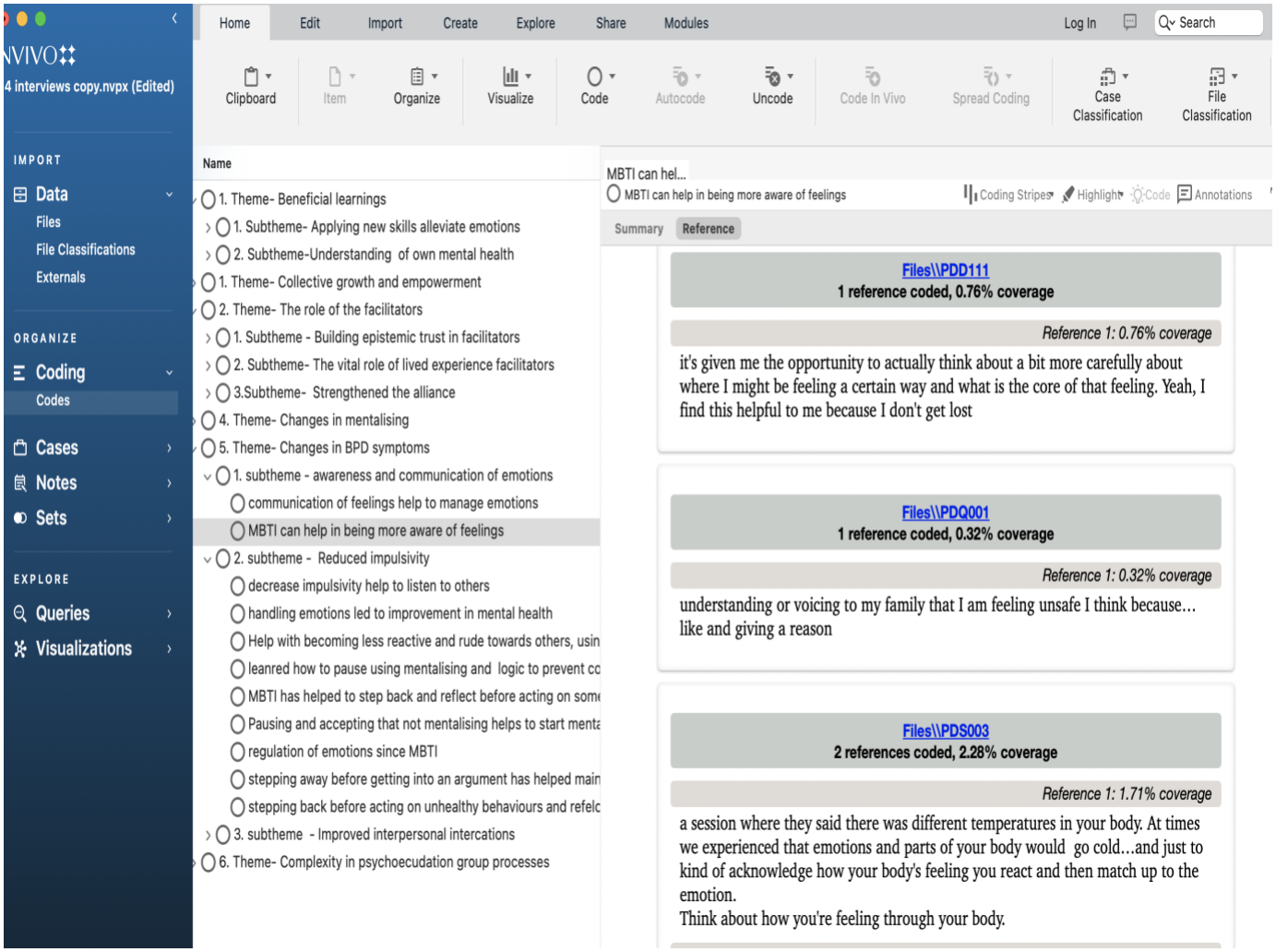
22. Were you able to build trust with the other group members?
    - If yes/no: what helped you with that/why was it difficult?
    - What would have made it easier?

