"But wait a minute, wait, Sarah, wait! Sarah! Sarah, wait a minute!"

Challenges in Mentalization–Based Group Therapy (MBT-G):

A Video-based Explorative Case Study

Graduate Thesis

Tryggve Sagen Inderhaug

Department   of   Psychology

Norwegian University of Science and Technology

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Forord

Jeg vil først rette en oppriktig takk til pasientene og terapeutene som tillot meg å få tilgang til

video-opptak av timene deres. Deres bidrag til denne hovedoppgaven var enormt viktig.

Videre vil jeg takke Truls Ryum for langvarig og grundig veiledning. Innspillene fra ham,

samt de påfølgende diskusjonene oss imellom, har utdypet min forståelse av hva det var jeg

holdt på med og hevet oppgavens kvalitet mange hakk. Sigmund Karterud skal ha æren for å

ha gjort dette hovedoppgaveprosjektet mulig, og jeg er høyst takknemlig for et meget

spennende og lærerikt samarbeid med ham. Jeg håper resultatet kan være et innspill til

utformingen av gruppeterapeutisk utdannelse og praksis.

Trondheim, mai 2013

Tryggve Sagen Inderhaug

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Abstract

This paper presents a video-based explorative case study of therapeutic challenges in mentalization-based group therapy (MBT-G) for patients with borderline-type problems. Employing qualitative methodology, we explored a MBT group as part of routine psychiatric care at a Psychiatric District Centre (naturalistic study). Several phenomena emerged as important in understanding the therapists' struggle to construe the group in a manner that foster mentalization. First and foremost, the main challenge seemed to be that the therapists did not succeed in establishing the authority needed to break through a strong pseudo-mentalizing group culture, alternating with more chaotic displays of psychic equivalence. This may be understood as a consequence of a misconstrued attempt by the therapists to take on a *not-knowing stance*, a central principle in MBT. Supposedly, the not-knowing stance towards the inner psyche of the patients interfused with a not-knowing stance towards the therapeutic process as a whole, undermining the authority of the therapists. The seemingly contradicting demands inherent in the MBT-G treatment manual, both being authoritative and taking a not-knowing stance, have not previously been highlighted in the literature. The results point towards the complicated process of transferring scientifically validated treatments to routine clinical practice.

Keywords: group therapy, mentalization, borderline, challenges, authority, not-knowing stance, video-based, case study

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Therapeutic Challenges in Mentalization–Based Group Therapy (MBT-G)

Mentalization-based treatment (MBT) is a psychodynamic therapy for borderline

personality disorder (BPD), which has demonstrated efficacy in randomized controlled trials

and follow-up studies (Bateman & Fonagy; 1999, 2001, 2008). MBT is referred to as a

combined or conjoint treatment, combining individual therapy (MBT-I) and group therapy

(MBT-G). Recently, manuals for MBT-I (Karterud & Bateman, 2010), psychoeducational

groups in MBT (Karterud & Bateman, 2011b), and MBT-G (Karterud, 2012) were published

in Norwegian. These treatment manuals follow the recommended standards of Luborsky and

Barber (1993), which suggest that all manuals include theoretical background, treatment

principles, therapeutic techniques with specific examples, in addition to a rating scale for

therapist adherence and competence.

Randomized controlled trials (RCT) are often referred to as the «gold standard» of

psychotherapy research, and is regarded as the method best capable of providing evidence for

the effect of psychological treatment (Roth & Fonagy, 2005). The rigor of controlled

experimental research is critical for understanding and evaluating outcome effects of

therapies, but features of the RCT design have also been criticized for a lack of external

validity, among other things (e.g. Roth & Fonagy, 2005; Miller & Crabtree, 2011).

Researchers thus face a major dilemma: conducting rigorous studies that conform to the

standards of the scientific community (e.g. RCT), and simultaneously keeping the research

relevant for practitioners. Kazdin (2008) suggests that qualitative research may play an

important role in bridging the gulf between research and practice. Elliot (2011) claims that in

spite of many theories about what brings change about, we know little of how change actually

occur, an argument for the appropriateness of qualitative discovery-oriented methods. Our

assertion is that important aspects of therapy processes may remain undetected by the rating

scales and assessment tools of quantitative science. Qualitative studies can add to the

knowledge base of our field, fostering theoretical developments, modification of treatment manuals and rating scales. In order to reveal new therapeutic phenomena, qualitative exploratory research is called for, which may serve as an effective mean to the further development of theory for the improvement of psychotherapy processes.

Measurement of treatment *adherence* (whether the therapists employ the prescribed procedures of the treatment) and therapist *competence* (the quality of the therapists judgment and skills) is commonly not reported in RCTs (Perepletchikova, Treat, & Kazdin, 2007), an omission that do raise important questions. Extending beyond the methodological details of the RCT's, questions concerning the adaption of specific treatments into routine clinical practice are deserving of attention. Specifically, an important question is whether there are factors inherent in a treatment manual that may complicate adherence to treatment principles? Candidate factors may be inconsistencies in theoretical foundations, therapist' misconceptions about central principles, or contradictory demands inherent in the treatment manual.

Interestingly, even though MBT is fronted as a conjoint therapy, there are few accounts of how to conduct MBT in the group modality. The MBT-G manual by Karterud (2012) represents the first attempt to formulate a complete manual for conducting MBT in the group format. Before this treatment manual, MBT-G has only been touched upon in book chapters (for a thorough account see: Karterud & Bateman, 2011a). Karterud (2012) states that the group is an excellent arena for exploring and transforming mentalization, and that we have barely started the work of cultivating the group situation for the purpose of MBT. With this opportunity in mind, it is called for a more nuanced understanding of how therapists construe a *mentalizing group culture*, and also, what challenges may hinder the development of such a group culture. So far, this has received no attention in the literature.

The objective of the present study is therefore to explore a MBT group in a naturalistic treatment setting, in order to understand eventual challenges therapists are facing in the

process of establishing a mentalizing group culture. Three group sessions from a MBT-group at a Psychiatric District Centre were video-taped, transcribed, and analyzed qualitatively following the procedures of Thematic Analysis (Howitt & Cramer, 2007; Braun & Clarke, 2006). The themes we arrived at from the analysis were checked against the MBT-G Adherence and Competence Scale (ACS; Karterud, 2012), to examine if the challenges could be associated with specific treatment principles. The purpose of the study is thus to explore potential hitches associated with delivering a scientifically validated and evidence-based treatment in routine clinical practice.

Before presenting the results of the present project, a short presentation of mentalization theory and borderline personality disorder is in order, followed by a condensed account of central MBT principles, emphasizing features with relevance to the results of the present study.

Mentalization

Mentalization theory is the latest psychodynamic contribution to the understanding of personality disorders, and has explicit links to evolutionary theory, attachment theory, neurobiology and developmental psychology (Karterud, Wilberg & Urnes, 2010). Bateman and Fonagy (2004) define mentalization as "the mental process by which an individual implicitly and explicitly interprets the actions of himself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs and reasons" (p.21). Mentalization is a capacity that enables us to attain some knowledge of our own and others' mental states; and in essence then, mentalization is social cognition (Karterud, 2012). Mentalization may be conceptualized as a trans-diagnostic process, since mentalizing addresses a fundamental human capacity which is central for the understanding of many mental disorders (Fonagy, Bateman & Bateman, 2011).

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Mentalization theory states that mentalization is the most important aspect of the self, providing the self with a sense of coherence. Mentalization gives meaning to changing states of self, as it enable us to put different self-states in perspective of one's life history. The capacity for mentalization is important for understanding other people, the ongoing interaction between people, and for anticipating the future (Karterud, 2012). In concordance with the formulation of Campos, Frankel and Camras (2004), mentalization is also seen as a vital requirement for emotion regulation.

Borderline Personality Disorder

Borderline personality disorder (BPD) is a diagnostic category in the diagnostic and statistical manual of mental disorders (DSM-IV-TR; APA, 2000) and is classified in the international classification of diseases (ICD-10) system as "emotionally unstable personality disorder" (WHO, 1993). However, it is not unusual to refer to patients having borderline-like personality traits, when core characteristics are present but do not sum up to fulfill the diagnostic criteria. In general then, borderline refers to a personality type with problems associated with relationships, self-image, and emotional regulation. Other typical characteristics are impulsivity and self-injuring or suicidal behavior.

Estimates from demographic studies suggest that BPD has a prevalence of about 1.2 % in the general population (Torgersen, 2005), but it is known to be the most frequent personality disorder seen in clinical contexts (Karterud et al. 2010). In general, personality disorders are associated with problems related to work, such as unemployment and early incapacitation, as well as interpersonal problems with family, romantic partners and friends (Skodol et al. 2002; Norén et al. 2007). Cramer, Torgersen and Kringlen (2007) found that the presence of a personality disorder was a stronger predictor of life quality than somatic health, other psychiatric symptom disorders or sociodemographic variables.

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Core characteristics of BPD patients are swift changes and easily provoked loss of mentalizing capacity in interpersonal relationships, problems with reestablishing this capacity, drastic attempts to self sooth, and an array of consequences due to prolonged exposure to non-mentalized experiences (Karterud, 2012, p. 20). BPD patients often lack a fundamental awareness of who they are and how they impact other people, which significantly limits their capacity to establish intimate relationships and represents a challenge in dealing with the interpersonal transactions of everyday life (Holmes, 2006). In close relationships that activate the attachment system, prementalistic ways of organizing subjective experience, usually observable in the mental functioning of young children, come into play (Bateman & Fonagy, 2004). MBT theory focuses on two distinct prementalistic modes of processing: *psychic equivalence* and *pretend mode*. In the former, mental events are "too real"; psychological events are seen as equitable to physical events, and the patients' mentalization is distinguished by being schematic, black/white, and insisting. In the latter mode, mental events have little connection to the real world, and patients produce a floating, metaphorical, and emotionally flat discourse (Karterud, & Bateman, 2010). Patients operating in pretend mode may seem to be mentalizing, but as their understanding bears no connection to genuine experience, it is understood as *pseudomentalization*.

