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Keeping Mentalizing in Mind: An exploration of participant experience and their capacity to mentalize following Mentalization-Based Treatment.

Study 1: What is the experience of engaging in Mentalization-Based Treatment? A meta-ethnography of client perspectives of the therapeutic process and outcomes.

Study 2: An exploration of the experience of mentalizing capacity development following an introductory Mentalization Based Treatment (MBT-I) group within an Irish prison service.

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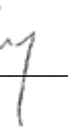
Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism.

Signed 

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Abbreviations and Terminology

ASPD	Antisocial Personality Disorder
AP	Assistant Psychologist
BPD	Borderline Personality Disorder
CPREC	Clinical Psychology Research Ethics Committee
CASP	Critical Skills Appraisal Programme
ET	Epistemic Trust
ES	Experiential Statement
GET	Group Experiential Theme
IPA	Interpretative Phenomenological Analysis
IPS	Irish Prison Service
MBT	Mentalization Based Treatment
MBT-G	Mentalization Based Treatment Longer Term Group
MBT-I	Mentalization Based Treatment Introductory Group
PET	Personal Experiential Theme
UCC	University College Cork

Chapter 1: Introduction and overview

What is Mentalizing?

Mentalizing refers to an individual's capacity to recognise and imagine their own internal mental states, as well as those of others, and to understand and interpret one's own and others' actions as meaningful on the basis of these states (Allen et al., 2008). It is a multidimensional construct that overlaps substantially with other interpersonal processes such as theory of mind, empathy, emotion regulation, metacognition, and reflective functioning (Adshead et al., 2013; Allen, et al., 2008; Fonagy et al., 2012). The capacity to mentalize is unique to humans, is evolutionarily prewired, is underpinned by specific neural circuits and is fundamental to a person's ability to navigate the social world (Luyten et al., 2020; MacIntosh, 2013). It develops in the context of an infant's early interactions with their primary caregivers and is refined through childhood and beyond as an individual develops a greater understanding of themselves and others within attachment relationships (Allen, 2013). As a result, the capacity to mentalize can vary greatly both interpersonally as well as intra-personally from context to context.

The Development of Mentalizing

The understanding of our own mental states, as well as the mental states of others is based on our social experiences in early life (Gergely & Unoka, 2008). At each developmental stage during infancy, a primary caregiver who is sensitive and attuned to their infant will facilitate the gradual development of the infant's mentalizing capacity (Bateman et al., 2009). This is achieved through the process of 'marked mirroring' (Gergely & Watson, 1999). During a caregiver-child interaction, a caregiver reflects the mental state of the child in an exaggerated way, either through facial expression or vocal tone. This communicates to the child that the caregiver is reflecting their state of mind while simultaneously indicating that the caregiver is not expressing their own feelings (Gergely & Watson, 1999; Stewart et al., 2011). As a result, the child feels understood and internalizes themselves as being in possession of their own mental state (Stewart et al., 2011). This process also facilitates the infant's ability to understand and regulate their own emotional experience, thus contributing to the infant's mentalizing capacity (Gergely & Watson, 1996; Sarkar & Adshead, 2006).

The capacity to mentalize is conceptualised as a developmental skill, akin to language acquisition, that is typically acquired between the ages of three and four years (Allen, 2013). This is demonstrated through the ability to pass the false belief test, a measure of an individual's ability to attribute false beliefs to others (Fonagy & Allison, 2012). At age four, children have developed the understanding that an individual's behaviour is influenced by transient mental states, such as thoughts and feelings, and stable characteristics, such as personality. This newly developed capacity also facilitates the structure for emerging self-concept within the child (Flavell, 1999).

Epistemic Trust

Recent developments in mentalizing theory have focused on the role of *epistemic trust*, or trust in the authenticity and personal relevance of interpersonally transmitted knowledge, as a crucial element in a person's ability to mentalize (Fonagy & Allison, 2014). The presence of epistemic trust within an interpersonal relationship enables an individual to accept and learn certain information from another and integrate it into their view of self and the world (Kamphuis & Finn, 2019). The development of epistemic trust is promoted by *ostensive cues* which are signals provided by a caregiver which indicate that information is about to be transmitted that will be relevant for the infant's adaptation or survival (Kamphuis & Finn, 2019). These cues include eye contact, contingent turn taking and the use of vocal tone and lead to the infant feeling recognised as an individual with agency (Bateman & Fonagy, 2016; Gergely, 2013). In order for an infant to develop epistemic trust, they must overcome the state of *epistemic vigilance*, the ability to identify and filter out information conveyed by others that may be misleading or inaccurate (Luyten et al., 2020). Early attachment relationships provide the opportunity for children to learn who is trustworthy and knowledgeable (Corriveau et al. 2009). A secure attachment relationship with a primary caregiver, which typically provides the most extensive ostensive cueing, is important for fostering the development of epistemic trust (Luyten et al., 2020).

Mentalizing and Epistemic Trust in the Context of Early Life Adversity or Trauma

An early caregiver's mentalizing plays a key role in the development of the child's mentalizing capacity. Early interactions with parents or caregivers that are characterised by poor mentalizing, or where their emotional experience is not adequately mirrored by the caregiver, can predispose a child to developing mentalizing difficulties (Crandell et al., 2003; Fonagy & Bateman, 2006). This may result in corresponding difficulties in a child's relationships with others and in their regulation of emotions and impulses (Bateman & Fonagy, 2016). In addition, early caregiving relationships that are characterised by violence, abuse or neglect may lead a child to inhibit mentalizing as a defence mechanism (Levinson & Fonagy, 2004). Within this context, an individual engages in a 'decoupling' of the mental processes that underpin the capacity to think about the feelings and thoughts of self and others to deliberately avoid the state of mind of the perpetrator of the abuse as a means of coping (Fonagy & Bateman, 2006). Situations where an infant's primary caregivers are hostile or abusive can also present difficulties for the development of epistemic trust. Infant-caregiver relationships that are characterised in this way can lead to situations where epistemic mistrust becomes entrenched and consequently develops into epistemic hypervigilance, the complete inability to trust others as a source of knowledge about the world (Fonagy & Campbell, 2017; Fonagy, et al., 2017).

The Multidimensional Nature of Mentalizing

Studies within the neuroscientific and behavioural literature indicate that mentalizing capacity can be organized around four dimensions or polarities (Lieberman, 2007). These four polarities are (a) automatic versus controlled mentalizing, (b) mentalizing with regard to the self and about others, (c) mentalizing based on external or internal features of the self and others, and (d) cognitive versus affective mentalizing. Each of these four dimensions are known to be served by relatively distinct underlying neural circuits (Luyten et al., 2020). Effective mentalizing requires an individual to maintain balance across these four dimensions and apply them appropriately according to a particular social context (Bateman & Fonagy, 2016).

Automatic (implicit) versus controlled (explicit) mentalizing

Automatic mentalizing is a rapid, unconscious process requiring little intention or effort whereas controlled mentalizing is a slower and conscious process involving intention and awareness (Bateman & Fonagy, 2016, Luyten et al., 2020). During typical run-of-the-mill interactions with others, mentalizing tends to be automatic. However, when a disruption or misunderstanding occurs within these interactions, an individual may switch to controlled mentalizing. For example, an individual may be chatting with an old friend and detect a change in the tone of a person's voice or posture. At this point the individual may stop to wonder about the reasons for this person's change in behaviour. This ability to switch flexibly from automatic to controlled mentalizing indicates a well-functioning mentalizing capacity (Bateman & Fonagy, 2016).

Self versus others

The second dimension of mentalizing involves the capacity to mentalize the self, one's own mental states or the mental states of others (Bateman & Fonagy, 2016). An imbalance in the capacity to reflect about the self or others is relatively common and may only present difficulties for an individual when this imbalance becomes extreme. An excessive concentration on the pole of either the self or other can lead to one-sided relationships and distortions within social interactions (Bateman & Fonagy, 2016).

Internal versus external

External mentalizing occurs when an individual infers mental states from the external facets of a person's behaviour. This can include facial expressions, body language, gestures, or body posture. For example, an individual may infer that someone with a scowl or frown as a facial expression is feeling angry or annoyed (Allen, 2013). On the other hand, internal mentalizing involves a focus on one's own or others internal states such as thoughts and feelings. These may be inferred from what we know about ourselves or others and the specific situations that they find themselves in (Bateman & Fonagy,

2016). For example, a person may know that a friend of theirs dislikes being late, so might use this information to infer their mental state if they are travelling on a train that is delayed.

Cognitive versus affective

Lastly, cognitive mentalizing involves the capacity to name, recognise and reason about mental states in oneself and others, while affective mentalizing involves the capacity to understand the feeling of these states in oneself and others. A high level of mentalizing integrates both cognitive and affective processes. These dimensions are necessary for empathy and sense of self (Bateman & Fonagy, 2016).

Mentalizing impairments

Irrespective of previous attachment or early life experiences, temporary lapses in mentalization can be experienced by any individual during high levels of emotional arousal such as periods of stress or anxiety (Fonagy & Bateman, 2006). Those with resilient mentalizing capacities will typically be able to regain their mentalizing capacity relatively quickly after these lapses, whereas those with more general difficulties in their mentalizing capacity may find that impairments are more likely to persist (Bateman & Fonagy, 2013; Gunnarsen, 2020). When attempting to make sense of mentalizing difficulties for any individual, it is helpful to consider these impairments in terms of *hypermentalizing*, an overattribution of mental states to others where there is no objective evidence to support such attributions or *hypomentalizing*, an underattribution of mental states that are overly concrete (Luyten et al., 2017; Sharp et al., 2011). Hypermentalizing typically refers to an imbalance within the four dimensions of mentalizing, whereas hypomentalizing is occurring when non-mentalizing modes are active. These impairments are described in further detail in the subsections below. Optimal mentalizing occurs when the dimensions of mentalizing are in balance and non-mentalizing or hypomentalizing modes are inactive.

Impairments in mentalizing across the four mentalizing dimensions

Lapses in mentalizing capacity occur across the four mentalizing polarities described above. Impairments in the *Automatic versus Controlled* dimension occur when an individual relies exclusively on automatic assumptions about the mental states of the self or others, or where a situation makes it difficult for the individual to appropriately apply their automatic assumptions (Bateman & Fonagy, 2016). This can occur during periods of stress, particularly within an attachment context, where the neural systems associated with controlled mentalizing are inhibited (Nolte et al., 2013). In terms of the *Self versus Other* dimension, mentalizing difficulties are signalled by a preferential focus on either self or other but can also be impaired on both sides of the polarity. Mentalizing difficulties within the *Internal versus External* polarity present when an individual over relies on external

indicators of mental states. Lastly, an imbalance in the *Cognitive versus Affective* mentalizing dimension occurs when undue weight is given to one side over another (Bateman & Fonagy, 2016).

Pre-mentalizing modes

Mentalizing impairments across three pre-mentalizing modes of functioning have also been distinguished (Fonagy et al., 2002). These modes of function are referred to as 'pre-mentalizing' as they are deemed to be equivalent to the thought processes of a child prior to the development of their full mentalizing capacity (Bateman & Fonagy, 2016). In situations where there is a failure to mentalize effectively, individuals can often revert to these non-mentalizing ways of thinking, and these modes can emerge in any individual who is faced with a situation of emotional distress. The first of these, *psychic equivalence* mode refers to a 'concreteness of thought' where thoughts are considered to be real or true and an individual believes that only their perspective is possible. While in this mode of functioning, an individual may present with an overriding certainty about their subjective experience (Bateman & Fonagy, 2016). The second of these modes of functioning is *teleological mode*, where states of mind are only recognised and believed if their outcomes are physically observable (Bateman & Fonagy, 2016). An individual operating in this mode may only understand the intentions of others in terms of what they physically do (e.g. they are sad because they are crying), and may not recognise or believe that a person is sad unless this is the case. Lastly, an individual presenting in *pretend mode* will demonstrate a disconnection of their thoughts and feelings. This may be evidenced by speech which lacks emotion or demonstration of a cognitive understanding of mentalizing states with little affective understanding (Bateman & Fonagy, 2016; Gunnarsen, 2020).

The 'alien' self

In addition to reverting to pre-mentalizing modes, during situations of mentalizing impairment an individual may feel compelled to externalize un-mentalized aspects of the self, also known as the *alien self* (Luyten et al., 2020). A lapse in mentalizing capacity can destabilize an individual's sense of self which leads them to project these aspects of themselves onto others, in order to maintain this sense of self or identity. This can lead to situations where an individual may attempt to dominate the mind of others (e.g. by shouting or accusing them of being controlling) or by engaging in self harm or behaviours such as substance abuse in an attempt to relieve tension and arousal (Bateman & Fonagy, 2016; Luyten et al., 2020).

Mentalizing model of personality disorders

Difficulties with mentalizing are proposed to underpin the majority of mental health disorders or psychopathology such as depression, social anxiety, eating disorders, addiction and psychosis

(Ballespí et al., 2018). Mentalizing models have predominantly been applied to the understanding of personality disorders, most prominently borderline personality disorder (BPD) and antisocial personality disorder (ASPD). However, as mentalizing is known to fluctuate across all individuals, it is important to note that personality dysfunction does not occur simply due to a loss in mentalizing capacity. Rather, mentalizing models of personality presentations are conceptualized in terms of an individual's overall patterns of mentalizing impairment. What is considered in these formulations are: the contexts in which an individual is vulnerable to the loss of mentalizing capacity, the overall flexibility of this capacity, how quickly mentalizing is regained once it is lost and the deficits that occur for the individual across the four dimensions of mentalizing (Bateman & Fonagy, 2016).

Mentalizing model of BPD

Borderline personality presentations are characterised by a pervasive pattern of difficulties with emotion regulation, impulse control as well as instability within interpersonal relationships and sense of self (Bateman & Fonagy, 2013). The mentalizing model of BPD proposes that the vulnerability to a frequent loss of mentalizing, particularly in interpersonal interactions, underlies these difficulties. These difficulties can be conceptualised through considering the patterns of imbalance across the four dimensions of mentalizing (Fonagy & Luyten, 2016). An example will also be used to illustrate how this occurs. For individuals with BPD, there is a vulnerability to a loss of mentalizing within contexts involving attachment relationships, for example a situation of perceived rejection in an intimate partner relationship (e.g. Joe has forgotten that today was his and Mary's anniversary as he is currently feeling very stressed in relation to a situation that occurred in his workplace). In these contexts, high emotional arousal, inhibits the neural systems associated with controlled mentalizing, thereby facilitating automatic mentalizing (Lieberman, 2007). As a result, explicit mentalizing is lost and is temporarily restricted to the affective polarity of the cognitive-affective dimension. (e.g. When Joe doesn't wish Mary a happy anniversary that morning, Mary is unable to stop, reflect, explicitly mentalize and consider that he may have forgotten because he is currently dealing with a stressful situation at work. Mary becomes overwhelmed by her feelings of anger). This can lead to an over-focus on external features of the behaviour of their partner, such as facial expression, and a corresponding difficulty with making internal mental state judgements (Bateman & Fonagy, 2016; Fonagy & Luyten, 2009) (e.g. Mary overfocuses on the fact that Joe has spoken very little at the breakfast table). In terms of the Self versus Other dimension, this may lead an individual to become excessively concerned about their own mental state which is not balanced by social reality. This can then lead to exaggerations in either a negative or positive direction to self-image (Bateman & Fonagy, 2016) (e.g. Mary begins to think 'he hates me because I'm a terrible partner'). This leads to the emergence of pre-mentalizing modes, for example psychic equivalence, where that individual is unable to see alternative perspectives to their own. This may also trigger the emergence of the alien self, where a person may project their feeling of rejection on to their partner (e.g. Mary accuses Joe of

planning to leave the relationship) or the engagement in self-harm or suicidal behaviour as a means of coping with their high levels of arousal (Bateman & Fonagy, 2016; Fonagy & Luyten, 2009).

Mentalizing model of Anti-Social Personality Disorder (ASPD)

ASPD is a pervasive pattern of personality dysfunction that is associated with significant intra- and inter-personal dysfunction (Dolan & Fullam, 2004). The clinical characteristics of ASPD include; impulsivity, aggressive behaviour, deceitfulness, a disregard for the safety of others, a failure to conform to social norms in relation to lawful behaviour and a lack of remorse (American Psychiatric Association, 2013; Bateman & Fonagy, 2016). ASPD is highly predictive of violence and other offending behaviours, demonstrated by the high prevalence observed within forensic populations (McGauley et al., 2011; Newbury-Helps et al., 2016). The mentalizing model of ASPD evolved from the mentalizing model for BPD due to the considerable overlap between the two presentations (Fonagy et al., 2016). It is proposed that an engagement in antisocial behaviour or violence occurs as a result of a dysfunction of the attachment system which results in a temporary inhibition of affect regulation and the capacity to mentalize (Newbury-Helps et al., 2016). This can occur when an individual perceives a threat to their sense of self such as interpersonal rejection, disrespect, shame, perceived weakness or vulnerability (Adshead et al., 2007; Bateman & Fonagy, 2016). Due to the high level of emotional arousal that is experienced during these situations, pre-mentalizing modes dominate, particularly that of psychic equivalence in terms of the self and other. As a result, violent behaviour may occur due to a misperception of the actions or intent of others or as a way of externalizing the alien self in terms of affect or bodily sensations that cannot be tolerated (McGauley et al., 2011).

The mentalizing difficulties in ASPD can also be considered across the four dimensions of mentalizing. This will be illustrated through the use of a similar example as the one used above (e.g. Mary is upset as she has been experiencing stress in relation to an incident that occurred in her workplace). Individuals with ASPD typically demonstrate an understanding of cognitive mental states but experience a difficulty with the understanding of affective mental states and therefore the emotions of others (e.g. Joe knows that a situation occurred in Mary's workplace but doesn't understand why she is so upset about it). As such, there is a limited capacity to recognise the external indicators of emotion such as facial expressions or body language that conveys affect. As a result, individuals with ASPD have less access to, or consideration for, the internal mental states of others (e.g. Mary is sitting at the breakfast table with her head in her hands, but Joe doesn't recognise this as a sign that she is upset). In ASPD there is a consistent imbalance between the polarities of automatic versus controlled mentalizing. Due to a difficulty with understanding the emotional significance that occurs when explicit mentalizing is encouraged, it is not experienced as meaningful for that

individual. Therefore, the individual relies on implicit mentalizing which can be largely self-serving, resulting in an individual ignoring the typical social or external cues which would trigger an individual to switch to controlled mentalizing (e.g. Joes does not stop to reflect on how Mary might be feeling about her situation at work because he has a difficulty with understanding why she was upset in the first place). Lastly, in terms of self versus other, some individuals with characteristics of ASPD can become fixed on the pole of 'self' and on their own mental states and will interpret the mental states of others in a self-serving way to get others to do things that meet their needs or requirements (e.g. If this were the case, Joe may consider encouraging Mary to go out and meet her friend to chat about the work situation so that he can stay home and watch the football on his own). In contrast, some individuals are effective at interpreting the mental states of others but from a cognitive perspective only. This partial recognition of the other, can lead to depersonalisation, therefore facilitating the likelihood of violence towards the other or increasing the likelihood that they will use them to meet their requirements (Bateman & Fonagy, 2016).

Mentalization-Based Treatment (MBT)

MBT is an integrative approach to psychotherapy with a theoretical basis in attachment theory which includes both cognitive and relational components (Bateman & Fonagy, 2016). It was developed in the 1990s as a therapeutic approach for BPD by Anthony Bateman and Peter Fonagy. MBT is a structured therapeutic program with the central aim of increasing the resilience of an individual's mentalizing capacity. In this way, MBT seeks to support an individual to rekindle their mentalizing capacity when it is lost, maintain mentalizing when it is present and increase the resilience of the capacity to keep it going when otherwise it would be lost (Bateman & Fonagy, 2016).