Appendix H: Coded Transcript Extract



Appendix I: Extract from Data Analysis Coding Nvivo




NVIVO
4 interviews copy.nvpx (Edited)
IMPORT
Data
Files
File Classifications
Externals
ORGANIZE
Coding
Codes
Cases
Notes
Sets
EXPLORE
Queries
Visualizations
Home
Edit
Import
Create
Explore
Share
Modules
Log In
Search
Clipboard
Item
Organize
Visualize
Code
Autocode
Uncode
Code In Vivo
Spread Coding
Case Classification
File Classification
Name
1. Theme- Beneficial learnings
1. Subtheme- Applying new skills alleviate emotions
2. Subtheme-Understanding of own mental health
1. Theme- Collective growth and empowerment
2. Theme- The role of the facilitators
1. Subtheme - Building epistemic trust in facilitators
2. Subtheme- The vital role of lived experience facilitators
3.Subtheme- Strengthened the alliance
4. Theme- Changes in mentalising
5. Theme- Changes in BPD symptoms
1. subtheme - awareness and communication of emotions
communication of feelings help to manage emotions
MBTI can help in being more aware of feelings
2. subtheme - Reduced impulsivity
decrease impulsivity help to listen to others
handling emotions led to improvement in mental health
Help with becoming less reactive and rude towards others, usin
leanred how to pause using mentalising and logic to prevent cc
MBTI has helped to step back and reflect before acting on some
Pausing and accepting that not mentalising helps to start menta
regulation of emotions since MBTI
stepping away before getting into an argument has helped main
stepping back before acting on unhealthy behaviours and refelc
3. subtheme - Improved interpersonal intercations
6. Theme- Complexity in psychoecudation group processes
MBTI can hel...
MBTI can help in being more aware of feelings
Coding Stripes
Highlight
Code
Annotations
Summary
Reference
Files\\PDD111
1 reference coded, 0.76% coverage
Reference 1: 0.76% coverage
it's given me the opportunity to actually think about a bit more carefully about where I might be feeling a certain way and what is the core of that feeling. Yeah, I find this helpful to me because I don't get lost
Files\\PDQ001
1 reference coded, 0.32% coverage
Reference 1: 0.32% coverage
understanding or voicing to my family that I am feeling unsafe I think because... like and giving a reason
Files\\PDS003
2 references coded, 2.28% coverage
Reference 1: 1.71% coverage
a session where they said there was different temperatures in your body. At times we experienced that emotions and parts of your body would go cold...and just to kind of acknowledge how your body's feeling you react and then match up to the emotion.
Think about how you're feeling through your body.

Appendix J: Research Diary Extract

Patients report feeling invalidated by previous professionals, necessitating a careful and patient approach. Rushing them can exacerbate feelings of invalidation, potentially hindering the therapeutic process. Hence, I think that it is crucial for me to establish a supportive and validating environment from the beginning.

24/02/2024
Today marked a significant shift in my approach to interviews. Listening to the pre-interview for participant PDU001 before conducting the post-interview deepened my connection with her. Her expressed anxiety about group settings and visible distress during the initial interview evoked strong feelings of empathy within me. This recollection underscored the emotional complexity of these interviews and the importance of empathetic engagement.

26/02/2024
Post-supervision, I conducted two interviews that extended to 50 minutes each, driven by my anxiety about obtaining the right information. The late arrivals (30-40 minutes) of both participants, PDU001 and PDU002, compounded my stress. PDU001's emotional state from the onset suggested a challenging interview, prompting me to adopt a warm and understanding approach. This, however, blurred the lines between a therapeutic session and an interview. Technical issues during PDU002's interview further exacerbated my insecurities, impacting my communication effectiveness.