Largely due to the tendency to pendulate between psychic equivalence and pretend mode, borderline patients are known to be difficult patients to deal with therapeutically, and summoning them together in groups is generally presumed to represent even greater challenges (e.g. Roth, Stone & Kibel, 1990). However, mentalization-based therapy in groups is based on therapeutic principles aimed at addressing the seemingly insurmountable challenges often associated with group therapy for this patient population.

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Mentalization-based Group Therapy

According to Karterud and Bateman (2010), the main treatment objective in MBT is to

enhance the patient's inherent capacity for mentalization for the purpose of improving their

management of complicated and problematic feelings in close relationships (p. 44). MBT

requires the cultivation of a mentalizing stance in both therapist and patient, which entails a

humble acknowledgement of not-knowing, patience in identifying different perspectives, as

well as an active effort to make detailed accounts of specific experiences rather than

explaining them. The patients are engaged in a mentalizing discourse where beliefs, feelings

and interpersonal transactions are challenged to bring about changes in perspective, while

solutions and answers play subordinate roles (Karterud & Bateman, 2010).

MBT is considered psychodynamic in the sense that a central component of treatment

is the intersubjective transaction between therapist and patient. In MBT-G, considerable

emphasis is put on the group process, and therapists' are supposed to make use of whatever

transpires in the here-and-now in order to stimulate patients' mentalizing efforts. The group

format is considered an excellent arena for practicing mentalization, and is particularly suited

for exploring interpersonal events. As patients in MBT-G conjointly meets with separate

individual therapists, the group therapists can intensify the interpersonal emphasis in the

group sessions, leaving intrapersonal exploration to the individual therapy sessions. This is a

great advantage, as intrapersonal exploration demands much time and attention spent on one

patient at the time, and thus would leave much of the intersubjective potential in the group

setting unused (Karterud, 2012).

The group format adds to the complexity of individual therapy; the therapeutic

phenomena experienced in individual therapy are still present, but they are taking place in a

crowd of minds and are fueled by collective emotional forces of the group. Transactions are

taking place between many people at many levels, which places extraordinary demands on the

therapist to tolerate confusion and ambiguity. Therefore, MBT-G is conducted by two coordinate therapists, and the treatment manual specifies procedures to ensure a professional collaboration between the two of them. Furthermore, mentalization-based group therapy may be contrasted to individual MBT as the therapists are explicitly encouraged to be authoritative leaders; closely structuring the group process and countering tendencies of the group moving towards chaos and prementalistic thinking modes is important to achieve positive treatment outcomes (Karterud, 2012). In the following, a brief outline of some core characteristics of MBT-G is given, limited to aspects of particular relevance to the present study.

Structure

Given that mentalization deficit is the hypothesized pathogen core of BPD, Karterud (2012) stresses the importance of a meticulously organized treatment programme that serves as a holding environment for the patients. As borderline patients have an unstable self-image and rapidly changing self-states, a core component of the group treatment is establishing some structure through conducting the phases of the therapeutic process. MBT-G structuring principles can be understood as a response to the inherent dangers of chaos, and the penduling between psychic equivalence and pretend mode, often seen in groups with BPD patients.

A session typically starts out with a short recapitulation of the previous session. Then, for the sake of planning the present session, patients call in events from their present life, only mentioned as a brief outline, and the therapists do a short prioritization before the group starts working with one patient at a time. Thus, MBT-G encourage *turn taking* as a central therapeutic and organizing principle, which puts it in contrast to the typical unstructured psychodynamic group therapies. A structured group process is hypothesized to contribute to a sense of coherence, which is why therapists' should remind the patients of what was accomplished in the previous session, as well as rounding up with a summary of the present

session. The session should be ended calmly, with affect regulated down to a level that allows for mentalization and perspective taking.

Managing authority

"Managing authority" is an item specific to the MBT-G ACS (Karterud, 2012; our translation), and is not part of the individual treatment manual. Karterud attends closely to this principle, and in particular, emphasizes how therapists' authority may be challenged by devaluating or aggressive patients (pp. 152). The therapists have invited the patients to participate in a specifically designed project, with a particular purpose and a set of ground rules. The therapists lead the group with a firm hand, and makes sure issues of relevance for the therapeutic project are attended to. If a patient derails the process, the therapist must interrupt the ongoing transaction and get the group back on track. In contrast to more typical psychodynamic group therapists, MBT-G therapists provide the group with more structure and guidance, and are more explicitly responsible for the therapeutic process.

The not-knowing stance

One precaution that is given special attention in both individual and group MBT, is that the therapist should not appear to be an omnipotent expert with the privilege of knowing what goes on in the group or in the mind of its members (Karterud, 2012). Instead, the therapeutic stance should be curious, active, empathic, and at times challenging. The therapist is focused on the patients mind, and he is engaged, questioning, and not-knowing (Bateman & Fonagy, 2006a). The principle of not-knowing functions to stimulate the curiosity and engagement of the patients, and ultimately fosters mentalization. It is also considered anti-therapeutic and potentially harmful to take on an expert attitude, as the patients may accept a therapist's point of view indiscriminately, following his lead while leaving their own feelings of what is important behind. This would be disastrous to the objective of stimulating mentalization (Bateman & Fonagy, 2006b).

Mentalizing discourse

A typical MBT-G session revolves around a constant effort to understand specific situations from the patients' life, or situations unfolding in the group here-and-now. The therapists should continually ask questions to stimulate mentalization. A mentalizing discourse is hallmarked by an emphasis on details of events that allows for the realization of what goes on in the minds of the actors. Thus, it is necessary to be specific about what happened, at what time, who was involved, and what one were thinking, doing, and feeling. Without giving attention to minute and irrelevant details, the patients should sketch the situation to the degree that both therapists and the other patients are able to tune in on what happened. Another prerequisite for mentalization is diving into one single event instead of sketching many events superficially. The therapists are responsible for stopping and rewinding the narrative, going over intersubjective transactions again and again in order to grasp what is going on in the minds of the actors. Thus, the therapists will guide each patient's narration in order to obtain relevant and useful information for the purpose of mentalization (Karterud, 2012).

The Present Study

Although MBT is an evidence-based treatment package consisting of both group and individual therapy, no studies of each separate treatment modality (i.e. group, individual) and the specific principles inherent in them have been executed. Furthermore, the dubious external validity of RCT's lends us very little information about how treatments work when applied in routine clinical practice. In adressing the future of psychotherapy research, Wachtel (2010) stresses the importance of studying therapeutic principles and processes. The therapy group in the present study is examined in order to capture the conditions of clinical reality. Both for the purpose of conceptual understanding, and for the purpose of practical wisdom, a case study

may clarify the deeper causes behind a problem instead of the descriptive and statistical

accounts of quantitative research (Flyvbjerg, 2006).

The aim of the current reseach project is twofold: (1) studying the therapeutic process

of a MBT-group to explore what challenges therapists may be facing in their quest to establish

a mentalizing group culture, and (2) connecting these challenges to MBT-G principles.

Method

Research Design

Strategy. This being an exploratory case study, we advanced no propositions as to

what we might find. This does not mean, however, that we have no criteria for interpreting the

findings. From the beginning of the research project, it was clear that we wanted to explore

phenomena that had some relevance for clinical practice in general, and to MBT specifically.

We draw on theoretical propositions to guide data collection and analysis. The purpose of our

study was to examine how MBT principles worked out in clinical practice, paying special

attention to the challenges therapists are facing. If our findings were meaningful and

interesting from a psychotherapeutic standpoint (i.e. pointed out some new patterns, revealed

hitherto unknown challenges), we could judge the exploration successful.

Analysis. We based our employment of Thematic Analysis (TA) on the accounts of

Howitt and Cramer (2007) and Braun and Clarke (2006). For the purpose of the present

research project, TA has a clear advantage in flexibility, yet we acknowledge the importance

of diligently following the methodological guidelines for TA.

TA is basically a method for pattern finding. Themes derived from a TA organize and

describe data. TA does not demand the researchers to adhere to a distinct theoretical

framework. However, it is important to note that in the present research project, we essentially

take TA as a realist method, as opposed to a constructionist method. This implies approaching

the data with an assumption that it is possible to find patterns that reflects clinical reality.

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With clinical reality, we mean that the analysis is driven by our theoretical interests – our analysis is explicitly analyst-driven – and that within our theoretical framework, the clinical psychological phenomena we encounter are real. As a consequence of our theoretical framing, this study calls for a detailed analysis of some aspects of the data (i.e. therapists interventions based on MBT principles), at expense of a rich description of the data as a whole.

Participants

Therapy group. The study object was a slow-open mentalization-based therapy group at a Mental Health Centre in Norway that met regularly 1.5 hours every week. The group had existed for just over a year at the time of data collection.

Patients. The group consisted of six female patients in the ages 21-46 with borderline-type problems. Thus, all patients had sought treatment for problems associated with emotion regulation, relationships and the self. In addition, patients presented with co morbid disorders such as eating disorders, substance abuse, and schizotypal and avoidant personality traits, either as a secondary or as primary diagnosis. Four of the patients had been members of the group from the start, and had also attended six sessions of a MBT psychoeducative group in advance. The last two patients had attended the group in ten and four sessions prior to data collection. In addition to participation in group therapy, all patients underwent individual therapy with other therapists as part of the conjoint MBT programme.

Therapists. The group had two male therapists of psychodynamic orientation. Both had been working clinically for about seven years, they were educated and experienced group therapists, and had one and two years of MBT training. They worked in a treatment team with the individual therapists of the conjoint treatment, and the team held meetings every second week. The treatment team also had expert supervision from Oslo University Hospital for two whole days every six months.