The initial phase of MBT involves completing an assessment of an individual's mentalizing capacity and personality functioning. The therapist also focuses on engaging and contracting the individual into treatment as well as building the therapeutic relationship and identifying any potential treatment difficulties that may occur. During this phase the individual also attends sessions of psychoeducation, in the form of an introductory group (MBT-I) typically of 10-12 weeks duration for BPD or 6-8 weeks duration for ASPD. The aim of this group is to introduce individuals to the concept of mentalizing and personality disorder as well as prepare and motivate individuals for long-term treatment. The number of sessions provided for MBT-I may vary from service to service depending on capacity. However, it is noted by the authors that the tasks of increasing understanding and motivation through knowledge and empowerment and the development of the therapeutic relationship with clear goals are more important than the absolute number of sessions provided. The framework for MBT-I for BPD and ASPD differs slightly in order to specifically address the needs for each individual group (Bateman & Fonagy, 2016).

The primary aim of the middle phase of MBT, comprised of group and individual therapy, is to facilitate the mentalizing process of participants. Group psychotherapy often elicits interpersonal interactions that are highly complex, and it is these interactions which are harnessed to support participants to reflect on the mental states of themselves and others within the group setting. From week to week, participants are encouraged to discuss situations that they found emotionally evocative or challenging. As these situations are discussed within the group, facilitators ensure that the focus of the group process remains on mentalizing and prevents the collapse of group discussion into non-mentalizing. MBT group (MBT-G) sessions are typically held weekly for a duration of 75 minutes and have the format of an open group such that where one individual leaves, a new individual arrives. In addition to the group, individual sessions are typically held on a weekly basis for a duration of 50 minutes. These sessions focus on mentalizing but also emphasise the repair of any therapeutic ruptures that may occur and sustain the client's motivation to attend. The final phase of MBT commences when the client has six months remaining in treatment. The focus of this phase is on the interpersonal and social functioning of the client as well as aiding them to process the end of therapy (Bateman & Fonagy, 2016).

The overall goals of MBT are to both increase an individual's capacity to mentalize whilst also increasing the resilience of this capacity. This is achieved through interpersonal processes. As such, throughout each phase, the maintenance of a 'mentalizing stance' by the MBT therapist is crucial. The role of the therapist is to stimulate mentalizing processes within the client and to make this an essential feature within all therapeutic interactions. Throughout this process, the therapist maintains a 'not-knowing' stance. This stance models an acceptance that neither the therapist nor the client can be certain about what the other is thinking. In addition, a therapist may model a change of mind when presented with alternative views through explicitly describing their thought process. Over time, the aim is that this thought process will be internalised by the client who with therefore gradually become more curious about both their own and others' minds. As a result, the client is better able to reappraise themselves and their understanding of others (Bateman & Fonagy, 2013).

Quantitative Evidence base for MBT

The evidence supporting MBT as an effective therapy has continued to build over the past two decades. Two recent papers have systematically reviewed the current quantitative evidence base (Malda-Castillo, Browne, Perez-Algorta, 2018; Vogt & Norman, 2019). Vogt & Norman (2019) reported that MBT was found to achieve either superior or equal reductions in BPD symptom severity, parasuicidal behaviours, severity of comorbid disorders and use of psychotropic medications compared with standard psychiatric care and supportive group therapy (Bales et al., 2015; Bateman & Fonagy, 1999). Likewise, the findings of the systematic review completed by Malda-Castillo and colleagues (2018) reported that participants demonstrated positive clinical outcomes in the majority of

the 23 included studies, with two studies demonstrating no group differences and a further study demonstrating inferior results in comparison to a third wave cognitive therapy (Jakobsen et al., 2014; Laurenssen et al., 2018; Phillips et al., 2018). The evidence also suggests that MBT is effective in maintaining gains in long-term follow up studies of participants with BPD (Bateman & Fonagy, 1999; 2008). Moreover, there is emerging evidence to suggest that MBT is effective in participants with Anti-Social Personality Disorder (ASPD) and in producing positive clinical outcomes for clients with multi-faceted presentations which do not easily fit into diagnostic categories (Malda-Castillo et al., 2018).

Critical evaluation of the MBT evidence base

There is currently little evidence within the quantitative literature to support the hypothesised underlying mechanism of change in MBT, that of increased mentalization capacity. In the systematic review completed by Malda-Castillo and colleagues (2018), 23 studies were included that investigated the effectiveness of MBT across numerous presentations. Of the studies included in this review, few included outcome variables which pertained to mentalizing capacity; nine studies collected a measure of interpersonal functioning, two studies included measures of reflective functioning and only one study included a measure of alexithymia or emotional awareness. As a result, it is currently unclear whether an increase in a person's mentalizing capacity or reflective functioning is sufficient to improve their overall functioning (Vogt & Norman, 2019). It is purported that rather, positive clinical outcomes may occur due to the structure of MBT, that of individual and group therapy over a period of up to 18 months, in which participants learn to develop stable relationships (Vogt & Norman, 2019). As such, more extensive research which includes participant outcome measures that tap into the various facets of mentalizing is needed.

It is recognised that mentalizing as a construct is both difficult to measure and difficult to compare across individuals (Fonagy et al., 2011). The use of self-report measures to assess mentalizing capacity requires an individual have the ability to reflect on their own mental states, i.e. mentalize, in order to complete the measure accurately. An individual with a vulnerability to either hypermentalizing or hypomentalizing tendencies may introduce different biases into the self-report process which may compromise accurate responding (Fonagy et al., 2016). Quantitative measures of mentalizing capacity have also been criticised for only providing an indication of an individual's potential for mentalizing which may or may not be utilised depending on the different contexts in which that individual finds themselves in (Fonagy et al., 2011). This is particularly true for individuals with BPD who may present with mentalizing difficulties within interpersonal contexts but may demonstrate a normal ability to mentalize outside of these contexts. To overcome these issues, experimental mentalizing tasks which evoke 'online' mentalizing processes have been developed within the field of social neuroscience. To date several studies have provided initial evidence to

indicate that, in comparison to controls, individuals with BPD show an impaired ability to recognise emotions, thoughts and intentions (e.g. Preißler et al., 2010; Sharp et al., 2011). The increased use of these types of tasks within the clinical literature may provide more accurate information regarding how mentalizing unfolds in real life situations (Luyten et al., 2019).

Thesis aims

To date, several studies have demonstrated the effectiveness of MBT in achieving positive clinical outcomes for clients. However, few studies within the literature have focused on the measurement of the proposed mechanism of change of MBT, that of increased mentalizing capacity. As outlined above, the measurement of mentalizing capacity through quantitative means is problematic. Qualitative research may therefore aid in the understanding of the mentalizing processes that occur for individuals who engage in MBT, which in turn could inform future quantitative studies with more effectively designed measures. Qualitative research may also be of benefit for expanding the current understanding of mentalizing as a process of change through exploring the experiences of those that undergo MBT. Several qualitative studies which have reported on the participant experience of engaging with MBT have been published in recent years. The synthesis of qualitative research is necessary to inform and develop clinical practice (Mays et al., 2005). Therefore, to contribute to the further development of MBT as model of therapeutic intervention, it is essential that a meta-synthesis of the qualitative research published thus far is completed. As such, the aim of the first paper in this thesis was to synthesise the qualitative literature on the experience of those who have completed MBT.

To date, the efficacy of MBT has been demonstrated most prominently for BPD and is emerging across a number of additional presentations (Malda-Castillo et al., 2018). Since its conceptualization as a therapeutic approach for BPD, the mentalizing model has also been applied to the understanding and treatment of ASPD. The evidence to support MBT as an effective therapeutic approach for ASPD is sparse and a number of these studies have published preliminary data only (Adshead et al., 2013; McGauley et al., 2011). Although the prevalence of ASPD in the general population is estimated to be low, figures from the United Kingdom estimate that up to 49% of sentenced male prisoners meet the criteria for ASPD (National Collaborating Centre for Mental Health, 2010; Singleton et al., 1998 as cited in Fazel & Danesh, 2002). However, only a handful of studies have been completed on MBT in these contexts. The second paper in this thesis aims to narrow this gap in the literature and is an exploration of the experience of mentalizing capacity development following the completion of an MBT-I group within an Irish Prison, using an Interpretative Phenomenological Analysis (IPA) methodology.

Outline of Chapters

Chapter Two: Systematic Review

This chapter presents a meta-synthesis of the available literature of qualitative studies exploring the experience of those who have previously undergone MBT. This meta-synthesis was completed using a meta-ethnographic approach and is formatted for submission in Psychology and Psychotherapy: Theory, Research and Practice.

Chapter three: Empirical Paper/Major Research Project extended methodology

In this chapter, an extended outline of the methodology used for the major research project is presented. This includes a detailed section on the author's approach to reflexivity and reflections on the completion of the overall project.

Chapter Four: Empirical Paper/Major Research Project

This chapter presents an original empirical paper which explores participant experience of developing their mentalizing capacity following an introductory MBT (MBT-I) group within an Irish Prison. This study was completed using an Interpretative Phenomenological Analysis (IPA) methodology. This paper was also formatted for submission to Psychology and Psychotherapy: Theory, Research and Practice.

Chapter five: Discussion and conclusion

An overall discussion of the thesis in terms of the findings and contribution to the evidence base is presented in this chapter. Strengths, limitations, clinical implications, and suggestions for further research are also outlined.

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Chapter 2: Systematic Review

This paper is formatted for submission in Psychology and psychotherapy: Theory, research and practice. The word limit for this journal is 6,000 words.

Title: What is the experience of engaging in Mentalization-Based Treatment? A meta-ethnography of client perspectives of the therapeutic process and outcome.

Abstract

Purpose: The purpose of this meta-ethnography was to synthesize the available qualitative literature on clients' experience of Mentalization-Based Treatment (MBT).
Methods: A systematic search of seven databases was carried out. The Critical Appraisal Skills Programme (CASP) was used to appraise the papers suitable for inclusion. The data were synthesized using a meta-ethnographic approach in which the second order constructs from each paper were translated and reinterpreted creating a line of argument synthesis.
Results: Eleven studies were included in the meta-ethnography. Three overarching themes were identified within the included papers: navigating the therapeutic process, the processes of change in MBT, and mentalizing self and other.
Conclusions: This meta-ethnography offers new insights into how clients experience MBT as a therapeutic process and offers suggestions for implementation to clinical practice as well as areas of focus for research of this therapeutic approach.

Keywords: mentalization-based treatment; mentalization; meta-ethnography; meta-synthesis; client experience

Introduction

Theoretical Framework of Mentalization Based Treatment (MBT)

MBT is a structured psychotherapeutic intervention which draws its theoretical framework from psychodynamic, attachment and cognitive theory (Bateman & Fonagy, 2004). It was initially developed as a therapeutic approach for borderline personality disorder (BPD). The overall goals of MBT are to both increase an individual's capacity to mentalize whilst also increasing the resilience of this capacity (Bateman & Fonagy, 2016). Indeed, increasing mentalization capacity is a key aim of numerous psychotherapeutic models. However, the degree of emphasis placed on increasing mentalizing as a key treatment target constitutes a distinctive aspect of MBT (Bateman & Fonagy, 2016).

Throughout the therapeutic process of MBT, the clinician adopts a 'not-knowing' stance of active curiosity and engages in empathic validation with the client. The clinician also pays close attention to the client's non-mentalizing and works with the client's mental states as they occur within each session. Non-mentalizing is occurring when mentalizing is specifically blocked such as when a client is functioning in any of the non-mentalizing modes: psychic equivalence, pretend mode or teleological mode, or when a client is fixed at one pole of any of the four dimensions of mentalizing, automatic vs controlled, self vs other, internal vs external or cognitive vs affective (Bateman & Fonagy, 2016; Duschinsky & Foster, 2021). Through utilising the therapeutic relationship and principles of attachment, the client is supported to cope with the demands of the social world through increasing their reflective functioning and developing a more nuanced view of relationships outside of the therapy setting (Bateman & Fonagy, 2004; Karterud & Bateman, 2010).

Structure of MBT

MBT is structured around an 18-month treatment period in which the client engages weekly in both individual and group therapy inclusive of integrated psychiatric care (Bateman & Fonagy, 2004, 2006). Before commencing the treatment period, clients undergo a detailed assessment in which a shared formulation of the client's difficulties is constructed (Bateman & Fonagy, 2016). Following this, the client attends an introductory MBT psychoeducation group (MBT-I) of 10-12 sessions which covers all areas of mentalizing, attachment, personality disorder, emotion regulation and what is involved in the longer-term program (Bateman & Fonagy, 2016). The aim of the initial assessment and psychoeducation program is to prepare the client for longer-term treatment by supporting the client to understand their current difficulties and socialise the client to the MBT model and treatment structure (Bateman & Fonagy, 2016).

The Need for Synthesis within the Qualitative Literature on MBT

The evidence base underlying the efficacy of MBT for treating BPD and other mental health difficulties is still in its infancy. Until recently, the research literature for MBT had consisted solely of studies utilising a quantitative methodology. However, in the past five years, several qualitative studies which have explored participant experience of MBT have been published. The idiographic nature of qualitative research means that isolated qualitative research studies are rarely used to contribute to clinical practice or theory development (Evans & Pearson, 2001). To integrate the findings of qualitative research into clinical practice, fully evaluate and further develop MBT interventions, the findings of qualitative research need to be synthesized in a systematic way (Barbour, 2000; Centre for Reviews and Dissemination, 2008).

Aims

The aim of this meta-ethnography is to synthesize the available literature of qualitative studies exploring the experience of those individuals who have previously undergone MBT. The question that this meta-ethnography aims to answer is: 'what is the experience of those who have undergone Mentalization Based Treatment?'

Methods

Meta-synthesis Approach

The qualitative studies which met the criteria for inclusion in this meta-synthesis were synthesized using a meta-ethnographic approach (Noblit & Hare, 1988). Meta-ethnography allows for the synthesis of all types of qualitative research while preserving the interpretative properties of the primary data, while also considering the unique context of the included studies (Dixon-Woods et al., 2004; France et al., 2019). The experience of MBT may be influenced by the setting in which the person engages in this therapy, therefore considering the contexts of the arising themes and concepts in each individual study is important. Rather than simply aggregating study data, meta-ethnography aims to produce a new interpretation of the findings (France et al., 2019). The translation of the data used in meta-ethnography allows for fuller use of the interpretations provided in the included studies therefore providing a more complete synthesis of the included data (Noblit, 2018). The current meta-ethnography was guided by Noblit and Hare's (1988) seven steps for synthesising qualitative studies (Table 2.1) and incorporated adaptations to this method reported by Britten and colleagues (2002) and Malpass and colleagues (2009). Malpass and colleagues (2009) emphasise the distinction between first, second and third-order constructs (Figure 2.1). The review protocol was uploaded and published on PROSPERO (O'Leary & Moore, 2020).

Table 2.1: Overview of the seven steps of Noblit & Hare's meta-ethnography

1.	Getting started
2.	Deciding what is relevant to the initial interest
3.	Reading the studies
4.	Determining how the studies are related
5.	Translating the studies into one another
6.	Synthesising the translation
7.	Expressing the synthesis

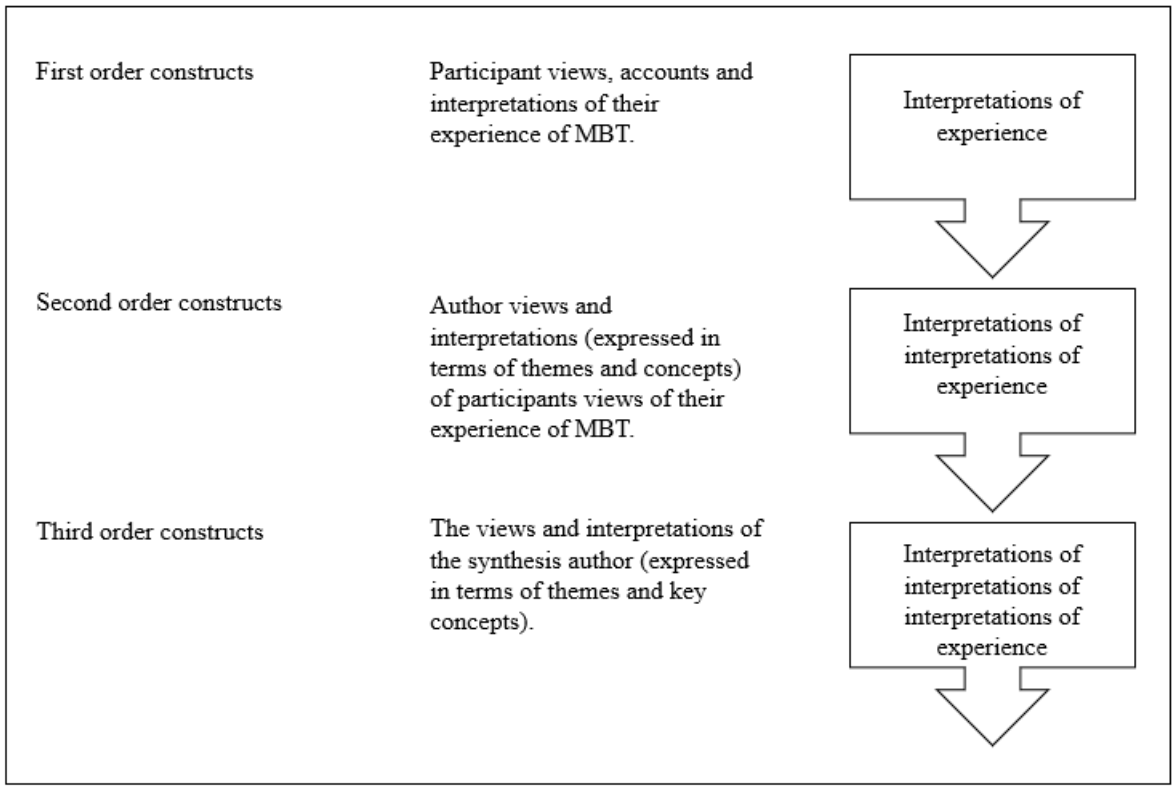

Figure 2.1: Definition of 1st, 2nd and 3rd order constructs (adapted from Malpass et al. 2009).

Deciding what is relevant to the initial interest: Search Strategy

The SPIDER framework (Cooke et al., 2012) is a tool used in the development of a search strategy for qualitative and mixed methods research studies and is illustrated in Table 2.2.

Table 2.2: Outline of Search Strategy using SPIDER Framework

Sample	Adults, 18 years or over
Phenomenon of Interest	Experience of engaging in MBT
Design	Interviews, focus groups
Evaluation	Experiences, perceptions, views, narratives, processes
Research type	Qualitative or mixed-method

Following consultation with a librarian for guidance on search terms and suitable databases, a comprehensive search was conducted across seven bibliographic databases: Web of Science, Scopus, PsycARTICLES, Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsycINFO, PubMed and Proquest Dissertations and Theses A&I.
The following combination of search terms were used:

*("mentali*ation based treatment"* OR *"mentali*ation based therapy")*

AND

(qualitative OR *"mixed-method*"* OR *interview* OR *"focus group*"* OR *experience* OR *perspective* OR *view* OR *perception* OR *narrative* OR *process* OR *mechanism** NOT *quantitative)*

Both *"mentali*ation based treatment"* OR *"mentali*ation based therapy"* were used as these terms are used interchangeably within the literature to describe the same therapeutic approach. The additional terms have been chosen to encompass a wide range of qualitative research designs and to exclude quantitative studies. The search syntax was modified according to the requirements for each database. The specific search syntax used for each database is outlined in Appendix B. Additional search methods including reference checking and citation tracking were also completed.