29/02/2024
Scheduling an interview with PDU004 revealed an unexpected emotional reaction. Her voice sounded almost aggressive, which I found intimidating. This interaction led me to offer a flexible appointment, reflecting my discomfort and desire to avoid confrontation.
04/03/2024
The frustration from previous participants' lateness (1-2 hours) prompted me to send reminders for upcoming interviews with PDU004 and PDU006. Timeliness is essential for my workflow and preparation. The interview with PDU004 left me feeling exhausted and intimidated. Her long, sometimes irrelevant responses, combined with a dismissive tone when interrupted, made the session challenging. I left the interview with a headache and a sense of irritation. The forthcoming interview with PDU006 was difficult for me due to the limiter time to reflect and connect to my own emotions from the interaction with PDU004 .

Analysis and Reflection
Reviewing my approach, particularly with PDU001, revealed a tendency to steer conversations toward positive aspects of MBT, potentially stifling critical feedback. Acknowledging this, I recognize the need for balanced interview questions that equally address unhelpful experiences, improvements, and adverse outcomes.

In the thematic analysis, initial themes were reevaluated, leading to the creation of a distinct theme for group dynamics, previously a subtheme under helpful aspects. Additionally, the understanding of personal mental health emerged as a separate subtheme. The broad theme of "changes linked to MBT" was refined to specifically address changes in BPD symptoms, ensuring a more precise categorisation of data

Appendix K: A tool for evaluating thematic analysis (TA) manuscripts for publication

Twenty questions to guide assessment of TA research quality.

These questions are designed to be used either independently, or alongside our methodological writing on TA, and especially the current paper, if further clarification is needed.

Adequate choice and explanation of methods and methodology

1. Do the authors explain why they are using TA, even if only briefly?

2. Do the authors clearly specify and justify which *type* of TA they are using?

3. Is the use and justification of the specific type of TA consistent with the research questions or aims?

4. Is there a good 'fit' between the theoretical and conceptual underpinnings of the research and the specific type

of TA (i.e. is there conceptual coherence)?

5. Is there a good 'fit' between the methods of data collection and the specific type of TA?

6. Is the specified type of TA consistently enacted throughout the paper?

7. Is there evidence of problematic assumptions about, and practices around, TA?

These commonly include:

- Treating TA as one, homogenous, entity, with one set of – widely agreed on – procedures.
- Combiningphilosophicallyandprocedurallyincompatibleapproachesto TA without anyac knowledgement or explanation.
- Confusing summaries of data topics with thematic patterns of shared meaning, underpinned by a core concept.
- Assuminggroundedtheoryconceptsandprocedures(e.g.saturation,constantcomparativ eanalysis,line-by -line coding) apply to TA without any explanation or justification.
- Assuming TA is essentialist or realist, or atheoretical.
- Assuming TA is only a data reduction or descriptive approach and therefore must be supplemented with other methods and procedures to achieve other ends.

8. Are any supplementary procedures or methods justified, and necessary, or could the same results have been

   achieved simply by using TA more effectively?

9. Are the theoretical underpinnings of the use of TA clearly specified (e.g. ontological, epistemological

   assumptions, guiding theoretical framework(s)), even when using TA inductively (inductive TA does not equate

   to analysis in a theoretical vacuum)?

10. Do the researchers strive to ‘own their perspectives’ (even if only very briefly), their personal and social

    standpoint and positioning? (This is especially important when the researchers are engaged in social justice- oriented research and when representing the ‘voices’ of marginal and vulnerable groups, and groups to which the researcher does not belong.)

11. Are the analytic procedures used clearly outlined, and described in terms of what the authors actually did, rather than generic procedures?

12. Is there evidence of conceptual and procedural confusion? For example, reflexive TA (e.g. Braun and Clarke 2006) is the claimed approach but different procedures are outlined such as the use of a codebook or coding frame, multiple independent coders and consensus coding, inter-rater reliability measures, and/or themes are conceptualised as analytic inputs rather than outputs and therefore the analysis progresses from theme identification to coding (rather than coding to theme development).
13. Do the authors demonstrate full and coherent understanding of their claimed approach to TA?