Procedures for Collecting Data

Recruiting. The researchers had no direct contact with the group, and knew none of the patients in advance. The therapists were responsible for informing the group orally about the research project, and patients read and signed an informed consent form before participating in the study (appendix). Recordings of the next three consecutive therapy sessions were then made available for the research project. The therapists had made video recordings of their sessions on a regular basis, so the research project did not represent a deviation from existing routines. The research project was approved by the Regional Ethical Committee (Regional Komité for medisinsk og helsefaglig forskningsetikk; REK) registered with the title "2012/685 Teknikker for mentaliseringsbasert terapi"

Transcripts. The three therapy sessions, summing up to 4.5 hours of video data, was transcribed into about 59.000 words. All patients were given fictional names, and all content that could compromise their anonymity were altered (i.e. names of friends and relatives, workplaces, toponymes). Therapist were designated the titles T1 and T2.

The transcriptions were detailed enough to permit an unacquainted reader to understand the following:

- Who spoke and to whom

- In verbatim what was said (including communicative sounds, laughter and stuttering)

- Descriptions of communicative gestures and facial expressions were written in parentheses

- Silent pauses with duration of less than two seconds were indicated with an ellipsis after the last uttered word, and longer pauses were written out in seconds

- Interruptions and overlapping speech were indicated with en dashes at the end of the interrupted sentence and at the beginning of the interrupting sentence

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Richness of data. This study is exceptionally thorough considering the substantial quantity and quality of data. Video-taping, transcribing and analyzing group therapy to the extent done here represents an extraordinary example in group therapy literature. Nevertheless, it must be acknowledged that the 4.5 hours of video-tape lends us only a glimpse into the reality of this particular group.

Procedures for Analyzing Data

As for most qualitative methods, familiarization with data is vitally important in TA. The author handled the data himself from the transcription phase, throughout the analysis and the writing phase. Effectively, the analysis started while the data was transcribed and continued in a period of 6 months. The analyzing process moved through transcription, repeated read-throughs of the transcripts, several meetings and discussions with supervisors, a feedback session with the therapists of the group in question, and ultimately ended while the first draft of the report was written. During these months there were periods of weeks where the data was put away, only to be brought back on the table for a new read-through. After arriving on a small selection of themes from the initial coding, the video material was watched once more to see if the themes could be supplemented or altered on the basis of visual and auditory information. Even though the inquiry was concentrated on therapist activity, patient activity was a necessary part of the analysis in order to appreciate the therapeutic process as a whole.

Thematic Analysis. A limited number of themes which adequately reflected the textual data were identified through an analytic process of coding, and integration of codes into themes. In the coding phase, the data was read over and over again, coding small segments with intuitive verbal descriptors. The codes were modified from one reading to the next, in the light of the developing apprehension of the totality of the data. Attempting to approach the data without preconceptions and expectations, the boundaries of the analysis was

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set on the basis of the emerging codes and themes (*focus-determined boundaries*; Lincoln &
Guba, 1985). In turn, themes that integrated substantial sets of the codes were formulated, and
at last, the themes were compared to the items of the MBT-G Adherence and Competence
scale (Karterud, 2012). The analytic process progressed from a mere description, where the
data was organized to show patterns without considering theoretical concerns, to an
interpretative phase where MBT theory served as an organizing principle in formulating
themes.

Credibility

We worked to achieve credibility following the standards suggested by Williams and
Morrow (2009). Several strategies ensured what we regard as a sufficient level of
trustworthiness in the results.

The first-author and one of his supervisors held a meeting with the therapists after
having landed on some core themes in the analysis. This meeting served as a means of
member checking (Lincoln & Guba, 1985), ensuring that the therapists were able to appreciate
our interpretation of the data. The meeting was primarily an opportunity for the therapists to
receive some in-depth feedback on their work, but before we presented them with our
observations, they were asked to say something about their own thoughts on the therapy group
in question. Then, when we had provided them with our feedback, the meeting took the form
a reflective dialogue where we "negotiated the outcomes" of our analysis (Lincoln & Guba,
1985). The therapists could help us adjust, develop, or confirm our understanding of the data
by providing us with information that was not part of the video-material.

The analyzing process lasted for 6 months, a time span that bear witness of a
prolonged engagement (Lincoln & Guba, 1985). By formulating themes we thought
subsumed important patterns in the data (hypotheses), we permitted the derivation of
appropriate counter examples.

The author had the primary responsibility for the analysis, and had regular discussions with supervisors (peer debriefing) about his findings. Being under supervision is thought to ensure trustworthiness (Williams & Morrow, 2009; Lincoln & Guba, 1985).

We are determined to make a thick description of the context and to illustrate our findings with examples from the dataset. Thus, we present our data thoroughly, as to make the transferability judgments possible for the reader. Alongside this reservation, we tentatively suggest ways in which our findings could be applied to the further development of MBT-G principles.

Results

It was immediately clear to us that the therapists met substantial challenges in dealing with this group. Significant borderline pathology influenced the discourse and the group process, evident both in what patients told about their life outside therapy and in the way patients acted in the group. The therapists obviously struggled to take the reins in a group characterized by chaos and diffusion of leadership.
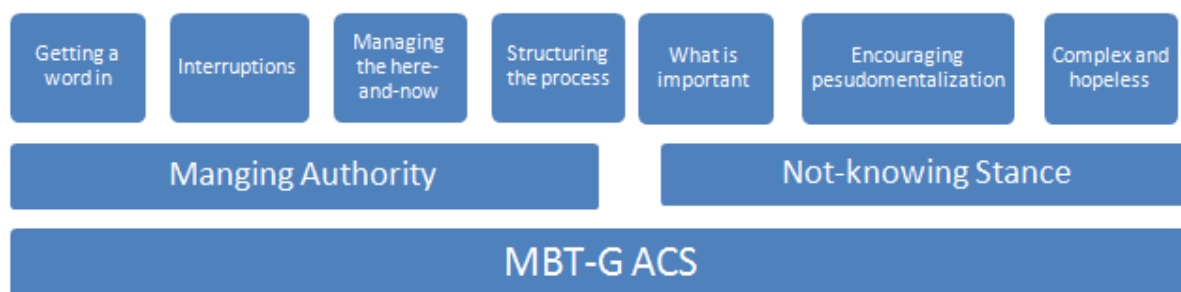
The main therapeutic challenge appeared to be that the therapists did not stand out as authoritative leaders. Furthermore, the analysis revealed that the therapists seemed to have retreated from their role as experts on psychotherapy and group dynamics, and instead, some patients had taken central positions in the group, controlling the discourse and conducting the process. Conceptually, this tendency could be associated with the not-knowing stance in MBT, and might explain why the therapists had been assigned a mere supporting role in the group, abdicating from their leadership. It was also clear that the observed alliance problems, primarily concerning lack of agreement upon the therapeutic project (tasks and goals), could be attributed to a lack of authoritative leadership as well as an exaggerated non-expert humility on the part of the therapists.

Indeed, our impression was confirmed by the therapists when we met them for the feedback session. They attributed their struggle to the fact that the group at an earlier point had been less structured (closer to a regular unstructured psychodynamic group), and that some patients seemed to work against the shift to a more closely structured MBT group. Early in the history of the group, the therapists were more laid-back and let the patients take on more responsibility for the therapeutic process. Along the way, some patients had become very influential in shaping the group discourse, and eventually, the therapists became reticent about their endeavor to transform the therapeutic process to conform to MBT-G standards. The observable effects of these circumstances were that the therapists (1) lacked authority, (2) seemed to "not-know" how the therapy ought to be performed, and consequentially, (3) had an ineffectual alliance with the patients, as they did not agree upon the therapeutic project.

Seven themes emerging from the analysis addressed the bulk of the therapists' challenges, and these themes corresponded to two MBT-G principles, namely *managing authority* and *exploration, curiosity and not-knowing stance* from the MBT-G ACS (Karterud, 2012; our translation). Figure 1 depicts the themes from the analysis, organized as they relate to the relevant MBT-G ACS items.

Figure 1: Organization of themes and corresponding MBT-G principles

Note: the figure displays seven themes from the analysis, and two of the 19 items in the MBT-G ACS;

Mentalization-based Group Therapy Adherence and Competence Scale

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Before text examples are presented, it should be mentioned that one of the therapists
(T1) is a recurrent character in the example transactions. Indeed, we are mainly concerned
with therapeutic challenges here, but we focus on challenges that have some connection to
MBT principles. The other therapist (T2) was commonly not involved in these issues, as he
generally adhered less to MBT principles[1].

We refer readers back to the method section to see how pauses, interruptions, and
overlapping speech are indicated in the transcripts. In the text examples, an ellipsis in
parenthesis [(…)] means we have omitted parts of the segment irrelevant for appreciating the
result.

Managing Authority

One would expect to see that MBT-G therapists would hold an elevated position in a
group of patients, especially when it comes to conducting the dialogue, deciding which
subjects to be discussed, when to stop up and think, and other tasks related to structuring the
process. As therapists are experts in mental health and group dynamics, one would expect
patients to listen to their suggestions, letting the therapists guide them through a narrative,
answering the therapists' inquiries, and so forth. However, in the group observed here, the
therapists were put aside, and a few influential patients were controlling the process. The
patients were permitted drowning their narratives in minute details, continuing on irrelevant
or unproductive sidetracks, bringing in non-essential events, and laughing off significant
problems.

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[1] One of the themes we arrived at on the analysis, but that was not included in this paper, was a
challenge associated with the collaboration between therapists. Perhaps a better functioning collaboration
between the therapists would have raised the total quality of the interventions. We would also assume that the
therapists may have strengthened their authoritative position through better collaboration.

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VIDEO-BASED EXPLORATIVE CASE STUDY

The challenges associated with managing authority will be presented through the four following themes: (1) *getting a word in*, (2) *interruptions*, (3) *managing the here-and-now*, and (4) *structuring the process*.