Study selection

Database searches were completed by the first author in July 2021. All duplicates were subsequently removed. The first author screened the titles, then abstracts and lastly full texts of all search results to assess for eligibility based on the inclusion and exclusion criteria. The inclusion criteria were qualitative studies that focused on first-hand participant accounts of their experience of MBT, where MBT was delivered either in an individual or group format and participants were 18 years or older. The types of publications considered for inclusion were any peer-reviewed journal articles or,

unpublished dissertations or theses, written in the English language, with online access to the full text. Exclusion criteria were quantitative studies, studies which used adapted forms of MBT, those that incorporated mentalizing techniques that are not specific to MBT or those that explored participant experience of specific individual therapeutic events (e.g. ruptures in the therapeutic alliance). The search strategy is presented in Figure 2.2. The second author reviewed a random selection of 10% of the search results independently and both authors were fully in agreement on what papers to include and exclude.

One paper, which was familiar to the first author as suitable for inclusion in the meta-ethnography (Beattie et al., 2019), was not returned during the initial search strategy. The keywords of this study were reviewed, and an additional search was conducted to include a keyword which had not previously been included in the original search *("mentali*ation based treatment"* OR *"mentali*ation based therapy")* AND ("*service user experience*"). This search returned 461 search results, 381 of which were duplicated in the previous search. A review of the remaining 80 search results revealed only one further paper (Beattie et al., 2019) which met the criteria for inclusion in the current meta-ethnography.

Data were extracted into a pre-designed proforma which included: study authors, year of publication, country where the research was published, research setting, number of participants, participant demographic characteristics, details of participant clinical presentation, MBT intervention details, data collection method and data analysis method. Study characteristics are presented in Table 2.5. A summary of the main constructs identified within each study was also extracted and is included as a separate table in Appendix C.

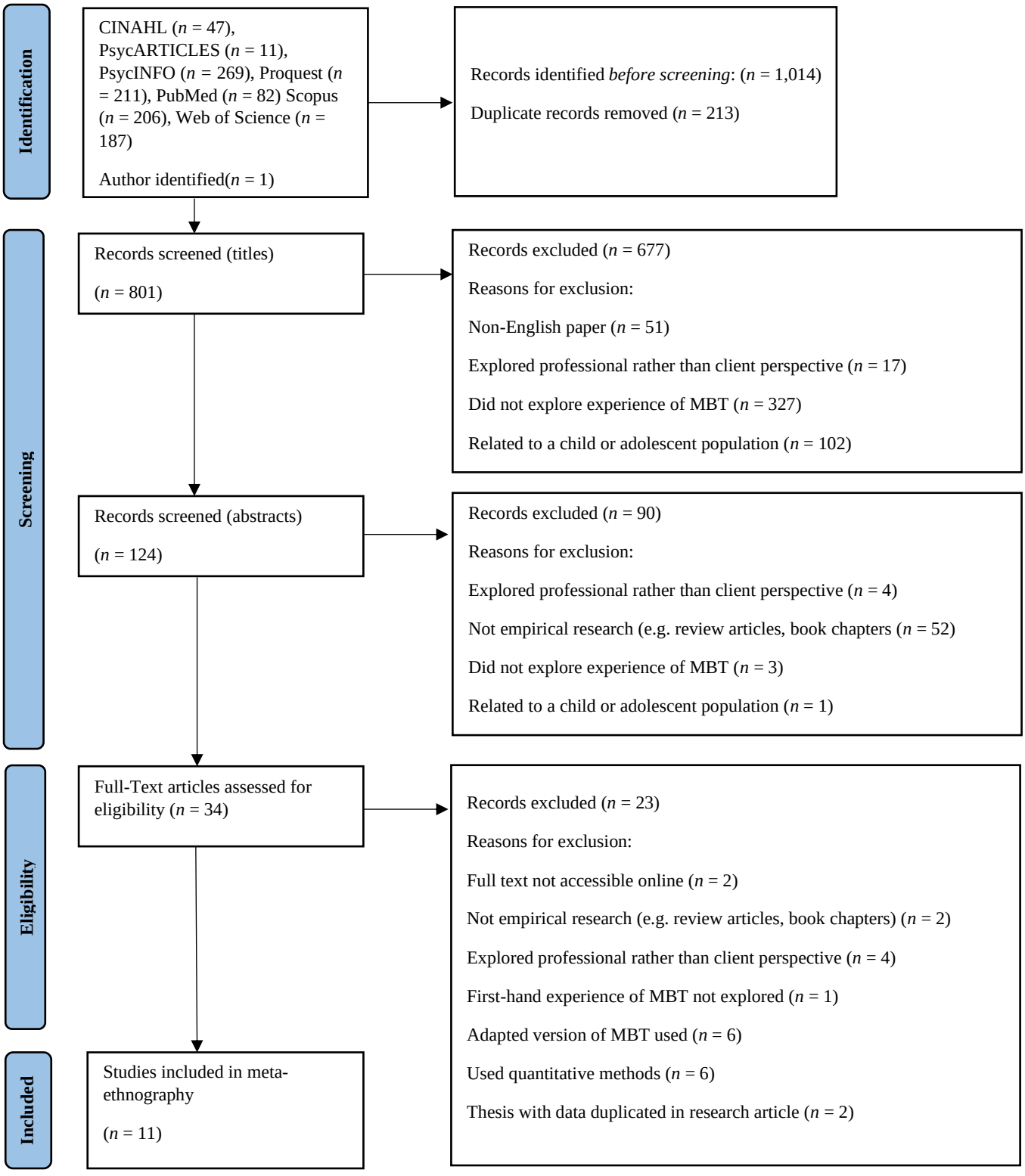

Figure 2.2: PRISMA flow diagram

Study Quality Appraisal

The Critical Appraisal Skills Programme (CASP, 2002) checklist for qualitative research was used to evaluate the methodological quality of the included studies (Appendix D). This tool was used as an appraisal of quality to contextualise the findings of the meta-ethnography only and studies were not excluded based on the CASP score. The scoring method outlined in Duggleby and colleagues (2010) was used to quantify each item of the CASP to provide an overall score of quality for each study. The maximum possible score that a study could be obtained using this method was 30. This scoring criteria is outlined in Table 2.3.

Table 2.3 CASP scoring system adapted from Duggleby and colleagues (2010).

Score	Scoring Criteria
3 (Strong)	Article extensively justified and explained the issue at hand.
2 (Moderate)	Study addressed a particular issue but did not fully elaborate on it.
1 (Weak)	Study offered little to no justification or explanation for a particular issue.

The first and second authors read and scored the articles independently. Both authors then discussed any major discrepancies between scores, paying close attention to items where they had a difference of two points. Through discussion of why certain scores were awarded and consensus agreement amongst both authors about these scores, each author agreed to amend several of their scores following this discussion. Each authors scores, which included the amended consensus scores, were used to calculate the percentage agreement between the first and second author which was 77%. The first author's scores, with included the altered consensus scores are presented for each study in Appendix E.

Data Synthesis

Reading the studies: Identifying second order constructs

The first stage of the synthesis process consisted of reading and re-reading the included papers. The second-order constructs were noted, and a table was created for each paper into which the second-order constructs, word for word, to preserve original meaning, were extracted. Raw data which illustrated each second order construct, were also extracted from each paper into a third column. An example of a table used for one of the studies is presented in Appendix F.

Determining how the studies are related through second order constructs

The next stage of the synthesis process aimed to determine how the second order constructs extracted from the 11 included papers related to one another. Each paper was added into a separate row in a

spreadsheet in chronological order. The second order constructs from each paper were added into the columns of the spreadsheet.

Translating the studies into one another

To translate the studies into one another, second order constructs which overlapped between the papers were noted and captured in the column headings on the spreadsheet. To preserve the original data, these headings used the original author's words or a close paraphrase. Next, the second order constructs from each paper were rearranged within each row to a position where the column heading represented that construct (See Appendix G for an illustrative screenshot). This facilitated the first author with reading down the grid, in order to compare conceptual descriptions across studies and subsequently construct a translation of each second order construct across the 11 included papers. This was completed through the use of two approaches: (i) *reciprocal translation*: identifying where key concepts between studies agree and; (ii) *refutational synthesis*: identifying where key concepts between studies do not agree. The outcome of this process is demonstrated in Table 2.4.

Synthesizing the translations

The final stage involved synthesizing the translations. This was an iterative process involving a repeated back-and-forth approach between the secondary constructs and subsequent translations of the secondary constructs. This resulted in an interpretation of the translated second order constructs into sub-themes and themes that represented the dataset. Relationships between the included studies appeared to be reciprocal. Through this process, a line of argument synthesis of the data was created.

Table 2.4: Translation of second order constructs

Temporal sequence used to organise 2nd order constructs	2nd Order Constructs	Summary definition of the 2nd order construct	Papers that included the 2nd order construct
1.	Ownership	Importance of autonomy in the decision to participate in MBT.	4, 10, 11
2.	My hopes and expectations: the last chance saloon	Beliefs and expectations about MBT and whether it would be beneficial.	3, 5, 11
3.	Become more prepared for longer-term therapy	Psychoeducational group seen as important for engagement in longer-term MBT.	3, 9
4.	Demands of the treatment	The physical, emotional and logistical challenges of attending MBT.	2, 3, 5, 9
5.	Building trust	Building trust with individual therapists, fellow group members and in MBT as a treatment is challenging but essential in benefitting from MBT.	2, 3, 5, 8, 9,
6.	Group MBT: A necessary evil	Recognition that participating in the group is a difficult but necessary aspect of MBT.	1, 2, 3, 5, 9, 10, 11,
7.	Individual Therapy: where it all comes together	Individual therapy considered to be a core component of MBT and where participants learn to integrate their knowledge and experiences from the other components of MBT.	9, 10
8.	The power of shared experiences	Being with people with shared experiences and who understood their difficulties provided a sense of support and belonging.	1, 2, 4, 5, 6, 8, 9, 10, 11
9.	Feeling the feeling	Increased understanding and awareness of emotions. For some this was beneficial for regulating emotion but others were left with an increase in felt emotion and a difficulty in coping with these feelings.	2, 3, 4, 6, 7, 8, 11
10.	Perceiving challenging incidents in a new way	Developing a more nuanced view of the world through a greater capacity to see the perspectives of others and reduced self-referencing.	2, 3, 6, 7, 9, 8, 10, 11
11.	Thinking things through	Thinking through past and present situations allowed participants to engage in less impulsive behaviour towards themselves and others.	7, 11

12.	MBT and the real world	Generalizing and applying MBT skills to the world outside of therapy or the group.	2, 3, 5, 6, 9, 10, 11
13.	Understanding of self	MBT played an active role in improved self-understanding.	1, 2, 5, 11
14.	BPD & Me	Understanding and relating to my BPD diagnosis and traits.	4, 5,
15.	MBT in secure facility	MBT appeared to fit productively into secure hospital life for participants.	11
16.	Being on a journey	Analogy of MBT as a journey that included periods of stability and instability for participants.	5

Results

Study Characteristics

Characteristics of the 11 included studies are presented in Table 2.5.

Participants

The sample size in the included studies ranged from 2 to 13, with a total of 69 participants included across all studies. The same participants were used in both studies published by Morken and colleagues (2017; 2019) therefore they are only considered once in the aggregate of participant data. The study completed by Beattie and colleagues (2019) was a mixed-methods study and, whereas 18 participants completed the quantitative aspect, only the two participants who took part in the qualitative aspect are considered in the participant data above. Participants predominantly identified as female (n = 38 across all studies), however data on gender were not presented in one study (Ditliefsen et al., 2020). Most participants had a clinical diagnosis of a personality disorder (PD), either BPD, Emotionally Unstable Personality Disorder (EUPD) or Anti-Social Personality Disorder (ASPD), or of difficulties associated with PD. Five of these studies also included participants with PD and other co-morbid disorders (Beattie et al., 2019; Ditliefsen et al., 2020; Morken et al., 2017; 2019; Ware et al., 2016). All studies were carried out in Europe; seven within the UK, three in Norway and one in Ireland.

Setting and treatment

Participants took part in MBT programs across inpatient, outpatient and community mental health settings. One study took place within a probation service (Thomas & Jenkins, 2019) and another recruited its participants via twitter and the treatment setting was not described (Dyson & Brown, 2016). The MBT intervention received by participants varied widely across the included studies. Participants in two studies had taken part in MBT-I, the introductory psychoeducation component of MBT only (Bradley-Scott, 2017; Ditliefsen et al., 2020). In one study participants were drawn from those who had completed a combination of MBT-I and at least nine months of MBT (Beattie et al., 2019) and participants in another study completed 18 months of MBT with individual sessions and group-based art therapy (Johnson et al., 2016). Across the remaining studies, participants had undergone MBT of both individual and group-based sessions for a duration ranging from 3-36 months.

Data collection and analysis

Data from 10 studies were collected via individual interviews with interviewers using topic guides or interview schedules, with one study using a participant constructed timeline as the basis for discussion

(Johnson et al., 2016). In six studies, data was analysed using IPA methodology. The remaining studies used thematic analysis or a variation of thematic analysis such as inductive thematic analysis (Johnson et al., 2016) or thematic analysis using a hermeneutic phenomenological epistemology (Morken et al., 2017; 2019).

Quality Appraisal of Included Studies

Quality appraisal scores on the CASP ranged from 19 to 30 out of a total possible score of 30. Individual scores on each item of the CASP for each included study are presented in Appendix E and total scores are presented alongside the study characteristics in Table 2.5. A qualitative methodology was appropriately utilised across all eleven studies. There was considerable variability across the included studies for the remaining CASP items. Most notably, seven of the included studies did not provide sufficient information pertaining to ethical considerations. Six studies did not provide sufficient information pertaining to researcher reflexivity. Five of the included studies provided sufficient information to justify the appropriateness of the recruitment strategy. Sufficient information to justify the use of the research design, rigour of the data analysis or value of the research was not provided in four of the included studies and two studies did not provide sufficient information on the findings or provide adequate information regarding whether the data was collected in a way that addressed the research question. One study did not provide sufficient information as to the aims of the research.

Table 2.5: Characteristics of included studies

Study	Country and setting	Participants	Clinical presentation	MBT Intervention	Data Collection	Data Analysis	Aims	CASP Score
1. Beattie et al. (2019)	Ireland General adult mental health service	*n*=2 Female (*n*=2) Age not reported for above subset of participants who took part in qualitative part of the study.	Clinical diagnosis of personality dysfunction with co-morbid disorder.	MBT psychoeducation (12 sessions), weekly group and individual sessions (Range: 9-27 months)	Semi-structured interviews	Thematic Analysis	1.Are service users likely to engage? 2.What are service-users' experiences of the program? 3.What are therapists' experience of delivering the program? 4.What are the direct/indirect benefits to individuals/the service?	22
2. Bradley-Scott (2017)	England Community Mental Health Team	*n*=8 Female (*n*=5) Male (*n*=3) Age: 31-45 years (*n*=6) 20-30 years (*n*=2)	Clinical Diagnosis of BPD/EUPD	MBT psychoeducation (10-12 sessions)	Semi-Structured interviews	IPA	1.What are people's experiences of MBT-psychoeducation groups in secondary care settings? 2. In what ways does the group impact how participants think about themselves and cope in everyday life? 3. In what ways does the group influence how participants think about others and experience interpersonal relationships, both inside and outside the group?	30
3. Ditlefsen et al. (2020)	Norway Outpatient specialist mental health service	*n*=12 No breakdown of gender included Mean age: 28 (21-36)	Diagnosis of personality disorder with co-morbid disorders	MBT psychoeducation: (13 sessions) Commenced individual and group MBT while completing psychoeducation.	Interviews	IPA	Explore participants' subjective experience of the psychoeducation group within the MBT program, its effects, challenges, and impact as an introductory part of the treatment program.	24

Study	Country and Setting	Participants	Clinical presentation of participants	MBT Intervention details	Data Collection Method	Data Analysis Method	Aims	CASP score
4.Dyson & Brown (2016)	England Setting not described.	*n*=6 Female (*n*=5) Male (*n*=1) Mean age: 31.6 (20-44)	BPD	MBT	Open-ended interview	IPA	What is the experience of MBT for individuals diagnosed with BPD?	23
5.Gardner et al (2019)	England Outpatient MBT programme	*n*=8 Female (*n*=8) Mean age: 41.6 (22-55)	Difficulties associated with BPD	Outpatient MBT Range: 10-18 months	Interview	IPA	To better understand service users' lived experiences of MBT including their experiences of change.	28
6.Johnson et al (2016)	England Community mental health setting	*n*=3 Female (*n*=3) Age not reported	Diagnosis of BPD	Individual MBT sessions and group-based art therapy (18 months)	Interview of MBT timeline	Inductive thematic analysis	Examine a gap in knowledge about the interaction between mentalizing skills and social inclusion activity immediately after completing an intensive MBT program.	19
7.Morken et al (2017)	Norway Inpatient and outpatient	*n*=13 Female: *n*=13 Mean age: 28 (Range not described)	Borderline traits and diagnosis of substance abuse disorder (SUD)	MBT (up to 36 months)	Semi-structured interviews	Thematic analysis	How do female patients with clinically significant borderline traits and comorbid SUD experience their own central change processes after participating in an MBT programme?	29

Study	Country where research conducted	Participant Demographics	Clinical presentation of participants	MBT Intervention details	Data Collection Method	Data Analysis Method	Aims	
8.Morken et al (2019)	Norway Inpatient and outpatients	*n*=13 Female: *n*=13 Mean age: 28 (20-41)	Comorbid PD and substance use disorder (SUD).	MBT (up to 36 months)	Semi-structured interviews	Thematic analysis	1.How do patients with PD/SUD experience MBT? 2.What elements of MBT do they describe as useful?	30
9. O'Lonargáin et al (2017)	England Outpatient	*n*=7 Female: *n*=2, Male: *n*=5 Mean age: 29.86 (26-52)	BPD	MBT group and individual therapy Mean number of months attended: 7.7 (range: 3-13 months)	Semi-structured interviews with topic guide	IPA	How do adults with difficulties associated with BPD experience outpatient MBT?	30
10. Thomas & Jenkins (2019)	Wales Community MBT programme delivered in a probation service	*n*=6 Male: *n*=6 Mean Age: 41 (33-57)	ASPD	MBT (range 12-52 sessions)	Semi-structured interview	Thematic Analysis	1.To explore the experiences of offenders with ASPD who have participated in an MBT programme in the community 2.To explore the perceived effectiveness of the group from service-users' perspectives and contribute to the research base for MBT as a treatment for offenders with ASPD.	25
11. Ware et al (2016)	England High secure hospital	*n*=4 Male: *n*=4 Mean age: 40 (27-57)	Personality disorder or paranoid schizophrenia	MBT individual and group sessions (18 months)	Semi-structured interview	IPA	To explore MBT as within a forensic setting as an intervention designed to moderate deficits linked to violence and to improve adaptive coping	28

Meta-synthesis findings

A line of argument synthesis was comprised from the three superordinate themes identified within the data (Figure 2.3). This line of argument outlined that participant experience of engaging in MBT consisted broadly of three different developmental stages. Firstly, the experience of navigating the structure and therapeutic process of MBT itself was described, next the processes that had facilitated change during therapy were reflected on and considered last was the application of these newly developed processes outside of the therapeutic space.