A well-developed and justified analysis

14. Is it clear what and where the themes are in the report? Would the manuscript benefit from some kind of overview of the analysis: listing of themes, narrative overview, table of themes, thematic map?
15. Are the reported themes topic summaries, rather than 'fully realised themes' – patterns of shared meaning underpinned by a central organising concept?

    - If so, are topic summaries appropriate to the purpose of the research?
    - If the authors are using reflexive TA, is this modification in the conceptualisation of themes explained

and justified?

- Have the data collection questions been used as themes?
- Would the manuscript benefit from further analysis being undertaken, with the reporting of fully realised

themes?

- Or, if the authors are claiming to use reflexive TA, would the manuscript benefit from claiming to use

a different type of TA (e.g. coding reliability or codebook)?

16. Is non-thematic contextualising information presented as a theme? (e.g. the first 'theme' is a topic summary

providing contextualising information, but the rest of the themes reported are fully realised themes). If so,

would the manuscript benefit from this being presented as non-thematic contextualising information?

17. In applied research, do the reported themes have the potential to give rise to actionable outcomes?

18. Are there conceptual clashes and confusion in the paper? (e.g. claiming a social constructionist approach while

also expressing concern for positivist notions of coding reliability, or claiming a constructionist approach while

treating participants' language as a transparent reflection of their experiences and behaviours) 19. Is there evidence of weak or unconvincing analysis, such as:

- Too many or two few themes?

Too many theme levels?

Confusion between codes and themes?

Mismatch between data extracts and analytic claims? Too few or too many data extracts?

Overlap between themes?

20. Do authors make problematic statements about the lack of generalisability of their results, and or implicitly conceptualise generalisability as statistical probabilistic generalisability (see Smith 2017)?

Appendix L: Consolidated Criteria for Reporting Qualitative Studies

Table 2

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?
2.	Credentials	What were the researcher's credentials? *E.g. PhD, MD*
3.	Occupation	What was their occupation at the time of the study?

No	Item	Guide questions/description
4.	Gender	Was the researcher male or female?
5.	Experience and training	What experience or training did the researcher have?
Relationship with participants		
6.	Relationship established	Was a relationship established prior to study commencement?
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.*g. personal goals, reasons for doing the research*
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. *Bias, assumptions, reasons and interests in the research topic*

No	Item	Guide questions/description
Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? *e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis*
Participant selection		
10.	Sampling	How were participants selected? *e.g. purposive, convenience, consecutive, snowball*

No	Item	Guide questions/description
11.	Method of approach	How were participants approached? e.*g. face-to-face, telephone, mail, email*
12.	Sample size	How many participants were in the study?
13.	Non-participation	How many people refused to participate or dropped out? Reasons?
Setting		
14.	Setting of data collection	Where was the data collected? e.*g. home, clinic, workplace*
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?

No	Item	Guide questions/description
16.	Description of sample	What are the important characteristics of the sample? *e.g. demographic data, date*
Data collection		
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?
20.	Field notes	Were field notes made during and/or after the interview or focus group?

No	Item	Guide questions/description
21.	Duration	What was the duration of the interviews or focus group?
22.	Data saturation	Was data saturation discussed?
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?
Domain 3: analysis and findingsz		
Data analysis		
24.	Number of data coders	How many data coders coded the data?
25.	Description of the coding tree	Did authors provide a description of the coding tree?

No	Item	Guide questions/description
26.	Derivation of themes	Were themes identified in advance or derived from the data?
27.	Software	What software, if applicable, was used to manage the data?
28.	Participant checking	Did participants provide feedback on the findings?
Reporting		
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.*g. participant number*
30.	Data and findings consistent	Was there consistency between the data presented and the findings?
31.	Clarity of major themes	Were major themes clearly presented in the findings?

No	Item	Guide questions/description
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?