Getting a word in. The most conspicuous tendency witnessing the lacking authority of the therapists, was the obvious trouble they had making themselves heard in the group. As an illustration, we will first present a short segment from the first session. Rose – a patient the group seems to think has problems saying "no", setting sound limits for herself, and who seems to serve others at expense of her own needs – is telling the group about her Easter holydays. Rose talks fast and deliver extended monologues. Ahead of the following segment, she has been talking for about 7 minutes while T1 has made unsuccessful attempts to stop her, asking her to elaborate certain details. Interestingly, she seems to be responsive to the other patients, while ignoring T1's questions, and she continues an excessively detailed account of several loosely associated episodes.

> *Rose: (resigned exhalation) and then the father says-*
> *T1: -wait now, why do you (the group) believe Rose said that?*
> *(2.0)*
> *Rose: go ahead!*
> *Trudy: it's about being liked too, not saying «no», in a way-*
> *Rose: -yes but! It's eeh, not that way with Steve and Kirsten, because we get along so well. But it is-*
> *Trudy: -you're probably used to saying it anyway*
> *Rose: yes. This thing is related-*
> *T1: -what about the rest of you, why do you believe Rose said so?*
> *T2: why say «yes» when you mean «no»?*
> *(Laughter)*
> *Rose: and they're so fond of Trondheim, and-*
> *T1:-but hold on, hold on, hold on, hold on!*
> *Rose: yes, I'm sorry*
> *(laughter)*

<div align="right">(Session 1 – pp. 32)</div>

T1 is barely able to break in, and his previous attempts to get a word in were either unsuccessful, or Rose continued in her own way, ignored his inquiries. At this point, the group had been provided with seemingly irrelevant details concerning her visiting relatives, what food they ate, and minute-by-minute accounts of what happened from the beginning to the end of several frustrating episodes. Neither the patients nor the therapists were in the

position to adequately mentalize on the basis of the narration. The laughter transpiring in the segment appears to come as a result of Rose's feverish haste in telling her story from A to Z, and also T1's frustrated attempts to stop her. The group was obviously finding her rampant narration amusing, and seemed to find T1's awkward attempts to stop her funny. Even though one can imagine the frustration felt by the therapists, they joined the group in its amusement. T2's short and apt wording of the account is humoristic, but it does not help T1 reaching his agenda. In the following segment, T1 also leans upon humoristic irony to verbalize what evidently is a significant problem to him. Sarah is talking and he is trying to stop her, but she waves him away claiming she will soon be done.

> T1: -what are, what are the rest of you thinking?
> Sarah: -and I have also been saying «it's not- I'll not set up criteria to a man about "hey you are not allowed to" and stuff like that». I've only said that «I don't want to, based on my own»-
> T1: -let's hear from the others (holding his palm up: stop)-
> Sarah: -yes but eeh, I'm finished now! And then he said like, that-eeh «I'm not so sure of that»
> T1: -(nods)I believe you (ironically)-
> (scattered laughter)

(Session 2 – pp. 13)

Interruptions. A related challenge was a high rate of interruptions on the part of the patients, and this tendency was most evident when T1 was speaking. As mentioned, T1 is also the therapist who most eagerly confronts the groups with mentalization-based interventions. Interestingly, T1 seems cautious to excuse himself when he is the one interrupting a patient. In our feedback session with the therapists, he could inform us that being interrupted was an issue he was aware of, but also, that he restrained his urge to interrupt patients because they had reacted with aggressive accusations of being gaged on earlier occasions.

In advance of the following segment, T1 had made many unsuccessful attempts to stop the ongoing interaction. He opens with excusing himself for interrupting Sarah, but ends up being ignored and not getting his point through.

> T1: I wond- I'm wondering, I s- I think I interrupted you earlier, Sarah, eh if that's the case I'm sorry
> Sarah: (shakes her head)
> Isabel: (to Rose, while T1 speaks) not to be nasty

Randi: no! But I see what you're saying
Sarah: (to T1) what?
T1: I thought- uh, you said something like «what can youth understand? »
Sara: yes
T1: (draws his breath) wha- how-
Sarah: -I think she may have to high expectations to them -
Rose: -now I tell you what, I don't think so! That's the least you can expect from someone who's turned twenty years old!-
Sarah: -nooo-
Rose: -but – but youth, are different too!-
T1: -yes, wha-
Rose: -that's, they are
Sarah: you must bear in mind that people express love differently!
Rose: yeah!
Sarah: like Jesus, you can't, like I understand that you may hav-
Rose: -but! Yes that's exact- that's exactly what they-
Sarah: -what kinda expectations- if you have expectations it's just the same as being let down
T1: but wha-
Sarah: -you're better off having no expectations and let them show you love in their own way!
Rose: and that's what I think I'm doing too, cause that's how I am, and that has nothing to do with the kids, and it can be something that, maybe something is supposed to take place and I think «no, it's not gonna happen anyway»
T1: (draws his breath)
Isabel: that's something to remind them of too then. What you actually do for them! Because they're- most kids are certainly, spoiled!
Sarah: yes but how are they supposed to know- and we acknow- or express love when you don't tell them what you want then?! It's like you have-
Rose: -I have told them!
Sarah: yes but, once then!
Rose: no, I have told them several times after that too-
T1: (says something that drowns in Rose's speech)
        (In the sequel: T1 does not get a word in)

(Session 3 – pp. 18)

The next segment has a similar structure. T1 tries to conduct the discussion and to stimulate mentalization of Isabel's son, Justin, who is being very inquisitive about Isabel's reasons for being unemployed. It opens with T2's tendentious laughing, and continues with T1's unprofitable endeavor to turn the perspective towards the minds of the people involved in the subject matter. Instead, Sarah is eager to recommend Isabel ways to answer her son.

T2: yes ha ha (laughs)
T1: okay-
Isabel: -okay! Who is-
T2: -he oversimplifies-
Isabel: -driving them to practice? Who picks you up and brings you to school? Who is it that sits down with you to do homework? Who washes your house? Who is
T1: what do you think-
Isabel: -ah!-
T1: -what ma- what- what makes Justin say something like that? Why-
Sarah: -why can't you (Isabel) say that-
Isabel: -he doesn't see what he has! You know, a kid-
T1: -okay but let's! Let's check in with the others! (Looks over to Isabel) Let che- okey I'm interrupting you (Isabel)-

Isabel: -(laughs a bit)-
T1: -but I'm thinking it might be necessary-
Sarah: -why can't you say that – can't you say that you stay at home, because uuh, because you are taking care of your family and your home then? And resourceful parents have the opportunity to stay home?
Isabel: well I have said that. «you see, Justin we are lucky!»-
Sarah: -yes mum did the cooking, we were-
     (In the sequel: T1 did not get through)

(Session 3 – pp. 25)

In the continuation of this segment, T1 tries to track the progression of the discussion. Isabel has just brought in a new event, but the first event had not yet been explored fully. This is a frequent tendency in the group: patients jump from one account to the next, and the therapists are not able to help patients dive deeper into single events – an endeavor that might be thought of as a hallmark of MBT. First, Isabel seems irritated by T1's interruption. When T1 indicate that Isabel is following a side-track, and asks openly if it has any connection to the initial subject, he is more barfed at than answered. Whatever T1 is trying to do, he gives in and remains silent for a while afterwards.

T1: but-
Isabel: -right And this was a class that cost, thirteen thousand kroner, right-
T1: -Isa- Isabel
Isabel: yes?! (groans)
T1: what is – bcs- this sounds terribly frustrating
Isabel: and it is! Because I feel like just s- saying «okey!» to the social security guy so that he becomes satisfied and can draw aaa, smiley in his journal aand. Ah I'm fed up!
T1: where wh- ah- is this relat- that is, you- we started out with this-
Isabel: -(groans)-
T1: -this episode with Justin and those things, and then we came on to these things
 Isabel: m
T1: are these things related in some way or?
Sarah: it's certainly related-
Ingrid: -yes it's about having nothing to do!-
T1: -right (nods)-

(Session 3 – pp. 30)

In the sequel, it is clear that T1 pulls away and accepts that the patients regard the new event as significant and worthy of exploration. However, the same tendency continues: the therapists do not get in the position to ask for elaborations of single events.

Managing the here-and-now. In the following segment, a noteworthy event takes place, as Sarah launch an attack at Rose. The precedent event discussed here is a

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misunderstanding between June and Isabel, where June interpreted a comment from Isabel as

an accusation of being fat.