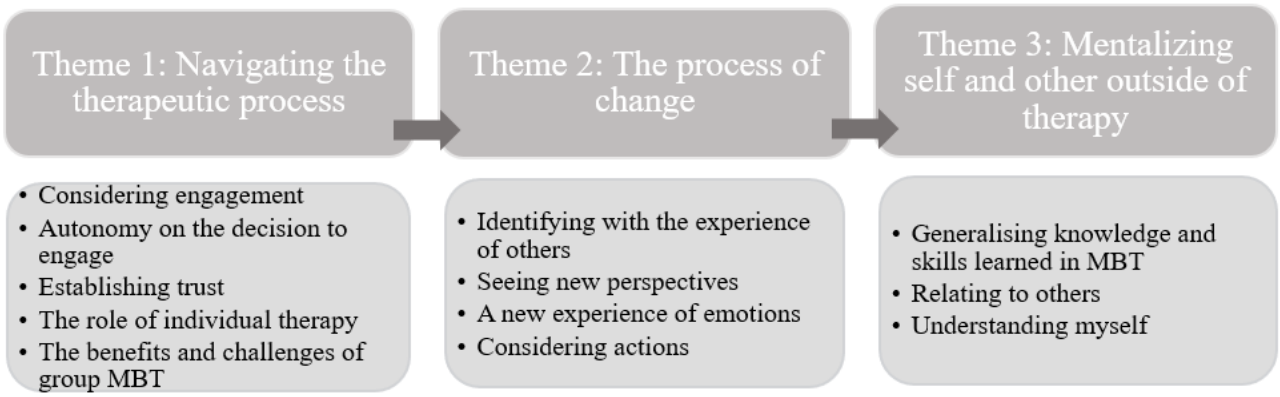

Figure 2.3: Line of argument synthesis identified from the data which comprised of three superordinate themes.

Theme one: Navigating the Therapeutic Process

Considering engagement

The expectations varied for participants about what undertaking MBT would entail and how it would support them with their difficulties. This appeared to be associated with how much knowledge and awareness that participants had about MBT before starting (Dyson & Brown, 2016; Gardner et al., 2019; Ware et al., 2016). *"...because there isn't a lot of information out there about mentalization, um, really. And so it was really kind of going in blind to do it…"*(Dyson & Brown, 2016, p. 591). Completing the MBT psychoeducation group before entering longer term MBT appeared to be helpful in terms of expectations with some reporting that it facilitated their engagement into longer-term therapy (Ditliefsen et al., 2020; Ó'Lonargáin et al., 2017).

Autonomy on the decision to engage

Participants spoke of the importance of having autonomy over their choice to engage in MBT (Dyson & Brown, 2016; Thomas & Jenkins, 2019; Ware et al., 2016). This sense of agency or control was of particular importance for participants who engaged with MBT within forensic services, where

participants had little control over their everyday lives (Ware et al., 2016). This appeared to positively impact both participant engagement and how MBT was viewed as an intervention (Thomas & Jenkins, 2019). *"I didn't have to do it . . . it was voluntary . . . I can get up and go . . . You know what I mean, it's very important. Never force anyone to do anything."* (Thomas & Jenkins, 2019, p.10). Where participants reported feeling pressured to attend MBT by their clinical team, this appeared to negatively impact participant engagement (Ware et al., 2016).

Establishing Trust

The building of a trusting relationship both between individual clients and their therapists and between individual members of the group was a prerequisite for engagement in MBT. Participants reported that it was easier to build a trusting relationship with their individual therapist (Gardner et al., 2019; Ó'Lonargáin et al., 2017). Building trust with other group members was more difficult and was described as a gradual process which took time to in order for participants to feel comfortable (Bradley-Scott, 2017; Ó'Lonargáin et al., 2017). When participants were absent or late to the group, this impacted participant's sense of safety and trust (Bradley-Scott, 2017). *"... when you're kind of getting in to the flow of it and you don't trust people easily… I don't think they thought it was a big deal, but I know that it distressed me"* (Bradley-Scott, 2017, p.57). Rolling groups also made the transition of new members into the group more difficult as the sense of trust and openness that had previously been built was disrupted when new members joined (Ó'Lonargáin et al., 2017).

The role of individual therapy

Individual therapy was described as the '*core component*' (Ó'Lonargáin et al., 2017, p. 21) of MBT. Participants felt more comfortable discussing topics in individual therapy than in the group and others reported that discussing uncomfortable topics in individual therapy gave them the confidence to subsequently discuss them in the group (Ó'Lonargáin et al., 2017; Thomas & Jenkins, 2019). Validation, acceptance, empathy, stability, consistency, and an ability to tolerate the participants distress were important qualities of the therapist as well as aspects of the therapeutic relationship which made participants feel safe (Gardner et al., 2019; Morken et al., 2019). Some participants reported having negative feelings towards their therapists but found it uncomfortable to talk about, placing the blame on themselves for having these feelings (Morken et al., 2019). However, when the therapeutic relationship was discussed openly within sessions, ruptures were resolved earlier and this created a place of greater safety for participants and a key factor in their continuing to engage with MBT (Morken et al., 2019). *"What I noticed was that there was less conflict with the therapist than with earlier therapists, and that when there was a conflict some effort were made to try and fix it …*" (Morken et al., 2019, p.8).

The benefits and challenges of group MBT

Participants valued the group sessions, reporting that they were an important part of the overall MBT structure. For some, the group itself provided learning and insight, while group processes were also often reflected on within individual therapy sessions, providing valuable opportunities for learning (Gardner et al., 2019; Ó'Lonargáin et al., 2017). However, the value of the group was frequently juxtaposed with the challenges that participants faced while attending and, as such, it was described by one participant as a '*necessary evil*' (Gardner et al., 2019, p.7). Participants reported feeling quite vulnerable within the group setting, reporting that it could feel unpredictable at times (Ó'Lonargáin et al., 2017). Speaking in front of others made people feel self-conscious and brought up feelings of anxiety, particularly when making personal disclosures, or talking about 'raw' emotions and difficult topics (Beattie et al., 2019; Bradley-Scott, 2017; Ditliefsen et al., 2020; Ó'Lonargáin et al., 2017). Others felt uncomfortable in the group due to their perceptions of being judged or criticised by other group members (Ó'Lonargáin et al., 2017).

The balance of group participation between members seemed to cause distress for several participants. Some found it difficult to fully participate or contribute to discussions within the group as it was perceived that other group members 'dominated' (Ware et al., 2016, p.8) or took up a lot of time during group sessions (Bradley-Scott, 2017; Gardner et al., 2019; Ó'Lonargáin et al., 2017). *'... people would just talk all the way through, and not give anyone a chance to speak'* (Ware et al., 2016, p.8).

Theme two: The Processes of Change in MBT

Identifying with the experience of others

Most participants described the shared experience of being in a group of individuals with similar difficulties as helpful, noting that it provided a sense of connection, belonging, support and trust (Beattie et al., 2019; Bradley-Scott, 2017; Dyson & Brown, 2016; Gardner et al., 2019; Johnson et al., 2016; Morken et al., 2019; Ó'Lonargáin et al., 2017; Thomas & Jenkins, 2019). *"it's sort of a sense of relief that 'God, it's not just me. It's not just me that feels this way about things, or has problems'"* (Bradley-Scott, 2017, p.60). Shared experiences within the group also led to increased self-acceptance among individuals as well as less shame around their difficulties (Ditliefsen et al., 2020; Morken et al., 2019). Being in a group of people with similar challenges also provided the opportunity to learn from others in terms of experiences and ways of coping (Bradley-Scott, 2017; Ditliefsen et al., 2020; Gardner et al., 2019). However, some described feeling a sense of isolation and sadness while participating in the group (Dyson & Brown, 2016) and others felt that the group highlighted the 'intolerable' parts of their identity (Bradley-Scott, 2017).

Seeing new perspectives

Before MBT, participants felt unable to make sense of the intentions of others. Through participating in the group element of MBT, participants had begun to think about the perspectives of others in the room. This gradually led to an increased ability to see the perspectives of others outside of the group (Bradley-Scott, 2017; Ditliefsen et al., 2020; Johnson et al., 2016; Morken et al., 2017; 2019; Ó'Lonargáin et al., 2017; Ware et al., 2016). *"I was able to open up and, sort of, listen to people more deeply. I was able to empathize more … and it's not all about me, it became more of a 'team' effort. I think that's what ultimately helped so, putting myself in their shoes".* (Bradley-Scott, 2017, p.61). Previously, participants had often blamed others for misunderstandings and conflicts. Now, participants were looking inwards and questioning their role in conflicts with others, rather than looking outwards for explanations or making assumptions about the intentions of others (Morken et al., 2017; Ó'Lonargáin et al., 2017; Thomas & Jenkins, 2019). Participants noted a shift from interpreting the negative behaviour of others as being solely directed towards them, to now being curious and empathetically reflecting on the reasons for another person's behaviour (Morken et al., 2017). This was due to their newly developed ability to differentiate between thoughts and feelings, juggle different potential explanations simultaneously and the realisation that others were responsible for their own behaviour (Morken et al., 2017).

A new experience of emotions

The experience of having intense emotions was normalized by participating in MBT. Through their engagement with MBT, participants felt supported to understand, process, tolerate and cope with these emotions (Bradley-Scott, 2017). MBT gave participants a vocabulary with which to describe their emotional experience for the first time (Morken et al., 2017; 2019; Ware et al., 2016). However, some described that their day-to-day felt experience had, in fact, worsened and the increased sense of self-awareness that participants had led to an increased sense of painful emotions and vulnerability (Dyson & Brown, 2016; Johnson et al., 2016). *"I think those going in to MBT need to be aware of the sadness that comes with really seeing yourself for the first time …*" (Johnson et al., 2016, p.48). Some participants felt that having an increased self-awareness without additional coping tools was not helpful and served to increase overall anxiety (Bradley-Scott, 2017).

Considering actions

Where previously, participants described impulsive behaviour as a common feature of their lives, now participants reported questioning their own mind-states and juggling different options back and forth before acting (Morken et al., 2017). *I was very impulsive, acted on impulse right,… now I think things through before I do them".* (Morken et al., 2017, p.8). This newly increased capacity for self-reflection allowed participants to consider more thoughtful ways of acting in future scenarios that could arise (Ware et al., 2016).

Theme three: Mentalizing Self and Other Outside of Therapy

Generalizing knowledge and skills learned in MBT

Participants noted that they had begun to apply the skills that they had learned in MBT to their lives outside of then therapeutic space (Johnson et al., 2016; Gardner et al., 2019; Ware et al., 2016). "*…None of us actually realised that we were using our mentalization based therapy skills. Because you don't just use MBT in the group, you use it throughout life, those skills; you're using them all the time."* (Ware et al., 2016, p.9). Initially, this had been a conscious process, but it became more automatic over time (Johnson et al., 2016). Continued use of mentalizing after the group helped participants to further develop a more nuanced view of the world (Johnson et al., 2016). For those that only undertook the psychoeducation component of MBT, there was a sense that this group was only the 'first step'. It was felt that they would not have sufficient competency to apply their mentalization skills without engaging in the next stage of MBT (Bradley-Scott, 2017). However, some participants described feeling able to proceed and experiment with the 'new tools' that they had obtained from participating in the group (Ditliefsen et al., 2020). Those that engaged in MBT within a probation service noted that it was more valuable to have completed the group in the community as 'trying things out' there felt easier (Thomas & Jenkins, 2019).

Relating to others

Before starting MBT, participants reported that they felt '*stuck in very rigid forms of relating*'. (p.47; Johnson et al., 2016). However, engaging in MBT had changed their interpersonal interactions (Dyson & Brown, 2016) as participants made attempts to use the knowledge, they had acquired in MBT to change how they related to friends, family, and colleagues (Bradley-Scott, 2017; Ditliefsen et al., 2020; Gardner et al., 2019; Thomas & Jenkins, 2019). Participants' new perspectives on relationships helped to improve and maintain current relationships (Beattie et al., 2019; Morken et al., 2017; Ó'Lonargáin et al., 2017) as well as build new ones (Johnson et al., 2016). *"I feel my life is a long story of repeated misunderstandings. Now I feel I have the tools to manage them, or even avoid, these from happening."* (Ditliefsen et al., 2020, p.9). As participants developed an understanding of both their own and others mental states, this opened up their understanding of how their previous behaviour had impacted on other people. Subsequently, they began to appraise how they had behaved in the past. This was particularly salient for those who had previously engaged in criminal behaviour (Ware et al., 2016).*"[MBT] makes you think of like, say you like do a house robbery, or rob someone in the street, how they feel about what happened, and how they feel about you…So you think about it, or how you would feel if someone did something to you."* (Ware et al., 2016, p.13)

Understanding myself

Participants indicated that undergoing MBT played an active role in them coming to understand their mental health diagnosis, their own mental states and make sense of what had happened to them in the past (Dyson & Brown, 2016; Ware et al., 2016). Directly relating to and applying the information from the group was a key element of this, leading participants to report feelings of increased self-acceptance, trust, self-worth and confidence as well as an improved sense of self (Beattie et al., 2019; Bradley-Scott, 2017; Gardner et al., 2019). Reflecting on past experiences with a mentalizing stance helped other participants to process past experiences which, in turn, further developed their self-understanding. This was a reciprocal process which in turn fostered their capacity to mentalize and understand others more (Ware et al., 2016; Bradley-Scott, 2017).

Discussion

Summary of Findings

The findings of this meta-ethnography described clients' experience of MBT. Three overarching themes emerged from the data which highlighted individuals' experience of the therapeutic process, the process of change and the therapeutic impact of engaging in MBT.

Navigating the Therapeutic Process

These synthesized findings describe participants' experience of the therapeutic process of MBT. Participants required a lot of information before making the decision to engage in MBT and having autonomy over their choice to engage was important. In essence, participants needed to gain a sense of trust in the therapy and its effectiveness before participating in MBT. Once participants started to engage, establishing trust among the different facets of MBT was highly valued. Individuals with difficulties associated with BPD or ASPD, typically will have experienced early life adversity and attachment trauma and can perceive others as untrustworthy and hold fears that they may be abandoned or rejected (Fonagy & Alison, 2014; Masland, Schnell & Shah, 2020; Stanley & Siever, 2010; Yakeley, 2004). Therefore, it is understandable that it may be difficult for these individuals to trust in the treatment, therapists, and other group members.

The development of epistemic trust, an individual's willingness to consider new interpersonally transmitted knowledge as trustworthy and relevant is a key target in the early stages of MBT (Fonagy & Alison, 2014). Epistemic Trust (ET) develops in the context of a secure attachment relationship and is facilitated by parental mentalization (Kamphuis & Finn, 2019). The model of MBT proposes that an attachment relationship is required for an individual to establish their capacity for ET, first within the therapeutic relationship and then moving to relationships outside of therapy (Luyten & Fonagy, 2019).

In MBT, the therapist aims to serve as an attachment figure for the client whilst also fostering ET in an individual by mentalizing within the therapeutic relationship (Karterud & Bateman, 2010). These synthesized findings illustrate the importance of the therapeutic relationship for participants in MBT. The qualities of the therapist that facilitated the development of the relationship as well as the therapist's ability to resolve ruptures were named as important for continued participant engagement. It appeared that group MBT posed a particular challenge for many participants for a variety of reasons such as the perception of being judged by others or due to the unpredictable nature of the group. It is possible that these factors made it more difficult to establish a therapeutic alliance with the group therapist and subsequently made it more difficult for participants to develop trust in this context. This may be particularly salient for those MBT interventions that involved participation in a group only, such as MBT-I.

Processes of Change

This meta-ethnography outlined participant reports of mechanisms of change experienced in MBT. These processes included increased self-acceptance due to shared experiences with others, the development of a better understanding of other's perspectives, experiencing and understanding emotions in a new way and increased self-reflection. It is notable that these facets of change all tie into the overall conceptualization of mentalizing capacity which refers to an individual's capacity to recognise and imagine their own internal mental states, as well as those of others, and to understand and interpret one's own and others' actions as meaningful on the basis of these states (Allen et al., 2008). There is currently little evidence within the quantitative literature to demonstrate that an individual's mentalizing capacity improves as a result of MBT. The research instead has focused on reporting the improvement in clinical outcomes such as reductions in self-harm or hospital admissions. The findings of this meta-ethnography, in terms of the specific changes that clients reported in the context of undergoing MBT, provides initial evidence for increased mentalization capacity as a result of engaging in MBT.

Some participants reported that as their insight increased, so did their experience of painful emotions. Although unveiling new insights is reported to be one of the most helpful events in therapy, these insights can also be emotionally challenging (Hill & Knox, 2008; Timulak. 2010). Within psychodynamic therapies, there is evidence to suggest that an increase in insight comes before increases in other areas such as interpersonal functioning (Johannson et al., 2010). A key focus within the MBT model is to provide validation and normalize the emotions associated with traumatic experiences in order to facilitate the client to mentalize these experiences. The aim is to facilitate the client to develop alternative ways of viewing the past and impact that it has on the present. However, rather than focus on the content of previous experiences, the focus in MBT is to mentalize these experiences (Luyten & Fonagy, 2019). Some participants reported feeling frustrated that they were

left with this increase in insight but without any coping skills to deal with the painful emotions that this left them with. This may be a potential drawback of engaging in MBT-I as those who do not engage in long term MBT may be left with these unresolved feelings.

Mentalizing Self and Other

This meta-ethnography synthesised what the experience of generalizing new knowledge and skills to the world outside of therapy was like and unveiled the impact that engaging in MBT had on participants. The two main aspects of their lives where participants noted an impact of MBT were that of understanding themselves and of learning to relate to others. This appeared to be a reciprocal process whereby the more participants were able to make sense of their past experiences and their own mental states, the more they were able to understand the mental states of others. It is noted by Fonagy and Luyten (2018) that mentalizing is organised around four polarities, one of which is mentalizing with regard to self or others. Individuals who experience mentalizing difficulties often experience an imbalance in this polarity, leading them to focus preferentially on one side over the other or experience impairments at both (Fonagy & Bateman, 2019. The findings of this meta-ethnography indicate that participants have developed a new level of insight regarding themselves and others. Some of the studies have alluded to how engaging in MBT led to improvements in their interpersonal relationships with friends, family and colleagues, perhaps indicating that they have achieved greater balance in the self vs other polarity as a result of engaging in MBT. However, from these findings, the impact of MBT in participant's lives appears to be primarily one of understanding. This is of course of benefit to participants, and it may be that over time this insight will lead to ongoing life changes. Of note, even those participants who engaged in MBT-I appeared to gain significant understanding and insight, indicating that even engaging with MBT on a short-term basis may still have notable benefits.

Implications for Research and Practice

The findings of this meta-ethnography have several implications for both the clinical and research practice of MBT. As highlighted by the findings, the decision to engage in MBT is one which requires a lot of consideration for individuals. It appears that offering all individuals the opportunity to access MBT-I before considering long-term MBT would be beneficial for engagement. In addition, allowing participants autonomy over the decision to engage in MBT is of vital importance, particularly for those individuals in forensic settings. These findings also imply that increasing an individual's insight or understanding can lead to an increase in felt negative emotions. If services are considering implementing MBT-I as an intervention, consideration should be given to including some relevant coping skills for participants within the group curriculum. In addition, where services plan to implement MBT in a group format only, and not include individual therapy alongside this, the impact

of group factors on the development of the therapeutic alliance should be considered. Future research should note the duration between when the MBT intervention ended and when the research interview was completed, as there is evidence to suggest that when insight is developed within a therapeutic setting, therapeutic gains can continue to increase after therapy. This may have implications for what participants report when they are recalling their experience of MBT. Additionally, research with longer-term follow up times should also be completed. Within this meta-ethnography, the different configurations of MBT within each study made it difficult to tease apart the context of each participant's experience of the intervention. The design of future research should consider adhering to the manualised MBT structure to allow for more adequate comparison across different studies. Lastly, as MBT purports to be transdiagnostic in nature, future research in other types of presentations and settings would be valuable.

Strengths and Limitations

This meta-ethnography had several notable strengths and limitations. In terms of strengths, a large proportion of the included studies used a hermeneutical methodology which provided greater scope to allow the authors to interpret what participants felt were important in their lived experience of MBT. Additionally, the overall quality of the included studies was rated as high, with six of the included studies scoring 28 or above on the CASP. However, across several of the studies sufficient information pertaining to ethical considerations, the appropriateness of the research strategy, researcher reflexivity, rigour of the data analysis, or the value of the research was not adequately described. Further limitations included poor consistency regarding the description of the MBT interventions as well as the wide variability regarding the nature and duration of the MBT intervention that participants received. It is important that future research in this area takes these limitations into consideration. Lastly, only studies which were published in the English language were included

Conclusions

This meta-ethnography synthesized participant experience of engaging in MBT. The overarching themes highlighted participant experience of navigating the therapeutic process of MBT, the processes of change in MBT and the impact of MBT on their lives. This work offers new insights into participant experience of MBT and offers suggestions for how future MBT interventions could be implemented. Future research on long term therapeutic gains which include other types of presentations and settings would also be of value.

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Chapter 3: Major Research Project Extended Methodology

Study Design

Interpretative Phenomenological Analysis (IPA) was used in this study to explore how individuals made sense of their capacity to mentalize following their completion of an introductory Mentalization Based Treatment group. IPA aims to explore and provide a detailed account of both an individual's lived experience and how that individual makes sense of their lived experience (Smith, 2004). To examine this process, IPA draws on the principles of phenomenology, hermeneutics and idiography.

Phenomenology

Phenomenology is the philosophical approach to the study of experience and is concerned with how an individual comes to understand their experience of the world, particularly in terms of what matters to that individual (Smith, 2011). The field of phenomenological enquiry was initially influenced by Edmund Husserl's transcendental phenomenology. For Husserl, phenomenology was about identifying and suspending our assumptions, through the process of 'bracketing', in order to access the universal essence of a certain phenomenon (Larkin & Thomson, 2012; Smith et al., 2022). Studies which utilise a phenomenological method focus on how participants talk about their experiences rather than providing a description of these experiences (Pietkiewicz & Smith, 2012).

Hermeneutics

Hermeneutics, the theory of interpretation or meaning, is the second theoretical underpinning of IPA (Smith et al., 2022; Tuffour, 2017). Heidegger (1962) argued for the case of a hermeneutic phenomenology, where our access to the taken-for-granted nature of experience is always through interpretation (Smith et al., 2022). He further noted that interpretation is founded on 'fore-conception', meaning that the researcher will bring their prior experiences, assumptions or preconceptions into the analysis or interpretation of the text of the transcript. This view was also shared by Gadamer (1990), and both felt that while our pre-conceptions may precede our encounter with the text, it may also work the other way, from the text to the fore-structure. As such, sometimes preconceptions can be identified in advance and sometimes they will emerge as the researcher engages with the text through the analysis. As such, bracketing should be a cyclical rather than a linear process, while acknowledging that is a process which can only partially achieved (Smith et al., 2022).

The concept of the hermeneutic circle is an important idea in hermeneutic theory and provides a useful way of thinking about how to approach data analysis in IPA. It is concerned with the dynamic relationship between the part and the whole where, to understand any given part, you look to the whole and to understand the whole, you look to the parts. In the context of data analysis in IPA, when moving through a section of text, the meaning of a participant's use of a particular word may only become clear in the context of the sentence in which it is used, and the meaning of the sentence is dependent on the cumulative meanings of the individual words. The hermeneutic circle emphasises the iterative nature of data analysis in IPA (Smith et al., 2022). The process of analysis during IPA is typically described in terms of a *double hermeneutic*, where in the text, the participant is attempting to make meaning of their experience and where during the analytic process the researcher is attempting to make sense of the participant's meaning (Smith & Osbourne, 2008). Lastly, Ricoeur (1970 as cited in Smith et al., 2022) made the distinction between the hermeneutics of meaning recollection or empathic engagement and the hermeneutics of suspicion, which allows the researcher to engage with meaning that participants "would be unlikely, unable or unwilling to see or acknowledge themselves" (Smith, 2004, p. 46). Therefore, IPA is concerned with trying to understand what it is like from the point of view of the participants while at the same time ask critical questions of participants' accounts (Shinebourne, 2011).

Idiography

Idiography, which refers to an in-depth analysis of single cases and the perspective of individual participants is the third theoretical orientation which IPA relies on (Pietkiewicz & Smith, 2012). The idiographic approach postulates that each individual case should be explored before any general statements about the data are produced. In this way, in IPA researchers focus on the particular rather than the universal (Smith et al., 1995). Therefore, during the analytic process, the researcher will typically begin by examining the transcript of the first participant in great detail before moving on to subsequent transcripts in an equally detailed way (Pietkiewicz & Smith, 2012).

Rationale for study design

IPA was chosen as the most appropriate method of data analysis for this project as it is concerned with the detailed examination of personal lived experience, the meaning of experience to participants and how participants make sense of that experience (Smith, 2011). Mentalizing capacity develops as a consequence of an individual's early life experiences and can develop while undergoing Mentalization Based Treatment (MBT) in conjunction with the unique opportunities that may arise in everyday life to practice mentalizing. Therefore, it is appropriate to look at the lived experience of

each individual participant in attempting to broach the research question which asks: 'how do people make sense of their capacity to mentalize after completing MBT-I within a prison setting?' IPA is concerned with understanding how particular experiential phenomena are understood from the perspective of particular people in a particular context. Therefore, a further reason for choosing IPA as a methodology was due to its inductive nature which may contribute to a greater understanding of the idiographic experiences of men who undergo MBT within a prison setting, a population which has largely been neglected within the research literature. Lastly, IPA methodology has been employed in previous research which examines participant experience of MBT in wider contexts (e.g. Ditlefsen et al. 2020; Dyson & Brown, 2016; O'Lonargáin et al., 2017) therefore demonstrating its suitability for the current study.

Participants

Sampling

In keeping with an IPA approach, purposive sampling of participants was used in the current study. The aim of this research was to explore how individuals make sense of their capacity to mentalize after completing a short term mentalization-based treatment group within a prison setting. Therefore, the participants were recruited from a group of individuals in custody who had completed an introductory Mentalization Based Treatment (MBT-I) group within an Irish prison. Due to the idiographic nature of IPA, sample sizes are typically small to allow for an in-depth analysis of each individual case although numbers can vary depending on specific factors, such as the richness of data (Smith et al., 2022; Smith & Osborn, 2008). Four participants were interviewed for the current study and the data obtained from these interviews was considered sufficiently rich in order to explore the research question. Studies utilising an IPA approach also attempt to use a relatively homogenous sample on the basis of social factors or theoretical factors relevant to the study (Smith et al., 2022). The sample used in this study was considered homogenous as all participants who took part in the study were male, had a history of violent behaviour prior to their engagement with MBT-I, were all from similar socioeconomic backgrounds within the South of Ireland and all completed the same MBT-I group.

MBT introductory group (MBT-I)

The participants in this study completed a manualised MBT-I group adapted for those with antisocial personality disorder (Bateman & Fonagy, 2016). The topics covered within the group include mentalizing, antisocial personality disorder, emotions and emotion regulation. Within each session of

the group there is a focus on experiential mentalizing, developing the therapeutic alliance, increasing participant empowerment through understanding and increasing motivation to pursue longer term treatment. Sessions ran weekly for eight weeks and were 75 minutes each in duration. The group was run by two facilitators, a clinical psychologist and a counselling psychologist, both who were trained in MBT. To be considered for inclusion in the MBT-I group participants must be: (i) aged over 18 years; (ii) have a history of aggressive acts; (iii) be able and willing to provide written informed consent; (iv) demonstrate some motivation for treatment; (v) express a commitment to remain in the prison until the completion date of the course. Participants are referred to the group from a number of sources which include: (i) self-referral; (ii) referral from staff within the prison e.g. prison governor, medical staff; (iii) addiction services or (iv) staff of the psychology service may also offer a place in the group to those on the psychology waiting list or those on the list of people currently in custody.

Inclusion and exclusion criteria

The inclusion criteria for the following study were:

(i) aged 18 years or over
(ii) have completed the MBT-I group in past 12 months
(iii) be able and willing to provide written informed consent.

The exclusion criteria for participation in the study were:

(i) a history of severe traumatic brain injury or other significant cognitive impairment
(ii) inadequate English to participate in informed consent and group therapy

Recruitment process

Individuals who completed the MBT-I group and who met the inclusion criteria were approached and informed of the study by an assistant psychologist (AP) working within the prison. Individuals who expressed an interest in participating were provided with a copy of the study information leaflet. Any individuals with literacy difficulties were provided with support to read through this leaflet. Each individual was then provided with an expression of interest form and was asked to indicate whether or not they were interested in taking part in the research. Each individual completed their response out of the view of the AP and enclosed their response in an envelope provided so that the AP would not be aware of their decision. All participants were informed that their decision would not impact any future opportunities to engage with the prison psychology service. Individuals in custody are considered vulnerable research participants who may feel pressure to participate in research within the prison environment (Charles et al., 2016). Therefore, this additional step to the process for obtaining informed consent was added to the research protocol, to reduce the likelihood of social desirability

playing a role in their consenting to take part in the study. All envelopes were then returned to the research supervisor in the prison psychology service. The research supervisor opened each envelope and those who had expressed an interest in taking part had an interview scheduled either in person or by phone with the primary researcher at a time and day that was suitable for them. No further action was taken with those who had not expressed an interest in the study.

Participants

Five out of the eight individuals who had completed the MBT-I group expressed an interest in taking part in the study. Of those individuals who agreed, interviews were completed with four out of these five individuals. Interviews were completed with three participants over the phone and one interview was completed in person. An interview was not completed with the fifth individual due to his transfer to another prison and subsequent release.

Data Collection

Method

In-depth semi-structured interviews are considered to be the most appropriate method with which to collect a rich, detailed and first-person account of an individual's experiences and are considered optimal for IPA studies. Interviews in IPA studies do not follow a prescribed method and both the interviewer and interviewee play an active role in the process (Smith et al., 2022). The interview schedule is typically used flexibly throughout the process and participants are probed in order to learn more about their experience (Smith, 2017).

Interview schedule

A draft interview schedule was constructed through searching the literature and consulting supervisors. This was then submitted as part of overall research ethics application to the UCC Clinical Psychology Research Ethics committee (CPREC). The feedback received from CPREC asked for further clarification about how the research questions were developed and how they were informed by the literature, specifically the different domains of mentalizing. As a result of this feedback, the interview schedule was revised in consultation with the research supervisor and the semi-structured interview schedule was then finalised (Appendix H).

All questions in the interview schedule were open and non-leading in order to facilitate each participant to talk about each topic at length. The interview schedule was comprised of three sections.

The ‘Opening’ section was designed to allow the participant to become accustomed to the interview setting. The opening questions included; asking the participant to provide a descriptive account of how they came to hear about the MBT-I group, what things were like for them before they started the group, and what their overall experience of the group was like. The questions in the second section were designed to address the research question of “How do people make sense of their capacity to mentalize after completing MBT-I within a prison setting?” and aimed to serve as prompts to facilitate participants to reflect on their experience of developing their mentalizing capacity. This section of the interview schedule was informed by the definition of mentalizing as outlined in the literature, specifically, that mentalizing relates to how a person recognises and imagines their own internal mental states as well as the internal states of others (Allen et al., 2008). It was also informed by what is known about some of the difficulties experienced by those with poor mentalizing capacity such as emotional dysregulation, impulsive behaviours, dysfunctional relationships, aggressive behaviour and violence towards self and others (Jorgensen et al., 2013; Møller et al., 2014). The third and final ‘Closing’ section included two final questions which allowed the participant the opportunity to add any further information that they felt was important. This section also allowed for the researcher to determine what the experience of the interview was like for the participant and to ascertain whether the participant needed further debriefing around feelings or emotions that may have arisen during the course of the interview.

Interview procedure

Each participant took part in an interview of a duration ranging from 40 minutes to one hour either by phone or in person. At the outset of each interview, the information and consent form were outlined again with each participant. They were also reminded that their participation was entirely voluntary and that they could at this point still chose to withdraw from the study without providing a reason for doing so. All participants were also provided with the opportunity to ask questions. When the interviews were completed over the phone, participants were facilitated to sign the consent form by an assistant psychologist working in the prison. Interviews were recorded on a video camera with the camera pointed away from the participant in order to maintain their anonymity.

The interview schedule served as a guide throughout the interview process. A flexible adherence to the interview topics was employed to allow the participant to lead in expressing how they make sense of their own lived experience. At the end of the interview, all participants were asked how they found the interview process. All participants reported finding the interview a positive experience. After the interview has been completed, participants were asked a series of demographic questions to allow for description of the sample. Notes were taken after each interview for entry into the reflexive research diary.

Transcription procedure

Each interview was transcribed verbatim from the audio recording for each participant. All transcripts were double checked against their audio recordings to maintain accuracy of the raw data. Once the transcript from each recording was complete, the video recording was deleted. Each participant was provided with a pseudonym and any identifying information was removed from each of the transcripts.

Data Analysis

Recent amendments to the data analysis terminology

In the most recent edition of their book, *Interpretative Phenomenological Analysis: Theory, Method and Research,* Smith and colleagues (2022) made changes to the terminology used during the data analysis process. What were previously described as *emergent themes* are now called *experiential statements*. *Personal experiential themes* (PETs), previously known as superordinate themes, describes a collection of related experiential statements from a participant. *Group experiential themes,* previously known as group themes, are constructed from patterns of similarity or differences across the PETs from each transcript.

Data analysis procedure

Data analysis was carried out according to the procedures outlined by Smith and colleagues (2022). Although Smith and colleagues (2022) outline a series of sequential steps in which to analyse the data, these steps were applied in a flexible nature and the analysis was completed as an iterative and inductive process.

Step 1: Reading and re-reading

Each transcript was firstly read and then re-read in order to become immersed fully in the participants experience.

Step 2: Exploratory Noting

Each transcript was copied to a word document which contained three columns. The first column was reserved for compiling experiential statements, described in Step 3 below. The second column contained the original transcript of the interview. The third column was reserved for exploratory notes which were compiled during the first, second and subsequent readings of the transcript. There was no structure for the exploratory noting process and anything of interest was noted in this column. These notes typically included processes and events that were important to the participant and the meaning they held for the participant. They also included speculative interpretations about the participant's

experience as well as reflective notes about the potential meaning of specific words or phrases to the researcher and a reflection on what they may mean to the participant. A sample of the researchers exploratory noting is presented in Appendix I.

Step 3: Constructing experiential statements

In this step, important features of the exploratory notes made on each transcript were formulated into experiential statements, or statements that related directly to each participant's experience. During this process, the hermeneutic circle was considered where, for each statement, the aim was to capture what was considered important within the text while also considering the transcript as a whole. Each experiential statement aimed to reflect both the participant's original words and the analytic interpretation. The process of developing experiential statements for the first transcript was negotiated within research supervision. The initial draft of experiential statements identified in transcript one was considered to be too interpretative. As a result, these were revised by attempting to remain closer to the original text of the transcript.

Step 4: Searching for connections across experiential statements

The aim of this step was to consider how the experiential statements for a particular participant fitted together. The experiential statements for each participant were consolidated in a word document. A hard copy of this document was printed, and the statements were cut into individual pieces of paper. These were subsequently laid out on a large surface in a randomly distributed order to break up the initial ordering of the statements as they occurred in the original transcript. The individual experiential statements were then placed into clusters according to how they were considered to fit together. This process was repeated several times for the experiential statements in each transcript as each cluster was reconfigured several times to explore different possibilities (See Appendix J for illustrative example). One of the transcripts generated a large number of experiential statements. However, on further investigation it was identified that a number of these statements carried a similar experiential meaning. Therefore, these statements were stacked, which allowed for a reduction in the density of the data for this participant.

Step 5: Naming the personal experiential statements and consolidating them and organising them in a table

Each cluster of experiential statements was added to a table in a word document (See Appendix K for sample), alongside a quote or phrase from the original transcript which illustrated the statement. These were subsequently arranged as overall PETs and subthemes. Each PET was assigned a title which captured the characteristics of that theme. The PETs for each transcript followed a narrative organisation, as the ETs across all transcripts followed a loose narrative of life before prison, start of prison sentence, pre-MBT-I and post MBT-I.

Step 6: Continuing the individual analysis of other cases

The above process outlined in Steps 1-5 was repeated for each of the four transcripts. In order to allow the data from each transcript to speak for itself, efforts were made to bracket the experiential statements and personal experiential themes which had arisen in the previous transcripts.

Step 7: Working with personal experiential themes to develop group experiential themes across cases.

The purpose of this step was to generate a set of GETs from the patterns of convergence and divergence that were observed across the set of PETs from each individual transcript. To aid in this process, the PETs from each transcript were condensed into one single word document per transcript by removing the supporting experiential statements. This allowed the researcher to place four single word documents side by side on a large surface and look across the four documents for patterns of similarity and difference. Several ideas for GETs were generated but discarded as there was not sufficient evidence across all four transcripts to support them. Two examples of these were: (a) *the dichotomy of good versus bad*, where two of the participants described events in their life or their behaviour in terms of being either 'good' or 'bad' and (b) *the journey through the stages of change*: where some participants described their journey towards considering changes in their behaviour and ways of living. The consideration of GETs also comprised of an iterative process of referring back to some of the individual experiential statements that comprised each PET. In consideration of the hermeneutic circle, the researcher also referred to the original transcripts several times to review the context for a number of the experiential statements and associated excerpts and exploratory notes in order to consider or reconsider their meaning. This process culminated in the generation of a table of GETs (Appendix L) from which the results section was written.

Ethical Considerations

The ethical considerations outlined below have been guided by the *Psychological Society of Ireland's Code of Professional Ethics* (PSI, 2010), the *Research Ethics Guidance* Document published by the Irish Prison Service (IPS, nd), the *World Medical Association Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects* (WMA, 2013) and the *UCC Code of Research Conduct* (UCC, 2018).

Ethical approval

The study received approval from the UCC Clinical Research Ethics Committee (Appendix M) and the Irish Prison Service Research Ethics Panel (Appendix N).

Informed consent

Individuals in custody are vulnerable to exploitation and abuse by research as their freedom to consent can be easily undermined and also due to the high prevalence of learning disabilities, literacy difficulties and language barriers in prison populations (IPS, n.d.). To ensure that participants provided informed consent to take part in this study, a number of steps were undertaken. Exclusion criteria for the study regarding language barriers and cognitive impairment were considered (see section on inclusion and exclusion criteria above). The researcher ensured that all information and consent materials are written in plain English. The information leaflet and consent form were piloted with an individual in custody before being used as part of the study. These materials included some words which would be considered technical terms, e.g. 'mentalizing' or 'mentalization'. However, it was anticipated that these terms would be familiar to all participants as a result of taking part in the MBT-I group which explains and discusses these terms in detail. However, to ensure that this was the case, a definition of mentalizing was provided at the outset of each interview. If an individual had literacy difficulties, the researcher was to ensure that the information leaflet and consent form was read to them. However, it was not necessary to do this for any of the participants who agreed to take part in the current study.