> *Sarah: -like, that's just the way it is, but like, I- I und-. Isabel meant like, you know this «everything is better than being th- than being fat» I disagree with that. Like I would rath-*
> *Rose: -what can I say then, me being fat?!-*
> *Isabel: -(to Sarah) that's not normal you know-*
> *Sarah: -I would rather be «a bit chubby» (makes quotation marks with her hands) while having gorgeously rich hair, if I was having that, than being balled and skinny. So to me it's like, like something in between then.*
> *T1: «what can you say, you are fat» you said Rose.*
> *Rose: yes! What can I say? Being that! While you others are sitting here all slender. And dashing women! And I'm sitting here, soon to be fifty aaand, fat!*
> *Sarah: how much do you weigh?*
> *Rose: weeell thats… thats*
> *June: weight is really quite, you eh- shouldn't really trust the weight*
> *Sarah: weell, you do get like an indication of what*
> *June: an indication, but, but-eeh, you shouldn't eh- that's what I've learned*
> *T1: sounds like you're a little irritated, Rose*
> *T2: m-m yes*
> *Rose: and the two of you (therapists) know all about that-*
> *Sarah: -but I get a little irritated too when you (Rose) say that! Because, eh to be like, uh like «this» (gestures towards her belly), it's tough work, like it doesn't come of itself, I'll tell you I haven't been sitting around eating at night, candy aand overeating, that's, once a week at tops*
> *Rose: m-m*
> *Sarah: then you get g- mm, I'm hungry eighty percent of the time, so that, eh, it's like when p-, people, I get a little like ss-, fed up with people seeing a slender lady, and then going «oh look at her, she is like slender» and stuff like that, like but, it's tough work that has got me like this*
> *Rose: Sure! I get that-*
> *Sarah: -you get what I'm saying?-*
> *June: (raises her hand and is about to say something, but stops)*
> *Rose: -ye-ye-yeah! yes-*
> *Sarah: -it doesn't come of itself, it didn't come falling from the sky you know*
> *Rose: nonono! Not at all*
> *Sarah: so that's what I mean then*
> *Rose: m-m*
> *Sarah: yes*
> *June: (addressing Sarah) yes but like, she (Rose) is struggling with eeh (looking at Rose) wa- wasn't it overeating?*
> *Rose: m-m, yees, actually it's mostly that I'm eeh, too sedentary really… Because I'm not capable of eating that much after the surgery*
> *June: yees*
> *Rose: soo, so it's mostly that, with-ee… yes, that I've been too sedentary. It has ruined*
> *Isabel: how much are you actually able to eat?*
> *T1: (draws his breath, looks into the air and seems thoughtful)*
> *(…)*
> *T1: but- yes (looks blankly at Rose)it wa- it wa- are we turning to- eeh turning-*
> *Rose: (waves deprecating with her hands) –no we don't have to, just finish off-*
> *Sarah: -but you lost fifty kilos, didn't you? How much did you gain later then?*
> *Rose: well, gained around fifteen then, fifteen. Between fifteen and twenty*
> *T1: (tries to break in) but-but-*
> *T2: -but as I remember the scare was mentioned, in that discussion «whether it was», that is «where- when are you happy and when are you satisfied». That is, «will things be better if I lose weight? ». It was in association to that it came up, wasn't it?*
> *June: yes…*
> *T1: yes, because- eh because, I wasn't intending to interrupt you (Rose), but I was wondering if we were about to get into –eh, into food quanta and stuff like that. We get into that quite often-*

Rose: -no but, just finish it off already
T1: no but it's, I think reall- I think you are giving an important input. Bh-
T2: m
T1: Because you are saying something about eh, how you are reacting to, others, referring to themselves as fat

(Session 2 – pp. 26-27)

Sarah is clearly provoked by Rose complaining about having to hear the other

patients' fears about gaining weight, while she herself is overweight. The essence of Sarah's

attack on Rose seems to be that she can only blame herself for being fat. Furthermore, being

thin is hard work; there is no simple way to lose weight, while being fat is essentially being

too lazy to work out.

Sarah's attitude is more clearly articulated later in the same session. Here, Rose is

telling the group enthusiastically about a diet programme she has been admitted to. Both June

and Isabel is enthusiastic on behalf of Rose, but Sarah is skeptical about the programme, and

she assumes it does not involve the right kind of exercises. She also brings in the fact that

Rose had surgery (gastric bypass), which she seems to think is a simplistic and ineffective

way to lose weight, as you primarily lose muscle mass, she argues. She repeats that losing

weight is hard work, referring to the TV show "the biggest looser", implicitly accusing Rose

of not having the stamina needed to lose weight. In the following segment, the discussion has

cooled off a bit and the therapists tries to raise questions of what just happened:

T1: yeaaah-weund-we- how are you misunderstanding each other here?
T2: I didn't get his, what happened just now?
Sarah: no well I'm-eeh, she is-
T2: -weighttraining?-
(...)
T1: how ee-
Rose: -but it's partly that iiit's, but I have to check it out, cause I don't know-
T2: -sounds like-
(...)
T1: (tries to get a word in)
Isabel: -you're thinking, you're getting something to think of!
Rose: -yes-
Isabel: -like-
T1: -yo-you-you! What-
Isabel: - ah! I'm almost wishing it was me!-
T1: -eh wh-
Isabel: -that was having it like *crch!* (clenching her fist)
Sarah: it's an awesome gift to get like all-eh, all those opportunities

> *Isabel: m-m*
> *T1: it seems that-eh-*
> *Sarah: -because it's impossible to get hold of a nutritionist in this city, I have tried myself-*
> *T1: -it seems that Sarah and Isabel had somewhat differing approaches to this, did anyone else take note of that?*
> *June: I noticed*
> *T1: yes what did you take-take-what did you-*
> *June: -well she (gestures towards Sarah) got all caught up in how you lose muscle mass. So that's just bullshit*
> *Sarah: it's not bullshit (looking down at the floor)*
> *June: (looks with a little smile towards T2, then at T1, then at Sarah)*
> *Sarah: (turns towards June) it's not! (smiles)*
> *June: yes it is! (smiles)*
> *Sarah: no! You lose muscle mass-*
> *June: -yes, cause, if you merely do cardio training-*
> *T2: -is there a truth to this? Is there a truth to this then?*
>
> *(Session 2 - pp. 41)*

The therapists had significant problems handling this, and were not able to bring sufficient attention to the here-and-now. Instead, as the therapists attempted examining the current events, Sarah appeared to do a turnaround, and took on a positive attitude towards the diet programme. Then, instead of discussing the process, June and Sarah continued their quarrel about the specifics of the programme, and were not stopped by the therapists. Although we do not know the exact details of what went on here, it was clear that the situation was saturated with emotion, and there was more going on at an implicit level than the explicit discussion revealed. From a mentalizing point of view, it would be highly relevant to bring attention to the process here.

Structuring the process. The therapists had significant problems planning the sessions. Patients took long to call in their events, and if they did, they usually were not able to keep it brief, but started to give a detailed account as if the therapeutic work had already started. The therapist's task was then to stop them, and ask if there were any other contributions. The following segment serves as an illustration.

> *Sarah: and dating is like, so stiff! Getting home to take a shower, dress up, and fair enough I like that, I do, but-*
> *T1: -but wait a minute, wait, Sarah, wait! Sarah! Sarah, wait a minute-*
> *Sarah: -it's so,it's so stiff!- (laughs)*
> *T1: -hold on Sarah! (smiles) ee-*
> *(scattered laughter)*
> *Sarah: but is it important?*

T1: is-is, shall we- is – is your relation to him an important subject to you, and how it has been?
Sarah: no, we don't have a relation yet
T1: no okay, but okay, it's eh, I'm not speaking of a relation as a romantic relationship, but considering, you have a relation to him because you've met him, and it means something to you. And it is a relation in that respect, is what I meant. Becau- That is, not a relation as in a romantic relation, but your relation li-li, considering that he, is a man who arouse some feelings
Sarah: oh yes, but I fear that I will end up with the same thing I had with Chris, because, I already get a sense that-
T1: -yes, yes (gestures: wait, stop, enough already)
T2: -this sounds like an important event
Sarah: -it seems to be one of those warning signs, with all this, like fixation on appearance-
T1: -yes, but hey, but wait a minute
Sarah: yeah! I'm waiting!
Isabel: (laughs)
T1: yes (laughs)
Isabel: there's no way to stop you, when you've started!
Sarah: (laughs loudly, puts her hand in front of her face) aah! I feel like I'm (unintelligible)
T1: but perhaps, eh like, perhaps it's important for you to have a look on this matter?
Isabel: it would be even more abnormal if you did not feel like this! If not you would have gone blindly into something with someone- one that you might as well had found completely uninteresting, just to see if there was anything to it-
Sarah: -yes, but I'm thinking it's better-
T1: -hold on! Okey! (gestures: stop, wait)
T2: now we're working!
T1: now we're working again, let us –s-s-s,say this is a theme
T2: yes, it sounds very interesting
T1: are there anyone else who have eh… anything?

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(Session 2 – pp. 5)

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Ideally, the planning phases are confined to a few minutes, but ten minutes after the segment above the group had not yet started working. Between the segment above and the segment that follows underneath, T1 had a significant challenge helping Isabel specify an event she wanted to bring in. In the following segment, the therapists have another round of negotiation with Sarah about her contribution, and T1 ends up shouting out a plan for the session while Sarah has already started talking. T1's planning seems to be done haphazardly, and his leadership has no real function as the group is working independently of him.

T1: -but wait a minute! But are we- now we're discussing who goes first and last
T2: yes prioritization-
T1: –starting to prioritize. Eh, I think it seems to be an important theme, I don't know whether-
Sarah: -but I know! I've been bunt, I have, eeeh been burnt before from messing around with those kind of men-
T1: -yes(nods) mm-
Sarah: -and I've spent my time talking about them instead of talking about myself. It has been-
T2: -yes that's, we can talk about that, we can talk about that-
Sarah: -I'm not getting involved in some dependent, destructive relationship, where it's all like fixation on appearance and stuff it's
T1: go on and tell us about it, and weh- we'll help you reflect on it
Sarah: yes, but the most important thing is that I've been doing so good, really…
T1: yes

T2: yes (laughs)
Isabel: (laughs)
Sarah: that's what I've landed on-
T1: -but are we about to-h, hold in, Isabel, no Sarah, weren't you interested in talking, telling us about this today?
Sarah: yes, but I don't think it's important enough, because I'm doing fine. If there's, I'm sure some of the others (patients) are struggling more than me right now –
T1: -but what are you others thinking? What are you guys thinking?
Isabel: well I think it sounds important
Sarah: yeah but it's really not, I'm doing just fine (smiles)
Isabel: (laughs a bit)
(3 seconds of silence)
T2: but it occupies you?
Sarah: ...yes
Isabel: but is it- is it more of a lovely feeling of being uncertain, or are you more anxious about it-
Sarah: -both-
Isabel: -yes-
Sarah: -no, it's more anxiety, more anxiety, terrible-
Isabel: -is it? But yet you're smiling!
Sarah: Yes! But it's like.I think it's a hotchpotch of like, many things, but at the same time I've got some confirmation that-
T1: -yes, but hey!
T2: actually we're working right now with-ee Sarah, otherwise we haven't prioritized-
Isabel: -why can't we just go on then?-
T1:- yes, yes, m-m-
Sarah: -besides I've, eeh got confirmed that my brother has like pretty serious alcohol problems, so thats a downer…
T2: so it's mixed
Sarah: it's very, very mixed-
T1: -we'll start now, we'll start working with Sarah-
Sarah: -because eh-
T1: -then June, and then we'll see where we end up (gestures towards and looks at Rose)-
Sarah: -in the easter holyday-

(Session 2 – pp. 10 – 11)

A related task for the therapists is to stop the therapeutic work of one patient, and allow the next patient to enter the arena. Ahead of the following segment, T1 has been trying to stop Sarah for about four minutes. The segment bear witness of his struggle to structure the session, but this is also an example of an opportunity to bring attention to the here-and-now. Sarah is clearly mocking T1, and she is fully aware that she has been ignoring him for some time. Unfortunately, with Isabel praising Sarah for her effort and thus creating an optimistic atmosphere, it is difficult to insist on calling attention to an unpleasant aspect of the ongoing process.

T1: I'm thinking we might be stopping there
Sarah: yes, we've stopped several times! (smiles and imitates T1's «stopping-gesture») «we'll stop here!» «we'll stop here!»
(unintelligible comments and laughter)

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Sarah: no, I'll zip my mouth now (straightens herself up in the chair)
T1: you get eager, Sarah
Sarah: yeeah, but-eh-
Isabel: -but thats a good thing!-
Sarah: -but you'll have to praise me, I've been good and worked out a great deal-
T1: -yees-
Isabel: -I think you're doing great-
Sarah: -and I've been working on loads of other stuff here too
Isabel: I get really impressed with you, when you're doing well in your job, and you've been working out and have regular activities and stuff!
Sarah: yes
Isabel: it's got to be just wonderful!
Sarah: yes…
Isabel: (laughs)
Sarah: but then I feel sorry for myself some times
T2: (laughs)
Isabel: who doesn't?
T1: yeah, okay! Shall we move on?
T2: (laughs)
Isabel: not to render it commonplace though-
Sarah: -no, I know! I know, I get what you're saying, everybody feels the same. I'm normal! (looks at T2)
T2: mhm (nods)
Sarah: I'm one among many (smiles) I'm not-
Isabel: (laughs loudly)
Sarah: -I'm not on my spaceship anymore!
T2: (laughs)
Rose: (laughs)
T1: (smiles) I'm getting the feeling that eh, I've been repeating myself a number of times now
Isabel: (laughs on)
Sarah: okay, zip! ("zips her mouth")
T1: where were we?

(Session 2 – pp. 22)

Yet another aspect of structuring the therapeutic process is guiding the patients into a mentalizing discourse. The following segment lasts for two and a half minutes, but is shortened, as it proves the point without presenting it as a whole: T1 is not in the position to guide Rose to be more specific. Instead, Rose ignores T1, goes on in her own way, and finally gives Isabel the permission to speak at the expense of T1.

T1: -but!-
Rose: -but then, that's the way it goes, it's the food that eeh-
T1: -but whe-when! When are you eating then, yesterday? I-fee-I-thi- I think it's a good idea to be looking at «yesterday», not because it was unique or the worst of all-e-e episodes in the world, but because it was yesterday, and you remember it pretty well. Cause I, wonder what- when-when do you turn to the food, because now we've- because if we get this then we've got a descent-
Rose: -I turn to food when I'm glad when I'm sad, unhappy, depressed!-
T1: -but yesterday! (points his finger quickly at Rose)-
Rose: -and ordinary-
T1: -but in-
Rose: -a completely ordinary day!
T1: but yesterday, when did you turn to food?

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Rose: no you know I can't tell you that, because it's regular! It may be a bisquit I can stuff in an half an hour after I ate a slice of bread
T2: m
(…)
T1: no cause I-I bcs-…
Rose: yes go ahead, Isabel
T1: yes (gestured towards Isabel, laughing)
(…)
T1: (draws his breath, raises his hand to get a word in)
(…)
T1: -but!-
Rose: -so then- then I like had to decide to put my foot down cause this time I'll-
T1: -but-but guys-
(…)

(session 3 – pp. 9)

MBT-G therapists are responsible for starting and ending the sessions in a manner that contributes to a sense of coherence. This was not accomplished here. First, the therapists in the present group are not referring to the previous session in the beginning of any of the sessions we observed. Secondly, lacking the authority to interrupt an ongoing narration, they never get the chance to end the present session with a summary. Instead, all of the sessions we observed were ended haphazardly, usually with T1 attempting to stop the patients for several minutes before he is forced to refer to the time and end the session abruptly.

The following segment is the end of the first session. Rose is stopped in the middle of a frantic effort to pack in more details about her life in the very last minute.

T1: (draws his breath) okey
Rose: yes, cause now we're s-
T1: -it's – it's-
Rose: -we're watching some detective story, right? And Kirsten comes in halfway thorugh, because her girl wouldn't sleep. She had to lay down with her and sing, until she fell asleep! (frowns)
T1: clock is ticking
Rose: where the hell is normality then?
T1: well, so you say. Clock is ticking. And we could be looking at many things here, cause I can hear that-–
Rose: -could sit for one more hour!-
T1: -sounds as if, there is a lot being stirred up here, and it gives rise to many episodes that has provoked you. Eeeh, and I think it's great that you bring it up… Think it's-
Rose: -it's just whining
T1: is it just whining?
Rose: so now it's all about doing a turnaround, now, to begin thinking about myself again. And that's, something I have been thinking of alot, that's something I find so hard now. Because that's the way I am, now I'm all grumpy and irritable, and to make matters worse daddy just fell, cause he was moving, Saturday. (Looks at her wrist-watch) I'll hurry up!
T1: (laughs)

Rose: He fractured his kneecap! And boy do I feel bad for not visiting my mum in the Easter holydays, because we had visitors at home the whole time. So now I have. Thomas is calling me constantly, and jesus I'm driven crazy! So I think I have to go off to somewhere. Go to Hawaii or someplace like that-
Trudy: -Spain-
Rose: -be gone for a month. Or two, or three, or four.
Sarah: and why not?
T2: (laughing) take off or take a stand
T1: okey! That's it for today.

(Session 1 – pp. 34)

Not-Knowing Stance

Overall, the therapists were seen as exhibiting a meek attitude, not only towards the patients' inner world as MBT prescribe, but also towards the therapeutic process as a whole. This was evident in the way the therapy was unfolding throughout the sessions, and we also saw this tendency as interrelated with lacking authority. Our hypothesis is that not being seen as expert inevitably limits the possibility of holding a leading position in the group.

The following example is the continuation of a segment presented earlier, and is an illustration of T1 handling the structuring of the therapeutic process through "knowing" what is important. It serves as an excellent *counterexample* of the therapists tendency to overplay the not-knowing stance.

T1: -we'll start now, we'll start working with Sarah-
Sarah: -because eh-
T1: -then June, and then we'll see where we end up (gestures towards and looks at Rose)-
Sarah: -in the easter holyday-
T1: -but where are we starting now? Are we starting with your brother now?
Sarah: yes
T1: is that the subject?
Sarah: yees
T1: -I didn't get-
Sarah: -this was the first thing I thought of when I woke up this morning
T1: ok, but what you brought up earlier was your relation to this man-
T2: -man
Sarah: but! It's no relation when I met him-
T1: -indeed it's a relation-
T2: -no, but it's a person then, a pers-
Rose: -hey but, we're allowed to bring up two things?! (asking T1)
T1: ...eeh-uh, you easily, you often get more out of bring-bringing up one single thing
Rose: -but in my opinion it's important (unintelligible)
Sarah: (speaking simultaniously with Rose) but I have no relation to this man yet, perhaps I'll meet him tonight and find out «oh my god what a jerk! »
T1: m-m
T2: yes
Sarah: and then I've like wasted my time here-

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T1: -yes but we're not sure, yes but we're not sure that this is important. But if it's not important, then-eh, or-eh… is it more important for you to work with this relatio-or th-this episode with your brother?
Sarah: …no it can wait, cause I-eh I've handed it over to mum and dad, they are the ones to
T2: m-m
Sarah: talk to him and stuff
T1: but as I und- like, your relations to men, has been a pretty central issue for you
Sarah: yes indeed it's central-
T1: -and you've been, you've been wishing for it, and now you're in a dating situation, and you're afraid to repeat old patterns
Sarah: yes
T1: I think this sound like an important matter
Sarah: yes indeed it is, you know. What is happening is that I'm starting, already staring envisioniiing, that I'll go into the same stuff I had with Chris.
T1: why don't you tell us some more, and then we can help you think

(Session 2 – pp. 10-11)

We often observed that T1 was extremely hesitant to suggest that he had some knowledge of what the focus of a patients' therapeutic work should be. In this example, he was struggling to help Sarah specify a problem area to work with in the session, but as soon as he suggested that relations to men were troublesome to Sarah, she immediately agreed. Sarah was indeterminate of what to bring up, until T1's open proposition put an end to a prolonged indecisive process.

We will present three aspects of the not-knowing stance that seems to be important to understand the therapists' challenges. The challenges are associated with knowing (1) *what is important*, therapists' unwittingly (2) *encouraging pseudo-mentalization*, and chaotic narratives leading patients to conclude situations are (3) *complex and hopeless*.

What is important. The therapists had huge difficulties conducting the group, and especially, spent extremely long time on the opening phase of each session. Partly, this could be understood as a consequence of the phenomena already illustrated under the section "managing authority". However, it was also quite clear that, apart from not holding an authoritative position in the group, few signs of the therapist holding an expert position were apparent.