The information leaflet and consent form (Appendix O) were reviewed briefly with each participant and an opportunity to ask questions or clarify any terms used was provided. The researcher also provided the opportunity to ask any questions or queries regarding any aspects of participation and data collection, storage and usage thereafter. It was noted that none of the participants asked any questions relating to these aspects of the study. To address any concerns about perceived repercussions of refusing to participate in the study, it was clearly stated on the information leaflet and was reiterated at all stages of the research process that refusing to participate or withdrawing their data at a later stage would not impact their current or future opportunities to engage with the prison psychology service. In addition, it was ensured that the AP who completed the initial recruitment procedure and the primary researcher had not worked in a therapeutic capacity with any of the potential participants. It was also emphasised that the research was independent from interventions provided by the psychology service at all stages of the research process. Participants were reminded at several points throughout the research process, that their participation in the study was entirely voluntary.

Limits of confidentiality

Participants were informed that the information disclosed within the context of the study would be kept confidential but was subject to the limits of confidentiality as outlined in the Prison Psychology Service 'exceptions to confidentiality' protocol (Appendix P) with the exception of items seven and

eight. These items are applicable to clinical and therapeutic work carried out as part of the IPS psychology service, as per IPS policy, but are not a requirement for the purposes of IPS research. As such, they were not included as part of the participant information leaflet and participants were informed of this distinction. The researcher had a copy of this protocol on their person while carrying out the research. Participants had already signed a copy of this protocol prior to their participating in the MBT-I intervention.

Data storage

After each research interview, the audio-recordings were uploaded to *Citrix ShareFile*, a secure file sharing and transfer service which is currently used by the Irish Prison psychology service for sharing and storing video files for supervision purposes. These recordings were only accessible to the researcher and staff of the Irish Prison psychology service within the participating prison. The researcher accessed Citrix ShareFile to complete the transcripts remotely. For the purposes of this research project, the share-file in use for the project was only accessed remotely through a Health Service Executive encrypted laptop. The audio-recordings were stored on Citrix ShareFile for the duration of time it took to complete each transcript and were deleted when the transcripts were complete. The signed consent forms were stored in a locked filing cabinet in the psychology office of the participating prison. The transcripts from which the data will be analysed will be stored for a minimum period of ten years after the completion of the research project in line with UCC's *Code of Research Conduct (2018)*.

Data sharing

All transcripts were anonymised by removing all information that could be deemed identifiable. Once this process was complete, each participant was referred to by the pseudonym provided for the remainder of the research project. Anonymised data was shared with the research supervisor and staff of the Irish Prison Service Psychology service. As the data for this project was analysed using IPA, it was necessary to quote participants' own words within written reports or future publications in order to illustrate the extracted themes. As a result, a selection of the raw data will be available to all consumers of the research report. Participants had the opportunity to consent to this specifically in the consent form for the study.

Consent for data sharing and storage

The above procedures for the sharing and storage of confidential data are outlined in the information leaflet and consent form (Appendix O) and participants signed their name to indicate that the above procedures were explained to them. All participants agreed to have their data shared and stored as outlined.

Benefits of the research for a prison population

The World Medical Association *Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects* outlines that "Medical research with a vulnerable group is only justified if the research is responsive to the health needs or priorities of this group and the research cannot be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that result from the research." (World Medical Association, 2013, p. 2192). It is necessary to complete this research on MBT-I within a prison service as the development of mentalizing capacity within a prison setting may indeed be more difficult due to the inherently stressful experience of being held in custody. Therefore, it is necessary to build the evidence base with this specific population as evidence gathered from community samples may not be comparable. Furthermore, this research will contribute to the knowledge base in this area which will allow for further developments relating to clinical practice and the tailoring of this framework of intervention to this specific population.

Impact of covid-19 on the prison service population and data collection procedures

Participants recruited to the current study completed the MBT-I group at the end of February 2020. The initial plan for the study was that all interviews would take place in approximately April or May 2020. However, in March 2020, nationwide restrictions were put in place due to the Covid-19 pandemic. Individuals in custody within the Irish Prison Service were considered a population particularly vulnerable to the impact of Covid-19 due to the high-risk environment for the transition of infectious diseases due to conditions such as over-crowding and cell-sharing (Irish Penal Reform Trust, 2020). In comparison to the general population, prison populations experience higher levels of compromised health, ill-health and chronic conditions (World Health Organization, 2014). As a result, family visits and psychology groups were suspended, certain activities such as work, occupational training and use of the gym were curtailed, and the prison schools were closed within the prison service nationally (Department of Justice, 2021).

Due to the restrictions in place both nationally and within the prison service, it was decided that completing the interviews for the study in person would not be possible within the required time-frame. As a result, proposed amendments to the study, so that the interviews could take place over the phone, were submitted to UCC CPREC and were subsequently approved. Four out of the five participants who were recruited to the study agreed to complete the interviews for this study via this medium, while one participant opted to wait to complete the interview until it was possible to do it in person. Of the four who opted for phone visits, three interviews were completed. The remaining participant had been transferred to another prison at the time of the scheduled interview and he opted to wait until his return to the original prison to complete the interview. However, when he was followed up at a later date in order to schedule his interview, he had been released. The interview of the fourth participant was completed in August 2021, when visits to the prison from outside professions were once again permitted.

When the initial research proposal had been drawn up, it had initially been hoped that further participants from subsequent groups would be recruited. However, as psychology groups in the participating prison were suspended until March 2022, it was not possible to recruit any further participants within the timeframe of the current study.

Validity and Quality assurance

To ensure validity of the data, a mini-audit of the first transcript was completed by the second author. This involved following the trail of analysis from the first transcript, through to the initial exploratory notes and subsequent development of ESs and PETs. This is an additional method that can be used in order to ensure the validity of the reported data (Yin, 1989). The guidelines for achieving high quality in IPA research (Nizza et al., 2021) and the journal article reporting standards for qualitative research (JARS-Qual; Levitt et al., 2018) were used in the write up of this study.

Subjectivity and Reflexivity

Reflexivity is a key approach that helps the researcher to identify the potential influence of their pre-conceptions or beliefs about the phenomenon under study, throughout the research process. The process of reflexivity involves active acknowledgement by the researcher that their actions and decisions will inevitably impact on their interpretation of the meaning and context of the experience under investigation (Horsburgh, 2003). To do this, a reflective diary was used to note thoughts, feelings and perceptions throughout all stages of the research process. This allowed for the examination of the researcher's positionality and the bracketing of assumptions and biases as much as

possible throughout the research process. The use of bracketing is a means of demonstrating the validity of both the data collection and analysis process in IPA (Ahern, 1999).

Fore-conceptions identified at the outset of the research

I approached this research study as a white, Irish, middle-class woman in my mid-thirties. I am a trainee clinical psychologist, and I completed this research as part of a Doctorate course in Clinical Psychology. In the period after the data was collected and before it was analysed, I commenced a specialist placement in the prison where this research was conducted. I have also previously been a victim of crime. I have an interest in social justice issues and the impact of early life events and adversity on psychological development. I believe all the above information forms part of who I am as a person and subsequently may have influenced the interpretative process and how I conducted this research.

As discussed in the section on hermeneutics above, I was aware that some preconceptions can be identified in advance but that sometimes they will only emerge through the research process. Therefore, I considered bracketing to be a cyclical process throughout all stages of completion of the research study (Smith et al., 2022) and the use of my reflective diary aided me in this task.

Reflections on the interview process

My initial interest in mentalizing stemmed from my interest in the field of infant mental health. I had initially considered conducting research investigating the impact of early life experiences on mentalizing development. As part of the interview schedule, I had included a question in the opening section which asked participants ‘What were things like for you before you started the group?’ I left this question open for participants to respond by talking about any period of their life that they felt was relevant. I was aware that I had an interest in the impact of their early life experiences on mentalizing development so before commencing each interview, I was conscious of inadvertently or otherwise directing participants to talk about that period of their lives.

Due to my interest in mentalizing and mentalization-based treatment, I was also aware that I had a vested interest in MBT-I being effective for participants and for wanting to see that they had benefitted from engaging in this intervention. Due to my fore-conceptions noted above about wanting to see that MBT-I was effective for participants, I was conscious of asking open ended questions. However, throughout the initial interview, because the questions were phrased as before the group and then after the group, once or twice I caught myself asking the participant leading follow up questions. See example below from the first transcript below:

Interviewer: So I suppose if someone now was being aggressive towards you or was acting in a disrespectful way to you. Em…how would you feel or how would you…how might you feel or how would you respond now that might have been different to when you would have responded previously?

I was mindful of resisting the urge to do this in subsequent interviews. During the analysis process, I also considered the impact that my questioning style may have had on the participant's response that followed. I was conscious of resisting the urge to interpret the participant's experience during the interview (Smith et al., 2022). At times where I felt it was appropriate, I checked in with each participant to clarify that I had understood with what they had said. However, a couple of times I caught myself reflecting back to the participant an interpretation of what they had said.

Before the interview process, I had not been conscious of how my middle-class background may differ significantly to the backgrounds of the participants that I was interviewing. My realisation of this emerged as part of my reflections after the initial interview. This can be observed in the segment from my reflective diary below:

'I was so conscious of how I presented in the interview and was surprised that I was giving so much consideration to how I was coming across and what he was thinking about me. Why would he want to share his information with me? I'm worried that I came across as an outsider or as being too different from him.'

I had initially questioned why this participant would trust me to share this information and personal experiences. However, it emerged throughout each subsequent interview that identifying myself as a trainee clinical psychologist may actually have facilitated each participant's sharing of information throughout the interview process. This was illustrated by the following quote from Eric, the fourth participant I interviewed:

"But it's hard to open up sometimes about it like. It's alright with you because I know it's confidential and because I know you're a psychologist and I know you can understand. But…it's the same with the other psychologist. She can understand because she knows what I'm talking about."-Eric

The perception of a psychologist as someone who you can trust and will understand you had been carved out for me by the psychologists with whom these participants had been working with previously, in the group or otherwise. Each participant's previous engagement with psychology had possibly set a precedent for what was expected of speaking with a psychologist. This led me to consider that my identification with this role was possibly an asset and aided in the development of trust within the interview process. As a result, rather than being perceived as an outsider, it was possible that I was considered an extension of the psychology service of the prison. It is also possible

that if the participants in this study felt comfortable speaking with a psychologist, it is more likely that the issue of class may not have felt as prevalent for them.

Lastly, I had noted that there had been a difference in my approach to the interview process between the first three interviews and the last interview. In comparison to the first three interviews, the process of the last interview felt much easier, and it felt like the participant himself guided the interview process a lot more. Reflecting back, I considered several reasons why it may have felt this way, weighing up the context of the interviews, the contributions of the participants themselves and the development of my competence as a research interviewer. In terms of the context in which the interviews were conducted, the first three interviews were completed over the phone and the last interview was completed in person in the prison. I considered whether conducting the interview face-to-face allowed for the interaction between myself and the participant to feel more natural and flow more easily. I could see the participant as I spoke with him which had been different compared to the previous three interviews. This possibly allowed me to pick up on his non-verbal cues more in terms of asking probing or follow up questions. From the literature on individual's experience of telehealth in comparison to in person care during the covid-19 pandemic, it was noted that the relational quality of clinical encounters changed and even where participants were able to see someone's facial expressions, not being together in a room meant that building and maintaining a connection was problematic (Liberati et al., 2021). However, when comparing the two contexts in which I completed the interviews, it didn't feel more difficult for me to build a connection with the participants with whom I conducted the interviews over the phone. What I considered was different between the first three interviews and the final interview was the contribution made by the participant himself. I felt through the course of the interview process that that this individual had given a lot more thought to what had been learned as part of the MBT-I group and had made significant efforts to continue practicing mentalizing after the group had ended. This also likely played a role in his leading of the research interview in terms of how he described his experience. Additionally, as this was the fourth interview that I had completed, I also felt more confident as a researcher and felt less tied to the interview schedule and more comfortable with letting the process of the interview, and what was discussed as part of it, happen.

Reflections on the analysis and write up process

This was my first experience of completing research using an IPA methodology. I initially found the thought of completing the analysis quite daunting. Throughout the process I had to repeatedly reiterate to myself that the purpose of IPA was to develop and understanding of 'what the experience was like' for the participants of this study to develop their mentalizing capacity. I repeatedly returned to this phrase throughout the analysis and write up process. Despite my initial hesitations, I found that I enjoyed the analysis process immensely, particularly the initial phases of reading and re-reading the

text and making exploratory notes. I noticed a sense of frustration at times when I felt I should have probed participants further on topics that they had brought up during the interview. This occurred when I was trying to make sense of what a participant was saying as part of the analysis, and I felt that I should have probed the participant for more detail of their experience.

At the time that I was conducting the data analysis, I was completing two simultaneous placements in a Dialectical Behaviour Therapy (DBT) team and the other in the prison where this research was conducted. I noticed that I had to constantly bracket my knowledge of DBT during the analysis process as I found myself interpreting what participants had said with a DBT lens. I felt that the experience of working within the prison where this research was conducted allowed me to understand the context of what some of the participants were saying. For example, when participants repeatedly referred to the MBT-I group as ‘a course’. I was able to consider several reasons as to why this might be the case. One of these being that the room where the group is facilitated is in the school wing of the prison, which may have contributed to participant conceptualisation of the group as educational rather than therapeutic.

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Chapter 4: Major Research Project

Title: An exploration of the capacity to mentalize following an introductory Mentalization Based Treatment (MBT-I) group within an Irish prison service.

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Abstract

Objectives: In recent years Mentalization-based treatment (MBT) has been applied as a therapeutic approach to the treatment of mentalizing difficulties associated with anti-social personality disorder across both community and forensic settings. The current evidence base for MBT with these populations is limited and consists of predominantly preliminary findings. This study explored participant experience of their capacity to mentalize after the completion of an MBT-I group within an Irish prison setting.

Design: This was a qualitative study using an Interpretative Phenomenological Analysis (IPA) approach.

Methods: Data were collected from four participants using semi-structured interviews. Interviews were transcribed and analysed according to IPA methodology.

Results: Four group experiential themes were identified from the data. These themes were: making sense of difficulties with emotions in the context of early life experiences, learning to feel and manage emotions, keeping other minds in mind and mentalizing in practice.

Conclusions: This study adds to the wider qualitative literature on MBT and presents a unique insight into participant experiences of developing their mentalizing capacity within a prison setting. The findings indicate that, following their engagement in MBT-I, participants developed a greater understanding of both their own emotional experience and of the perspectives and mental states of others.

Keywords: mentalizing, mentalization-based treatment, MBT, anti-social personality disorder, prison, violence.

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Introduction

Mentalizing

Mentalizing refers to an individual's capacity to recognise and imagine their own internal mental states as well as those of others and to understand and interpret one's own and others' actions as meaningful on the basis of these states (Allen, 2008). The development of mentalizing is influenced by the social learning environment, most notably the quality of a child's early caregiver and attachment relationships (Bateman & Fonagy, 2016). A secure attachment relationship with a primary caregiver who has the capacity to keep their infant's 'mind in mind' will facilitate the development of enhanced mentalizing processes (Fonagy & Allison, 2012). Early interactions with parents or caregivers that are characterised by poor mentalizing, abuse or neglect can increase the likelihood that a child will also have difficulties with their own mentalizing abilities (Levinson & Fonagy, 2004). Irrespective of early life attachment experiences, temporary lapses in mentalization can be experienced by any individual during high levels of emotional arousal such as periods of stress or anxiety (Fonagy & Bateman, 2006). However, those with resilient mentalizing capacities will typically be able to regain their mentalizing capacity relatively quickly after these lapses (Bateman & Fonagy, 2013).

Mentalization Based Treatment

MBT is a structured therapeutic program which aims to increase the resilience of an individual's mentalizing capacity (Bateman & Fonagy, 2016). MBT was initially developed as a therapeutic approach for borderline personality disorder (BPD) but has since evolved into a more comprehensive approach for use with other personality presentations such as anti-social personality disorder (ASPD) and narcissistic personality disorder (Drozek & Unruh, 2020). MBT is organised around an 18-month treatment period and follows a specific structure consisting of an assessment and MBT introductory course (MBT-I) followed by concurrent individual therapy and group sessions (MBT-G) for the duration of treatment (Bateman & Fonagy, 2016). The evidence supporting MBT as an effective therapy has continued to build over the past two decades. Two recent papers have reviewed the current quantitative evidence base (Malda-Castillo et al., 2018; Vogt & Norman, 2019). Vogt & Norman (2019) reported that compared with other treatments, MBT achieved greater or equivalent decreases in BPD symptomology, self-harm behaviours, severity of comorbid disorders and use of psychotropic medication. Likewise, the findings of a systematic review completed by Malda-Castillo and colleagues (2018) reported that participants demonstrated positive clinical outcomes in the majority of the 23 included studies with two studies demonstrating no group differences and a further study demonstrating inferior results in comparison to a third wave cognitive therapy (Jakobsen et al., 2014; Laurenssen et al., 2018; Phillips et al., 2018).

Despite the support for positive clinical outcomes, there is currently little evidence within the quantitative literature to support the hypothesised mechanism of change in MBT, that of increased mentalization capacity. It is suggested that rather, positive clinical outcomes may be achieved as participants learn to develop stable relationships as a result of undergoing both individual and group therapy over a period of 18 months (Vogt & Norman, 2019). Therefore, more extensive research, which includes participant outcome measures which tap into the various facets of mentalizing are needed. However, it is recognised that mentalizing as a construct is both difficult to measure and difficult to compare across individuals (Fonagy et al., 2011). The use of self-report measures to assess mentalizing capacity requires an individual to be able to reflect on their own mental states, in order to complete the measure accurately and may only provide an indication of an individual's potential for mentalizing which may or may not be utilised depending on the context (Fonagy et al., 2011).

The Use of Qualitative Methodologies in the Study of Mentalization Capacity

Research utilising qualitative methodologies can investigate the subjective perceptions of those who have participated in MBT and can also address some of the challenges posed by the use of quantitative measures within the mentalizing literature. Qualitative research can provide the basis for a more nuanced understanding of the experience of mentalizing and undergoing MBT which may allow for the generation of new hypotheses about the underlying processes of change. A recent review of the qualitative literature illustrated, that as a result of participating in MBT, individuals experienced increased self-acceptance due to shared experiences with others, developed a better understanding of other's perspectives, experienced and understood emotions in a new way and experienced increased self-reflection (O'Leary, 2022). These are all facets which are consistent with a model of increased mentalizing capacity.

Mentalizing in ASPD and Offending Populations

Recently, there has been increased interest in the application of MBT for anti-social personality presentations which have largely been neglected in terms of therapeutic interventions within the literature. Due to the high prevalence of ASPD in offending populations, it makes sense to further investigate mentalizing or the impact of MBT with individuals in forensic settings. Research conducted with offending populations has also demonstrated significant impairments in mentalizing in those who have committed violent crimes compared with non-violent crimes (Levinson & Fonagy, 2004; Moller et al., 2014). A child's early experiences with their primary caregivers can influence their ability to recognise aggressive impulses and learn alternative ways of expressing and regulating these feelings (Allen et al., 2008). It is proposed that violent or anti-social behaviour may stem from an insecure attachment to a primary caregiver resulting in an impairment in the ability to mentalize oneself and others (Levinson & Fonagy, 2004). This hypothesis has been supported by subsequent studies who have emphasised that mentalization deficits significantly mediated the effects of

attachment style on impulsive aggressiveness and the relationship between early physical or sexual abuse and aggressive behaviour (Fossatti et al., 2009; Taubner & Curth, 2013). High levels of insecure attachment styles have also been observed in violent offenders, sexual offenders and perpetrators of domestic violence (Chiffriller & Hennessey, 2010; Ross & Pfafflin, 2007; Wood & Riggs, 2008).