In the following segment, Sarah has just been narrating about her beginning relationship with a new man. From the segment above, we understand that relationships are

problematic to her in many ways. But as T1 asks her what she is afraid will happen, she

answers that she is afraid to get stomach trouble and be embarrassed. This might be true, but

T1 draws on what Sarah said earlier when he asserts that there is another important aspect to

the situation. He suggests that Sarah is afraid of getting into a bad relationship and ending up

repeating old patterns.

> *Sarah: and I'm thinking like (smiles)*
> *T1: but-eh is that what you are most anxious about now, because bcs-th-*
> *Sarah: -I'm mostly-*
> *T1: -I-eh was a little surprised with your answer, cause you you-*
> *T2: -m-m-*
> *T1: -I would have thought you'd say «I'm afraid that-*
> *Sarah: -not s-*
> *T1: -I'll engage in a relationshipt that eh, is not making me feel, not making me feel good, and that is not good for me, and that may lead to me starting drinking again». That's what I would have thought was your answer*
> *Sarah: no, that's no problem*
> *T1: your're not afraid of that?*
> *Sarah: no like, I'm such a badass when it comes to that stuff, I... I'll just *pyssh* (gestures «tossing something over her shoulder») «enough of that», but-eh*
> *T1: what do you think about that I thoug-e-about my understanding of the situation?*
> *Sarah: I understand that because that's what's normal, but I feel that by now I've been working so hard with myself. I'm that independent, that I, have, I'm standing on my own two feet dammit, I used to be terribly emotionally dependent on Chris, but no more of that, I refuse to be emotionally dependent on another human being-or to be dependent on another human being in any way. Eeeem, and I have so many other things in my life that I've filled my life with, so there is no, even if I like meet him a couple of times more and find it's not working out, I'm thinking «well well, but at least it's one more lesson learned», like it's*
> *T1: what are you others thinking about this?*
> *Sarah: like it's not, life's not over*
> *T2: no*
> *T1: ... what are you thinking?*
> *Rose: well, it sounds like. Terrific and you seem so incredibly strong. M-*
> *T2: -how can you figure out how much he is drinking then?*
>
> *Session 3, pp. 17*

While T1 questioned Sarah's denial, he was cautious and mild. Instead of being more

persistent, he called on the group for support – a typical pattern seen in our data. T1 was

clearly on to something, and he was trying to raise some seemingly important questions,

challenging Sarah's understanding. He hinted towards alternative perspectives, but was also

extremely hesitant. He asked the group what they were thinking; apparently hoping they

would pick up on his cue, but unfortunately the other patients (or T2) seldom follow him, and

he ends up not getting his point through.

Encouraging pseudo-mentalization. We have already seen that the therapists had substantial problems conducting the group, and had small chances of structuring the therapeutic process because, we assert, they lacked authority. One of the standard interventions from T1 was, on the basis of narratives from patients, to ask the group what they were thinking about the situation, what they believe was going on in the minds of the subjects of the narrative, what they were feeling, and why they were behaving the way they were. However, as a consequence of a poorly structured process, the information material the patients are asked to use as a basis for mentalization, is extremely vague. Upon T1's questions, this vagueness leads the patients to make general assumptions, suggest stereotypical explanations of what is going on, and oftentimes simply provide solutions to the problem they are presented with. What seem to be efforts to mentalize is not grounded in an appreciation of real events, not physical nor psychic, and must therefore be based on their phantasies and assumptions of what went on. That is, the patients' mentalization is often not based on reality to a sufficient degree, and may therefore be understood as pseudo-mentalization. T1 is actively, but presumably not deliberately, stimulating pseudo-mentalization instead of mentalization.

> *T1: (expires:) hoi!*
> *T2: m-m*
> *Trudy: but not that exact episode thought, the condom-stuff, because then… I had already caught him cheating, so it was already over, but I had the key to his apartment, so that was no sweat. And eventually she got fired*
> *T1: but… there- there's been terribly much going on here-*
> *Trudy: -m-m, (laughs a little) there's usually some action –*
> *T1:- a-a-and, what are you (the group) thinking? Eeeh…. How do you think Trudy has been doing? (Trudy laughs)*
> *Rose: you do have a fierce temper*
> *Trudy: yes I do*
> *Sarah: it's because you're not able to free yourselves from the sorrow, I think. So you get angry instead. There's always something lying under the anger-*
> *Trudy: -but I've always had my temp-*
> *Sarah: - There's always something lying under the anger!!-*
>
> *Session 1, pp.21-22*

In the following segment, T1 has been attempting unsuccessfully to get Rose to be specific about one episode from the day before. In the end T1 seems to give up, and instead tries to involve the group in mentalization on the basis of Roses chaotic account.

> T1: I believe you're on to something. How to you think this, what was it- what do you think Rose may have wished for yesterday? On a day like yesterday?
> Sarah: it's like being seen as she is, and what she does, and who sheee
> T1: who do you thin- wh- who- who would she- wha- it's a bit of a guesswork but
> Sarah: I don't think this is about her father, but it's like that's. Mmh that's like one, out of all, but it triggers something, but it's not just that, it's a lot of stuff I think
> T1: it's a lot, but what about yesterday? Like with- who- I agree with that. Like it's- we can- like eh- yesterday can't explain everything
> T2: (says something unintelligible simultaneously with T1)
> Sarah: it's a real hotchpotch, about «no now, now» yes
> T2: m
> Sarah: it's like-
> T1: -what do you think she wants from, her father or Lindsay (Rose's daughter)-
> T2: -Lindsay-
> T1: -or-eh yeah stuff like that?
> Sarah: like more love. Or like more explicit love, I think
> T1: for example?
> Sarah: weeell «you're so good» aand «hang in there!» aand, I feel like when I get, when mum and dad are very like, praising, like dad thinks I'm clever simply if I pick up a plate from the dishwasher, so that's like-

> Session 3, pp. 13

Sarah says there are many factors involved here, it is a "real hotchpotch", and struggles to be specific. The claim that Rose needs more love seems to be a generic psychological explanation not specific to Rose's situation, and could be regarded as a cliché. She tries to bring in some experiences from her own life, but they are only loosely related to Rose. In our opinion, there is not much more to say on the basis of the information Rose provided the group.

Complex and hopeless. In connection to the phenomenon above, presumably as a consequence of poorly described situations, often with an array of irrelevant details and sidetracks, the patients are merely responding to T1's questions with answers that reflects their feelings: this is too complex to appreciate. Most narratives in this group are, in fact, extremely complex. They are overflooded with irrelevant information, and are not depicting a specific situation

On other occasions, with patients presenting more than one problem at the time, the group responds with hopelessness. Instead of diving into one problem at the time, the patients often reel off a number of problems, all with too little background information to appreciate the vital aspects of their struggles. This often leaves the group with concluding that the situation is "hopeless".

General Discussion

We did a video-based case study of a mentalization-based therapy group treating borderline patients. Our aim was to (1) study the therapeutic process of a MBT-group to explore what challenges therapists were facing in their quest to establish a mentalizing group culture, (2) and to connect these challenges to MBT-G principles. This leads us to a discussion of the difficulties associated with transfering scientifically validated treatments into routine clinical practice.

Through repeated coding and formulation of themes based on codes, we discovered that several themes were highly related to two principles in the MBT-G manual: managing authority and the not-knowing stance (Karterud, 2012). The therapists in the group we observed seemed to struggle to manage their authority in an efficient fashion, and also exhibited what we saw as an exaggerated not-knowing attitude towards their therapeutic work. That is, the therapists were seen to adhere minimally to the ACS-item managing authority, while the not-knowing stance was overplayed.

Upon further reflection, these two principles actually appear to be in conflict with each other, both logically and conceptually. However, this conflicting relationship has not been discussed directly in the treatment manual, which leads us to assume it has not been given sufficient attention in earlier writings. The MBT-G ACS consists of 19 items, of which nine are specifically formulated for the group modality (Karterud, 2012). The remaining ten are modified items from the individual version of MBT (Karterud & Bateman, 2010).

Interestingly, the ACS item describing the "not-knowing stance" is adopted from the individual manual, and is a central component of MBT in general, while the item "managing authority" is exclusively formulated for the group version of MBT. Perhaps the challenge of accommodating MBT to the group modality is the most vital aspect of this study. The bulk of the development of MBT has taken place in the arena of individual therapy, and strikingly few accounts of how to conduct MBT-G is available. While MBT in general encourage therapists to take a not-knowing stance, group psychotherapy with borderline patients seem to have some inherent challenges that complicate a straightforward interpretation of this particular principle. We assert that taking a not-knowing stance may be at odds with the authoritative leadership the group format requires, especially when the group consists of borderline patients. The not-knowing stance of the MBT therapists may have fundamentally different consequences in a therapeutic group compared to individual therapy.

Following the MBT-G manual, if a MBT group is as chaotic as the group observed here were at times, therapists should calm down the atmosphere, since mentalization is a capacity that is seriously depleted by high levels of affect. Karterud (2012) states directly that regulating group arousal necessitates an authoritative therapist (p. 172). Interventions such as stopping an ongoing interaction and changing perspectives to calm patients; anchoring the dialog, persistently drawing attention to the most important aspects of the situations described or unfolding in the group, and interrupting derailments – all implicitly involves "knowing what is important". We assert that a guiding principle behind authoritative leadership would be "knowing something", and intervening astutely on the basis of this knowledge. Further, when we claim that the not-knowing stance of the therapists seems to be misconstrued and exaggerated, we stress that therapists are not supposed to be not-knowing in matters of group dynamics or core borderline pathology. On these areas, therapists are experts, while the not-knowing stance is relevant in the understanding of a patients' specific state of mind and the

following intersubjective transactions. According to our understanding, the therapists did not

get in position to explore the patient's state of mind (mentalize) because they were too not-

knowing in areas relevant to authoritative leadership.

According to Karterud (2012), it has been suggested that borderline patients will be

more open to confrontations from their fellow patients than from an authoritative therapist, a

tendency that may reflect difficulties with authorities in general. It is interesting to observe

that T1, who is most eager to apply MBT-G principles in this group, was ignored considerably

more than T2, who at times adhered more to group norms than to the treatment manual. One

might speculate that the patients perceived T2 more as a peer, while T1 was perceived as an

authority to challenge and devaluate. We assert that one of the crucial aspects of the conflict

between the principles discussed here, is that one functions to ease the building of a

therapeutic alliance (the not-knowing stance), while the other strains the alliance (managing

authority). Taking on a not-knowing stance may work to straighten the inevitable asymmetry

between the therapist as an expert helper, and the patient as an unskilled help-seeker. Being

authoritative, however, implicitly involves being expert, and may accentuate the asymmetry

between therapist and patient. The concept of therapist transparency, often associated with the

group therapist Irivn Yalom, bears some resemblance to the not-knowing stance in this regard.

Therapist transparency often involves the therapist acknowledging his short-comings to the

patients, for example through shearing that he is confused by something, which may make

him seem less an expert and more of a peer. Yalom and Leszcz (2005) do warn that one

potential pit-fall of therapist transparency, is that it could work to egalitize the relationship

between therapist and patients to such a degree, that the therapist is no longer able to provide

leadership to the group (p. 227).

The concept of *responsiveness* (Stiles, Honos-Webb & Surko, 1998) is also relevant

here, as we observed that the therapists exhibited a restricted repertoire of interventions. The

tendency of the therapists to stick to the same strategies and interventions when facing

negative processes in therapy could be understood as insufficient responsiveness to the

situation. Indeed, Yalom and Leszcz (2005) do stress that what may be regarded effective

leadership behavior in groups will change as the group matures and develops. One specific

intervention may be effective in one situation and destructive in another. For example, some

situations call for a not-knowing therapeutic stance in order to stimulate patients to take

responsibility, and to participate actively in establishing some understanding of what is

transpiring in the group. However, if the patients are already taking responsibility, perhaps

actively undermining the therapists' authority, taking a not-knowing stance will be highly

unproductive.

There seems to be a contradicting or conflicting relationship between the two MBT-G

principles highlighted here, but it may also be understood as a *dynamic relationship*. As group

processes are not static, group treatments must include principles and interventions that can be

employed to a range of different dynamics. While taking a not-knowing stance may be called

for in certain stages of the process, there are times when the therapist must abandon this open

and curious attitude in favor of an authoritative one. Both principles should always be present

in the therapist's mind, but the balance may shift according to the demands of the situation.

We would recommend that future revisions of MBT-G manuals would emphasize the

relatedness between these principles, and to include a discussion about the balancing between

being authoritative and not-knowing in different situations.

Bateman and Fonagy (2009) argue that MBT demands minimal training and

supervision because it incorporates generic therapeutic principles and has a commonsensical

view of the mind. Without disputing their assertion in general, we may add that treating

borderline patients in groups seem to be extraordinary challenging, and that MBT-G seems to

require extensive training and supervision. Taking on a therapeutic group cannot be regarded

an easy task, and many would deem the whole endeavor impossible if the group consisted purely of borderline patients. This puts our findings in perspective, and we must admit that we are highly sympathetic of the therapists who agreed to have their sessions analyzed in the present study; they agreed to be scrutinized while embarking on one of the most demanding undertakings possible in the psychotherapy field. The therapists' willingness to participate in our study gave us a material that stands out as unique in the literature on therapeutic groups. Although not the primary focus of our study, the data bear witness of typical behavioral patterns in borderline patients. Central phenomena described in mentalization theory, such as psychic equivalence and pseudomentalization, can be observed in ample measure in our data. Thus, while we are attempting to address challenges specific to MBT-G in this paper, we would claim we are witnessing obstacles that will be topical to therapists of any orientation taking on borderline patients in groups.

We have witnessed the troublesome nature of borderline pathology as it unfolds in the group therapeutic process, but we would not conclude that group therapy with borderline patients is a hopeless undertaking. We would rather claim that MBT holds great promise as a treatment that has finally found a way to work psychodynamically with borderline patients in the group format. By the fact that MBT-G principles could be connected to the themes from our analysis, we can infer that the challenges we observed have already been addressed in the manual, and that therapeutic principles have been developed to conquer obstacles that actually do occur in clinical practice. In concluding, we will once again point to the fact that transcribing and analyzing video-data to the extent done in the present study is pretty unique in the literature, and this has allowed us to address some noteworthy issues in group psychotherapy.

Limitations

This being a case study, it is reasonable to question the transferability (generalizability) of the results; we cannot be confident that our results are relevant to other MBT-G groups. Neither can we be sure that the contradictory demands we observed in the MBT-G manual actually affected the therapists' work. We did not control for therapist variables, and the results may merely reflect poor adherence or low competence related to some of the treatment principles on the part of the therapists.

Since the scope of the present project did not allow for an independent research group to analyze the same data set, we have no way of checking reliability directly. Neither can we compare our findings to similar research, which testifies to the need for more research to be done. However, the subjectivity of the findings is nonetheless assumed to be minimized by the fact that the author achieved consensus with his supervisors – a general expert on psychotherapy and an expert on MBT and group therapy – as well as with the therapists of the group studied.

While studying a group in its natural setting provides us with data that most closely resembles routine clinical practice, it does represent some challenges. For ethical concerns, all patients had to agree to have their therapy sessions used in our study, prior to data collection. Inevitably, this compromises their confidentiality and may cause patients to restrain themselves to an unknown degree.

<div align="center">

Conclusions

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Our findings do highlight a critical need to discuss and puzzle out the optimal balance between the need for authoritative leadership to structure groups with borderline patients, and the concomitant need to take a not-knowing stance in order to stimulate mentalization. This may be an issue with relevance to MBT-G training specifically, and to group psychotherapist training in general.

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Appendix

Forespørsel om deltakelse i forskningsprosjektet

”Teknikker for Mentaliseringsbasert Gruppeterapi”

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en forskningsstudie for å få mer kunnskap om gruppeprosesser i mentaliseringsbasert gruppeterapi i vanlig klinisk praksis, med vekt på terapeutenes intervensjoner. Hva er terapeutenes intervensjoner typisk rettet mot, i hvilken grad etterlever de manualen, og hvilke gruppefenomener synes lettest henholdsvis vanskeligst å mestre? Studien vil resultere i en hovedoppgave for psykologstudent Tryggve Sagen Inderhaug ved NTNU, under veiledning av førsteamanuensis Truls Ryum (NTNU) og professor Sigmund Karterud (UiO).

Studien er godkjent av Regional komité for medisinsk og helsefaglig forskningsetikk Midt-Norge (11/09/2012)

Hva innebærer studien?

Prosjektet vil studere gruppeprosesser fra tre gruppemøter i din behandlingsgruppe ved Tiller DPS, Trondheim. Opptakene vil bli lagret ved Psykologisk Institutt, NTNU, og vil bli slettet innen 6 måneder etter opptak. Prosjektet ønsker tilgang til video-opptak av tre møter etter frivillig samtykke fra deltakerne og terapeutene i behandlingsgruppen. Videoene vil bli omskrevet til tekst (transkribert) og analysert med kvantitative og kvalitative tilnærminger. Du vil gis et fiktivt navn under transkriberingen av video-opptakene.

Mulige fordeler og ulemper

Det vil være mulige ulemper knyttet til om noen føler seg presset til å delta i studien, og dermed deltar lite i terapien, eller at forholdet til terapeutene blir skadelidende. Det er derfor viktig at din deltakelse er frivillig.

Etter at analysene er gjennomført, vil terapeutene få tilbakemelding. Dette vil forhåpentligvis komme hele gruppen til nytte. Sannsynligvis kommer det pasientene til gode at terapeutene får grundig tilbakemelding om sin stil.

Hva skjer med informasjonen om deg?

Informasjonen fra video-opptakene skal kun brukes slik som beskrevet i hensikten med studien. I hovedoppgaven vil noen av gruppesekvensene bli beskrevet. Det vil bli lagt stor vekt på at det ikke vil være mulig å identifisere noen av deltakerne i gruppen. I det som blir skrevet, vil deltakerne få fiktive navn. Det understrekes også at det er terapeutenes intervensjoner som er hovedinteressen for studien, ikke de enkelte deltakerne. Det er kun autorisert personell knyttet til prosjektet som har adgang til video-opptakene der du kan identifiseres. Video-opptakene vil slettes innen 6 månder etter opptak.

CHALLENGES IN MENTALIZATION– BASED GROUP THERAPY (MBT-G): A
VIDEO-BASED EXPLORATIVE CASE STUDY

Hovedoppgaven vil bli sendt til Tiller DPS og gjøres tilgjengelig for deg når den er ferdig. Etter at hovedoppgaven er fullført, vil Inderhaug og Karterud, eventuelt i samarbeid med gruppeterapeutene, skrive en kortfattet versjon av oppgaven på engelsk, til et internasjonalt tidsskrift.

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få konsekvenser for din videre behandling. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på neste side. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte hovedveileder og førsteamanuensis ved NTNU: Truls Ryum
truls.ryum@svt.ntnu.no, tlf. 735 50493

Tidsramme
Hovedoppgaven til psykologstudent Tryggve Sagen Inderhaug skal skrives høstsemesteret 2012. Video-opptakene skal benyttes i en periode på 6 måneder etter opptak og slettes etter dette. Transkripsjonen fra video-opptakene vil benyttes utover dette tidsrommet som ledd i arbeidet med hovedoppgaven og artikkelen som baseres på denne. Det er satt som mål at både hovedoppgaven og artikkelen som utledes fra denne vil være ferdig våren 2013.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(kontaktperson og terapeut ved Tiller DPS, dato)