Evidence base for MBT in ASPD and Offending Populations

In the last decade, several studies investigating the impact of MBT, or adapted MBT, on various outcomes related to mentalizing and offending behaviours have been carried out in ASPD or forensic populations. Decreases in anger, hostility, self-rated aggression towards others and alexithymia have been demonstrated as well as improvements in interpersonal functioning, social adjustment and psychological mindedness (Adshead et al., 2013; Bateman et al., 2016; Byrne et al., 2016; McGauley et al., 2011). Qualitative studies have also suggested that participant experience of MBT facilitated a greater understanding of self and others, an increase in empathy as well as the ability to manage problematic behaviours and emotions (Thomas & Jenkins, 2019; Ware et al., 2016).

Rationale for the Current Study

The evidence base for MBT applied to ASPD or forensic populations is limited. The quantitative research cited above, particularly for those in forensic settings, is very much preliminary and characterised by the same difficulties impacting the wider evidence base for MBT in terms of the measurement of mentalizing capacity. In addition, the two qualitative studies above focused on participant experience of undergoing MBT rather than the experience of mentalizing capacity, resulting in a focus on the overall structure of MBT rather than the specific processes involved. Recent evidence suggests that short-term psychodynamic psychotherapy with mentalization-based techniques may be beneficial in reducing alexithymia in individuals with depression (Bressi et al., 2017). There has been limited research on the individual components that make up the full MBT program such as MBT-I. If short-term MBT (MBT-I) is beneficial, it may be a way of increasing access to MBT across a variety of settings. This is of particular relevance in prison settings where longer term MBT may not be accessible to those with shorter sentences or to those who may be transferred to different services within the prison system. To address these issues and gain a deeper understanding of what it is like to develop one's mentalizing capacity after engaging with MBT within a prison setting, the current study asks: how do people make sense of their capacity to mentalize after completing MBT-I within a prison setting?

Method

Design

Interpretative Phenomenological Analysis (IPA) was the methodology used in this study to explore how individuals made sense of their capacity to mentalize following their participation in an MBT-I group. IPA was chosen for this study as it is concerned with the detailed examination of personal lived experience, the meaning of experience to participants and how participants make sense of that experience (Smith, 2011).

MBT-I Group

The participants in this study completed a manualised MBT-I group adapted for those with antisocial personality disorder (Bateman & Fonagy, 2016). The topics covered within the group include mentalizing, antisocial personality disorder, emotions and emotion regulation. Within each session of the group there is a focus on experiential mentalizing, developing the therapeutic alliance, increasing participant empowerment through understanding and increasing motivation to pursue longer term treatment. Sessions ran weekly for eight weeks across January and February 2020, and were 75 minutes each in duration. The group was run by two facilitators, a clinical psychologist and a counselling psychologist, both who were trained in MBT.

Recruitment Procedure

Purposive sampling of participants was used in this current study. Participants were recruited from a group of individuals in custody who had completed MBT-I within an Irish male prison. The inclusion criteria for the study were (i) aged 18 years or over, (ii) attended at least 6 out of 8 sessions of the MBT-I group, (iii) completed the MBT-I group in past 12 months and (iv) able and willing to provide written informed consent. Individuals who completed the MBT-I group and who met the inclusion criteria were approached and informed of the study by an assistant psychologist (AP). Individuals who expressed an interest in participating were provided with a copy of the study information leaflet. Individuals with literacy difficulties were supported to read through this leaflet. Individuals who expressed an interest in taking part in research had an interview scheduled either in person or by phone with the first author at a day and time that was suitable for them.

Participants

Five out of the eight individuals who had completed the MBT-I group agreed to take part in the study. There was attrition of one participant due to his transfer to another prison and subsequent release before the opportunity to complete his interview. Participant demographic information is presented in Table 1. Pseudonyms have been used to protect participant confidentiality.

Table 4.1: Participant demographics

Pseudonym	Age	Sex	Length of current sentence
Rob	27	Male	15 years
Lorcan	22	Male	7 years
Marty	49	Male	4.5 years
Eric	27	Male	Life Sentence

Ethical Approval

Ethical approval was obtained from the Clinical Psychology Research Ethics Committee at University College Cork and the research panel of the Irish Prison Service (IPS). All participants provided written informed consent before participating in the study.

Data Collection

In-depth, semi-structured interviews were conducted with all four participants. Interviews ranged in duration from 40-60 minutes. Due to restrictions in place due to Covid-19, three interviews were completed over the phone in June 2020. The last interview was completed in person in a clinic room within the participating prison in August 2021. There was a delay in completing the final interview due to the Covid-19 restrictions in place at the participating prison. As this participant had consented to participate in the study prior to this, it was felt that it would be unethical to exclude him based on this factor. An interview schedule devised through a search of the literature was comprised of a series of non-leading questions and prompts related to the constructs of mentalizing. The interview schedule was used flexibly throughout the interview process and, where appropriate, participants were probed to learn more about how they made sense of their lived experience. All interviews were audio recorded. After the interview has been completed, participants were asked a series of demographic questions to allow for the description of the sample.

Data Analysis

Each interview was transcribed verbatim from the audio recording for each participant. All transcripts were double checked against their audio recordings to maintain accuracy of the raw data. Each participant was provided with a pseudonym and any identifying information was removed from each of the transcripts. Data analysis was completed by the first author according to the procedures outlined by Smith and colleagues (2022). Although Smith and colleagues (2022) outline a series of sequential steps in which to analyse the data, these steps were applied in a flexible nature and the analysis was completed as an iterative and inductive process.

Step 1: Reading and re-reading each individual transcript.

Step 2: Exploratory noting during each reading of the transcript.

Step 3: Constructing experiential statements (ES) by formulating exploratory notes into statements that related directly to each participant's experience.

Step 4: Searching for connections across ES for each transcript in order to develop personal experiential statements (PETs)

Step 5: Naming the PETs, consolidating them and organising them into a table.

Step 6: Continuing the individual analysis for each transcript while bracketing the ES and PETs which had arisen in the previous transcripts.

Step 7: Development of group experiential themes (GETs) by working with PETs across cases.

To ensure validity of the data, a mini-audit of the first transcript was completed by the second author. This involved following the trail of analysis from the first transcript, through to the initial exploratory notes and subsequent development of ESs and PETs. This is an additional method that can be used in order to ensure the validity of the reported data (Yin, 1989). The guidelines for achieving high quality in IPA research (Nizza et al., 2021) and the journal article reporting standards for qualitative research (JARS-Qual; Levitt et al., 2018) were also used in the write up of this study.

Reflexivity

The process of reflexivity involves active acknowledgement by the researcher that their actions and decisions will inevitably impact on their interpretation of the meaning and context of the experience under investigation (Horsburgh, 2003). To do this, a reflective diary was used to note thoughts, feelings and perceptions throughout all stages of the research process. This allowed for an ongoing examination of how the first author's (NOL) fore-conceptions of the topic may have influenced each stage of the research from initial data collection to the write up of the findings. The first author's positionality in terms of gender, ethnicity, age, and class as well as previous experiences and interests which could relate to the topic were outlined at the outset of the study. However, it was also considered that some preconceptions would only emerge throughout the research process. Therefore, the cyclical bracketing of assumptions and biases was considered as much as possible throughout all stages of the research.

Results

Four group experiential themes were identified; making sense of difficulties with emotions in the context of early life experiences; learning to feel and manage emotions; keeping others in mind; and mentalizing in practice. While these themes presented themselves across all participant accounts, it is noted that each participant's experience of their capacity to mentalize was unique according to their individual life experience and context. In line with an idiographic approach, within each section, each participant's experience will be discussed first and a subsequent summary of the convergence and divergence across participants will then be presented.

Making Sense of Difficulties with Emotions in the Context of Early Life Experiences.

Rob spoke briefly of his earlier life noting that '*he hadn't got a good upbringing'* and described how he had witnessed '*a lot of violence down through my years'*. He linked these experiences to his initial use of illicit substances as a means of coping with his emotions which, to him, subsequently led to becoming a perpetrator of violence as he got older. The manner in which he spoke about his early life and engagement in violent behaviour was notable, often using language that signalled detachment and the sense that he wanted to distance himself from his previous situation and the behaviour that he engaged in.

Marty described how his parents did not express affection towards him '*or anything like that*'. He initially attributed this to the era in which he grew up in:

> *"I was born in 1973 like yeah? … We rarely showed our emotions, well I never, like*" (Marty).

Marty's use of the word '*we*' here, generalises this pattern of not showing emotions to that of his generation, though he subsequently uses the pronoun 'I' to clarify that *he* never showed his emotions. His statement above contrasts with his later account of emotional expression where he acknowledges his feelings of anger and describes past situations where he would '*lash out'*. This contrast indicates that, for Marty, emotions such as anger, were considered acceptable to express whereas other emotions were not.

Eric referenced the '*culture*' of the family in which he grew up:

> "*The only emotion that you were left to feel was anger, … and that was justified because that made you a man. If someone pissed you off and you got angry, you box the head off them and that's the way it was, but you can't feel upset, you can't feel sad, … or any of these emotions going on like 'cause then you're weak … "* (Eric)

The expression of emotion, sadness in particular, was perceived as 'weak' within Eric's family context while expressions of anger were reinforced as a defining characteristic of masculinity. In this

context, violent behaviour towards others was an accepted and almost expected way of communicating feelings of anger or annoyance.

Lorcan described finding it difficult to open up about events of the past. He noted that as MBT-I progressed and other group members shared more about their personal experiences, this facilitated his ability to open up and talk about the past. For Lorcan, hearing the experiences of others in the group, appeared to attenuate his previous experience:

> *"Some of the lads … shared some of their stories and ... in a way, I kind of felt like I wasn't as bad off as some fellas … Like, I probably had things a bit easier than some lads in there".* (Lorcan)

All participants referred to situations of violence or aggression which they had either witnessed, initiated themselves or responded reactively to, before or during their current prison sentence. The underlying factor in these scenarios were feelings of anger or frustration which at times individuals struggled to control. Their pre-disposition to feelings of anger and the tendency to engage in violence was understood in the context of their upbringing, which for all, was considered a difficult topic to speak about. There was a sense from the data that engaging in MBT-I had facilitated participants to reflect on their past experiences and make sense of their difficulties with their emotions in this context.

Learning to Feel and Manage Emotions

Rob described that a prominent point of learning from the group was learning how to manage his feelings of anger before they escalated. He outlined how he achieved this through engaging in activities where he could distract himself:

> *"Now I can just like stop it before it even gets to that point, right? Like do something, get active, read a book, go to the gym, play football … "* (Rob)

His portrayal of how he manages his emotions demonstrates that he now feels more in control of his feelings as he can '*do something*' to stop them before they feel uncontrollable or reach *'that point'*. The use of distraction to manage intense emotions was also recounted by Lorcan who used watching television or going to the gym for this purpose. Lorcan also described developing an understanding of the precursor events which led to him feeling angry. Understanding these precursors allowed him to process situations as they unfolded so that he did not *'get wound up as much'*.

Before the group, Eric described experiencing emotions in his head rather than his body:

> *"it was always a head thing for me like. It was never here (points to chest)…it was always up here (points to head)."* (Eric)

He described experiencing emotions in his head but having no corresponding physiological experience associated with these emotions. He noted that he was '*de-synchronised*' acknowledging that the physiological experience of emotion *was* occurring in his body but that he just '*never took the time to stop and sit down and reflect*' in order to figure out and feel what was going on. Participating in MBT-I enabled him to "*…listen to emotions and name the emotions'*. Here he describes the process of how he achieved this:

> *" … the negative thoughts are associated with the sad emotion, … So I'm having good thoughts then you realise I feel happy, so you know that happiness comes with good thoughts. So it's about learning the patterns like…".* (Eric)

In the extract above, Eric applied a cognitive approach in the attempt to connect his thought processes with his emotions of happiness and sadness. Through this approach, he links thoughts to emotions but does not talk about the physiological experiences that go with those emotions. His approach feels somewhat mechanical when he speaks about '*learning the patterns*' and illustrates an almost manualised approach in how an individual could come to understand their emotions. Later he goes on to provide a snapshot of his emotional experience after the success of linking his '*mind and body*':

> *"Joy or love like…they say it's like the butterflies? … I might get that and when I tune in sometimes it can be like bats and birds going on inside. D'ya know it's more like intense …"* (Eric)

This extract illustrates Eric's experience of emotion now and how he has learned to connect what is going on in his mind with the physiological sensations in his body in order to interpret what emotion he is feeling. However, his experience of emotion is more intense than that of others. He expresses this by comparing the commonly used metaphor of 'having butterflies' in one's stomach to his experience, which for him feels like '*bats and birds*', suggesting the possibility that he was still learning to modulate his emotions.

Marty recalled how in the past he had experienced his emotions in his body, whereas now, he experienced them in his head.

> *"They're all in my head like. Where before I used…things used to just build up inside of my stomach … I'd leave them build up and leave them build up until all of a sudden someday like it was all too…and the wrong person would push that button and then all hell would break loose ….*" (Marty)

Marty's use of repetition here conjures up the image of a pressure cooker, in which steam is continually building up and building up before bursting out. His use of the phrase '*all of a sudden'* signals the possibility that this build-up of emotion was happening almost unbeknownst to him so that the outburst he described would come as a surprise. There is a sense that he would reach a point where he was no longer in control of the emotion that followed. For Marty, now that his emotions are experienced in his head, he has more of a sense of control of them. He further illustrates this when he outlines how he does not *"…care about freeing them, no more like…since they're in my head like…"*

Marty acknowledged his past behaviour *"…like I do be scared to snap because I know what I'm capable of doing like yeah?"* It is possible that as a way of decreasing the likelihood that he would *'snap'* in certain situations, a move from feeling emotions in his body to experiencing them in his head, may instead be a resultant avoidance of his emotional experience. It is unclear the role that participating in MBT-I played in this process. However, it was possible that, due to participating in the group, and by starting to think about the things that he *'was trying to block out'* from his childhood, that he began to disconnect from his emotional experience as a means of coping with the difficult emotions evoked in these situations.

All participants described, through their engagement with MBT-I, changes in how they experienced or coped with their emotions. Change was particularly salient for feelings of anger. Whereas Lorcan and Rob described distracting themselves from their emotions after MBT-I, Marty and Eric both described being able to feel their emotions and spoke of the dualistic nature of their experience. Where, for Eric, this new experience of feeling his emotions resulted in a connection between what he experienced in his body and his mind, Marty described a somewhat opposite experience where he spoke of a sense of shifting his emotional experience from his body towards experiencing it '*in his head'*.

Keeping other Minds in Mind

Lorcan described that since engaging in MBT-I, he now stopped to reflect during interactions where another individual was displaying aggressive behaviour to consider how the other person may be feeling:

> *"…if someone was being angry towards me I kinda thought, right, what are they feeling? Put myself in their shoes."* (Lorcan)

Eric expressed that he was now starting to demonstrate a curiosity as to why other individuals behaved as they did as well as a consideration of the factors that were potentially influencing their behaviour. The following extract summarises Eric's thought process in these situations:

"like 'so let's just check it like so he's being aggressive…'why is he being aggressive' so I'd be more curious about the other person … maybe there's something going on in his life…" (Eric)

For Rob, interpreting the behaviour of others appeared to be somewhat more difficult. He spoke about this in a more general way by describing an awareness that the behaviour of others was linked to emotions. Rather than expressing a curiosity towards the thoughts and feelings of that person, he demonstrated a strong scepticism about how they may be feeling:

"*Like, no one knows what's going on in people's heads when they are having a bad day*" (Rob)

He also appeared to rely heavily on the external behavioural cues of others to make sense of their behaviour, rather than demonstrating a curiosity about that person's internal state. He describes how he would know someone was having a bad day by reading their external behavioural cues:

"*If you see them all slumped over and if you see them all on their own or, you know, if you see them not talking to anyone*" (Rob).

Considering the 'minds' of others appeared to be a completely new experience for Marty:

"*All my life, I'd have never thought about anyone … Family alright maybe yeah but all the rest of them I didn't think like …"* (Marty)

He appeared to consider his family as an extension of himself and considered that he had, on occasion, reflected on what had been going on for them, but that he had never previously considered others outside of this circle.

All four participants discussed their capacity to consider the feelings or emotions of others following their participation in MBT-I and were able to apply this to situations of conflict or misunderstanding. This appeared to be an explicit process whereby all steps needed to be thought through and considered. For some, this was initially imagined as an embodied experience where they had to imagine physically halting the situation or conversation and consider of the perspective of the other person by imaginatively placing '*themselves in the other persons shoes'*.

Mentalizing in Practice

Keeping mentalizing 'in mind'

Lorcan described experiencing a dissipation of the knowledge learned in the group and had attributed this to the Covid-19 restrictions acknowledging that his way of thinking had changed '*over the lockdown*'. Despite this, Lorcan acknowledged that integrating mentalizing skills into his life helped

keep the skills '*fresh in your mind*'. Eric considered that mentalizing was '*a skill and you need to work on it*' and to do this you '*need to be constantly aware of it*'. This had been Rob's second time completing the group. He spoke of initially being reluctant to repeat it, but then expressed surprise at how much he had learned the second time around:

> *'I was actually surprised at myself with the things that I did learn as well from the second one that I forgot from the first one …"* (Rob)

Conversely, Marty spoke of the '*battle*' to change since he finished the group. He noted that his thinking had changed '*a small bit*' since participating in MBT-I. However, he felt that the duration of course was too short to counteract his old patterns of thinking:

> *"That course was only on for 8 weeks … so I'm living my life like that, the way I'm living it like that since I been … about 12 or 13 … I just find it really hard like. … it's just very hard for a person like who didn't know any…who doesn't know any different … ."* (Marty)

Marty makes a comparison between the duration of the MBT-I group and the number of years that he has been living his life with his older patterns of thinking and behaving. In his mind, the two do not equate with each other and this is how he makes sense of his struggle to change his behaviour.

Participants reflected on the development of their mentalizing capacity in the time since they had finished attending the MBT-I group. They considered some of the challenges they had faced in putting what they had learned into practice such as overcoming old patterns of thinking or keeping mentalizing 'in mind' throughout other emotionally challenging experiences such as the Covid-19 restrictions. It was highlighted that mentalizing was a skill that needed to be considered regularly and integrated into daily life for it to be effective.

Mentalizing in prison

Lorcan described how he had previously been told that he had 'a problem with authority', particularly when he perceived a figure of authority to be in control of a situation. He seemed surprised that, initially, he was able to extend his mentalizing skills towards prison officers:

> "*I suppose even towards officers as well. If I was told 'no' or if I was told to do something I just did it*". (Lorcan)

However, he described a recent situation where a request had been refused by an officer and how he had reverted to engaging in old behaviours. It appeared that there was an additional challenge for him to mentalize the behaviour or intentions of prison officers in comparison to those of other individuals

in custody, where he considered them to be somewhat outside of the 'Self vs Other' mentalizing polarity.

Rob identified how prison was a place "*where you cannot let people like…step on your toes*", meaning that in prison, you do not want to develop a reputation for being 'weak' or being easily exploited. As such, he indicated that there are additional considerations that one must take into account when mentalizing others and using this skill to resolve conflicts with others in a prison context.

Marty described a recent situation in which he found himself unable to walk away from a situation of conflict, in which he described the need to defend the reputation of a family member.

> "*There was just a situation and I'd no choice really, … I'd like to walk away but I can't walk away*" (Marty)

In this extract, Marty described faced with a situation where hypothetically he could walk away but his perception here was that this was not a feasible option. Weighing up his options in this situation, it appeared that he had decided that the need to defend his family, and therefore his reputation and standing, in prison was more important.

Eric highlighted the '*culture in prison*' where you could not talk to other individuals in custody about emotions or you would be considered '*mad*'. He noted that mentalizing was a '*two-way process*' but described how if you brought up emotions in a conversation with someone the response was likely to be '*what the f*ck you on about emotions, what are you a woman*?' This extract from his account illustrates the culture of toxic masculinity where associations with being effeminate are considered highly offensive and as a result discussing topics such as emotions, typically equated with women, is prohibited.

All participants reflected on the challenges of mentalizing within a prison culture with specific hierarchies and rules about maintaining one's reputation, managing conflict, and where the culture of toxic masculinity is rife.

Discussion

Overview of Results

This study explored four participants' experiences of developing their mentalizing capacity after completing an MBT-I group within an Irish Prison. Four group experiential themes were identified: *making sense of difficulties with emotions in the context of early life experiences, learning to feel and manage emotions, keeping other minds in mind* and *mentalizing in practice.*

Making Sense of Emotions

Mentalized affectivity is an aspect of mentalizing that links the domains of emotion regulation and autobiographical memory. It relates to how reflections on past experiences and identity inform an individual's emotional experience (Jurist, 2018). The concept of mentalized affectivity is conceptualised as the prerequisite for autonomous emotion regulation and is comprised of three components: identifying emotions, processing emotions, and expressing emotions (Jurist, 2005). An underlying narrative within all participant accounts in this study was of how they made sense of their difficulties through reflecting and considering previous experience in their early life, both prior to and during their current sentence. These experiences echo with that of the participants in previous qualitative studies of MBT where considering past experiences facilitated an understanding of how their problems had developed. This was facilitated through the realisation that their parents or caregivers had similar difficulties, which subsequently fostered a deeper understanding of themselves (Ditliefsen et al., 2020; Ware et al., 2016). The findings of the present study suggest that participants were each perhaps at different stages of their journey towards autonomous emotion regulation, of which undertaking MBT-I had been the first step. Participants appeared to come away with different strategies of regulating their emotions following their engagement with MBT-I. From their reports, two participants described using distraction techniques to regulate their emotions before they became unmanageable. The remaining two participants appear to have developed opposing emotion regulation strategies, both which exist on the same cognitive vs affective polarity. When both cognitive and affect strategies are integrated, this polarity is in balance (Luyten et al., 2020). It appears that both participants have had a shift from opposite ends of this polarity towards the other, which is reflective of their individual experience both before, during and after engaging in MBT-I. From the data it is not possible to say whether either participant has achieved balance, but it does appear from their reports that the shift from where they were previously on this polarity to where they are now is currently adaptive for them. It has recently been proposed that the association between mentalizing and positive clinical outcomes may be mediated by emotion regulation (Schwarzer et al., 2021). This represents an exciting new direction within the mentalizing literature and may provide a deeper understanding of the processes of change that occur for individuals who undergo MBT. Indeed, mentalizing emotions, an aspect of which is how one recognises and names the different emotions can act as an implicit emotion regulation process and can attenuate emotional experiences (Torre & Lieberman, 2018). However, few studies have investigated the relationship between mentalizing and emotion regulation, even though the developmental origins of mentalizing and emotional regulation are theoretically, quite strongly linked (Schwarzer et al., 2021).

Keeping other Minds in Mind

Explicit mentalizing is a conscious, verbal, and reflective process and is associated with intention and effort (Luyten & Fonagy, 2015; Shai & Belsky, 2011). It is closely linked with the concept of meta-cognition, the ability to reflect on one's thoughts and actions (Frith & Frith, 2012). When participants imaginatively placed themselves 'in the shoes' of the other to get a better sense of their perspective, this potentially captured the imaginative aspect of mentalizing, where an individual must imagine what another is thinking and feeling (Fonagy & Allison, 2012). However, it was difficult to ascertain from the data how meaningful this process of explicit mentalizing was for participants. None of the participants spoke of the emotional salience of their understanding which was gained from this new way of approaching interactions with others. Rather, they spoke of how it allowed them to avoid conflicts and misunderstandings with others. Although the participants in this study were not formally assessed for ASPD, it is estimated that up to 49% of sentenced male prisoners meet the criteria for ASPD (National Collaborating Centre for Mental Health, 2010). Attaching emotional meaning to explicit mentalizing processes is reported to be a particular difficulty for individuals with ASPD (Bateman et al., 2013). It is possible that the descriptions of considering others within interpersonal interactions provided by participants was more akin to a meta-cognitive process, rather than a mentalizing process. However, until further research is completed in terms of the outcomes for individuals with either a formal diagnosis of ASPD or associated traits, it is difficult to hypothesise whether this is perhaps a limitation of MBT-I or a difficulty with applying MBT to individuals with these difficulties.

Mentalizing in Practice

The capacity to mentalize is an inherently relational skill, that is developed through interacting with others. An individual's capacity to mentalize can change throughout their life according to adverse or positive experiences they face and as they come to understand more about themselves and their own thoughts, feelings, wishes and beliefs. The experiences of participants in this study can be conceptualised in this way as they discussed the challenges they have navigated while trying to keep their 'mentalizing in mind'. Although surrounded by others almost constantly, loneliness can become a pervasive difficulty for individuals in custodial settings. Being separated from family and friends, having difficulties with relating to other prisoners and experiencing conflict with prison staff can all contribute to these feelings (Flanagan, 1980; Schliehe et al., 2011). Many individuals become part of prison sub-groups or gangs to avoid alienation and feelings of loneliness (Woodall, 2011). Subsequent attempts to make life changes or to fulfil personal development goals, such as engaging in education or training programs, can go against the social norms of these groups. It is likely that the prison environment can make achieving change for individuals difficult. In this study, participants spoke

about the difficulties of developing new insights about their emotions and behaviour but then having to continue to function within the same system as before. For some, this provided increased barriers to engaging with other individuals in custody, whereas others felt they had no choice but to engage in previous patterns of behaviour as that was what was expected by others within the wider prison culture. The challenges of keeping their 'mentalizing in mind' experienced by participants in this study overlap with those reported by Thomas & Jenkins (2019) who reported their difficulties in continuing to practice mentalizing after MBT, which they had completed as part of a probation service. Some of those participants spoke of the difficulty of shifting from being in the group where you felt understood by others back to a place where they no longer felt understood and where "*people think if you don't fight you're a sissy or weak*" (Thomas & Jenkins, 2019, p. 12). However, despite the challenges that completing MBT-I within custodial settings presents, it is important to continue to offer it within these settings. Therapeutic interventions offered to individuals with ASPD traits within community settings are often beset by poor concordance and high attrition rates (National Institute for Health and Care Excellence, 2013). Lower attrition rates are typically observed for interventions that are offered within institutional rather than community-based settings. Due to the associations between treatment attrition and increased likelihood of recidivism, it is important to provide MBT-I in settings where attrition is less likely (Olver et al., 2011).

Strengths and Limitations

To the authors knowledge, this is the first qualitative study on participant experience of completing MBT-I with a prison setting. The focus was on participant's experience of developing their mentalizing capacity rather than solely the experience of the group itself. This provides further insights into what processes of change are experienced by, and considered as important for, participants. There are several limitations for this study. Although measures were taken by the first author to ensure that preconceptions were bracketed and had minimum influence on the data, the first author's interest in MBT as a therapeutic approach may have influenced the findings of this study. Due to Covid-19 restrictions in place in the participating prison, one interview was completed 12 months after the initial three interviews. As such, it is possible that with practice, this individual's capacity to mentalize improved over time which may have impacted the data. Lastly, there is a risk of self-selection bias and it is possible that the group of men who agreed to be interviewed were those whose engagement in MBT-I was a positive experience and who noticed the benefits from their participation.

Clinical Implications

This study adds to the wider qualitative literature on MBT and presents a unique insight into participant experiences of developing their mentalizing capacity following their completion of an MBT-I group in a prison setting. These findings provide an insight into what the experience of developing the capacity to mentalize within a prison setting is like. Participants described their experiences of developing their understanding of emotions and the perspectives of others but also reflected on the difficulties of using their newly acquired mentalizing skills within a prison context. Despite these challenges, it is important to continue to offer MBT within prison settings, due to the potential for high attrition rates if only offered in community-based settings. Due to the unique challenges that engaging with MBT-I in a prison setting can present, further research on MBT completed within a prison setting is needed, particularly with participants who have completed the full MBT program.

In addition, as some participants had noted a dissipation of the knowledge learning within the MBT-I group over time it is important to consider how this may be minimised within a prison setting. Engagement in the full MBT program is one consideration but due to its extended duration, this may provide barriers to participation for those on shorter sentences or who are transferred to other prison services. This dissipation of knowledge may be counteracted by providing MBT 'booster sessions', facilitating individuals to complete the group a second time or by fostering a culture of mentalizing within the therapeutic or post-release probation services with which individuals continue to engage.

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Chapter 5: Discussion and Conclusions

Overview of Discussion

The aim of this thesis was to develop a deeper understanding of the experience of undergoing MBT and to gain further insight into how participants make sense of their capacity to mentalize after completing a short-term MBT introductory group. To address these aims, firstly a meta-synthesis of the qualitative literature on individual's experience of undergoing MBT was carried out. Secondly, an original empirical study was completed to answer the question: How do people make sense of their capacity to mentalize after completing an introductory mentalization based treatment group in an Irish prison? A summary of both papers and their findings will be presented in the sections below. Following this there will be a discussion of both the clinical and research implications of the papers as well as a brief discussion on the strengths and limitations of both.

Summary of the Systematic Review

A meta-synthesis of the qualitative literature on the experience of undergoing MBT was completed using a meta-ethnographic approach. This was presented in Chapter two of this thesis. Eleven papers met the inclusion criteria for this meta-synthesis. The synthesized findings of these eleven studies described participant's experience of the therapeutic process of MBT. Firstly, the importance of the therapeutic alliance with the MBT therapist for participants was illustrated. This was considered within the context of epistemic trust, which is a key target in the early stages of MBT. Participants also described what they experienced to be the processes of change following their participation in MBT. Facets of change that tied into the overall conceptualization of mentalizing capacity were described by participants, therefore providing initial evidence that participants experienced an increase in their capacity to mentalize as a result of engaging in MBT. Participants also noted the increase of insight and experience of feeling painful emotions for the first time and described how, in their experience, MBT had not provided them with a method or means by which to cope with these. Lastly, through engaging in MBT, participants developed new insights regarding themselves and others. This contributed to an increase in self-understanding which facilitated improvements in their interpersonal relationships.

Summary of Empirical Research Paper

The aim of the empirical research paper presented in Chapter four was to explore participant experience of developing their mentalizing capacity after completing an MBT-I group within an Irish prison. In-depth, semi-structured interviews were conducted with four participants which were analysed using Interpretative Phenomenological Analysis (IPA). The analysis yielded four group experiential themes. The first theme explored how participants made sense of their difficulties with

experiencing emotions in the context of their early life experiences. Participants made sense of their pre-disposition to feelings of anger and the tendency to engage in violence in the context of their upbringings. The second theme explored how participants made sense of their emotions after completing the MBT-I group. All participants felt that they were better able to manage their emotions, particularly that of anger, using different approaches. Some participants used distraction as a way of managing escalating feelings of anger, whereas others learned how to 'tune-in' to their feeling of emotion in the body. Theme three explored participant's experience of mentalizing and the processes underlying how they came to develop an understanding of the perspectives of others. The last theme delved into the challenges that participants experienced in putting their mentalizing skills into practice both more broadly and within a prison context.

Strengths and Limitations

There are several strengths and limitations of the research completed as part of this thesis. The strengths for the research will be discussed first, followed by the limitations in the paragraph below. A number of strengths were noted for the meta-synthesis presented in Chapter two. Eleven qualitative studies met the inclusion criteria for this paper. The CASP for qualitative research was utilised as a measure of the overall quality of the included studies. This tool provides an overall indication of the strengths and limitations of a qualitative research paper. The overall quality of the included studies for this paper was rated as high. Of the eleven studies that were included, six of these obtained a score of 28 or higher out of a maximum score of 30. Additionally, eight out of the included studies used a hermeneutical methodology. Interpretative phenomenological analysis was used for six of these papers, whereas a further two used thematic analysis based on a hermeneutic phenomenological epistemology. The use of this methodology allows for flexibility of the interview topic, therefore providing participants the opportunity to discuss what they felt was most important as part of their lived experience. As a result, this provided the authors of each included paper which used this methodology, greater scope to interpret what participants felt were important in their lived experience of MBT. As a result, this meta-synthesis was likely to have captured an in-depth account of participant experience which will allow for the further development of MBT interventions. A major strength of the empirical paper presented in Chapter four was that, unlike previous qualitative papers in this area, the focus was on participant's experience of developing their mentalizing capacity. This contrasts with the majority of qualitative research on participant experience of MBT that predominantly focuses on the experience of the group instead. As there is a requirement for further research underlying the mechanisms of change for MBT, this paper provides further insights into what processes of change are experienced by and considered as important for participants. To the authors knowledge, both of the papers presented are unique in terms of their contribution to the MBT

evidence base as the qualitative research completed on MBT has not been synthesized to date and there also have been no previous qualitative research studies on MBT completed with a prison setting.

In addition to the strengths outlined above, there are also several limitations to the research completed as part of this thesis. For the meta-synthesis, it was noted that the consistency of the description of the MBT interventions were poor among the included studies. There was also a wide variability regarding the nature and duration of the MBT intervention that participants received. Lastly, only studies which were published in the English language were included. As non-English study titles or abstracts were not translated as part of the screening process, it is not possible to provide a figure as how many studies, if any, were excluded on this basis. There are also a number of limitations in terms of the major research project presented in Chapter four. Firstly, although measures were taken to ensure that preconceptions were bracketed and had minimum influence on the data, it is possible that the primary researcher's interest in MBT as a therapeutic approach may have influenced the findings of this study. Secondly, participants who participated in this study may have represented a sample of those whose engagement with the group was a positive experience and who found that they had benefitted or gained positive outcomes due to their engagement in MBT-I. Lastly, four participants were interviewed for this study. Three of these interviews were completed by phone, whereas one participant opted to complete his in person. As outlined in Chapter three, there were extensive restrictions in place in the participating prison due to the Covid-19 pandemic, particularly for non-essential visitors. Due to this, one interview was completed 12 months after the initial three interviews. As such, it is possible that with practice, this individual may have demonstrated some therapeutic gains, in terms of his capacity to mentalize, over time. This may have influenced the data provided by this participant during his interview.

Clinical Implications

The research presented in this thesis poses numerous clinical implications for the implementation of MBT as a therapeutic intervention or indeed MBT-I as a standalone intervention. The findings of the meta-synthesis indicate that the decision to engage in MBT is one which requires significant consideration for individuals. As one of the primary goals of MBT-I is to introduce participants to the concept of mentalizing and increase the motivation for longer-term treatment, it is important that participants are offered the opportunity to access MBT-I before they are required to commit to longer term MBT. The findings of the meta-synthesis also indicated that, on occasion, participants felt under pressure to engage in MBT as it had been suggested as part of their clinical pathway or sentence management. As a result, participants spoke of how this had impacted their engagement with MBT in a negative manner. Therefore, it is emphasised that allowing participants autonomy over their decision to engage in MBT is of vital importance, particularly for those individuals in forensic settings.

Additionally, the results of the meta-synthesis indicated that trust in the facilitators, other group members and the therapeutic process took longer to achieve when MBT was offered in a group format without concurrent individual therapy. Where services plan to implement MBT in this manner, and not include individual therapy alongside group MBT, it should be considered that trust in the therapeutic alliance will likely take longer to achieve.

Both research papers presented in this thesis also hold several clinical implications specifically for MBT-I as a therapeutic intervention. The findings from both indicated that, as a result of attending MBT-I, participants experienced increased insight and understanding in terms of their emotional experience. In the meta-synthesis, it was noted that this increase in insight led to an increase in felt negative emotions, whereas within the major research project, talking about difficult experiences in childhood or hearing others talk about theirs brought up memories and challenging emotions for some participants. Individuals who choose to go on to complete longer term MBT will gain support with these through ongoing therapeutic input. However, as MBT-I is considered an introductory group to longer term MBT, it is highly likely that not all participants will progress to the full program for a variety of reasons. Due to this, consideration should be given to including some relevant coping skills for participants within the group curriculum or further follow up sessions should be provided to ensure that individuals who do not progress to longer term MBT are not left unsupported to cope with difficult memories or emotions which could lead to the experience of iatrogenic trauma. Lastly, as part of the empirical research paper in Chapter four, it was noted by some participants that aspects of the knowledge acquired as part of MBT-I had started to dissipate over time, particularly in relation to mentalizing others. One participant reported being able to maintain his mentalizing practice over time, but this appeared to be due to his inherent motivation to do so. This factor needs to be considered if offering MBT-I as a stand-alone treatment. This dissipation of knowledge may be counteracted by providing MBT 'booster sessions', facilitating individuals to complete the group a second time or by fostering a culture of mentalizing within the therapeutic or post-release probation services with which individuals continue to engage. Despite this, it was noted that participating in MBT-I provided participants with increased insight into their difficulties with emotions and interactions with others, as well as the context in which these difficulties developed. This development of insight itself should be considered an important outcome of the therapeutic process, one which is known to play a role in long-term outcomes in psychodynamic psychotherapy (Connolly-Gibbons et al., 2007).

Recommendations for Future Research

The findings of the two research papers presented as part of this thesis propose several recommendations for future research in this area. The findings of the meta-synthesis highlighted that the different configurations of MBT interventions within the evidence base make it difficult to tease

apart the context for participant experience of the intervention. In the service delivery of MBT-I, Bateman & Fonagy (2016) have indicated that it is not the absolute number of sessions which is the crucial factor but rather the therapeutic process. This focus on therapeutic process may be applicable to MBT-G also. Two measures of the treatment integrity of individual MBT and group MBT have been developed: the Mentalization-Based Treatment Adherence and Quality Scale (MBT-AQS; Karterud & Bateman, 2011) and the Mentalization-based Group Therapy Adherence and Quality Scale (MBT-G-AQS; Folmo et al., 2017). It is suggested that future research incorporates either of the above measures where appropriate, to assure the quality of the interventions provided, especially if there continues to be inconsistency of the MBT interventions provided across service contexts. Additionally, the findings of the meta-synthesis highlighted that few studies noted the duration between when the MBT intervention ended and when the research interview was completed. As there is evidence to suggest that when insight is developed within a therapeutic setting, therapeutic gains can continue to increase after therapy, this may have implications for what participants discuss when they are recalling their experience of MBT. Similarly, the findings of the empirical study indicated that participant knowledge developed as part of the group had dissipated over time, so the likelihood of this occurring, needs to be considered also. It is suggested that future research should include a follow-up period with participants in order to monitor gains made after the group, or indeed the potential for the therapeutic impact to wane with time.

The findings of the empirical research highlighted that participant experience of developing their mentalizing capacity focused largely on the understanding of their emotional experiences. This evidence, in addition to the recently proposed hypothesis that the association between mentalizing and positive clinical outcomes may be mediated by emotion regulation (Schwarzer et al., 2021) indicates that the relationship between mentalizing and emotional regulation warrants further empirical investigation. Due to the paucity of research of MBT within ASPD populations, future research, of both quantitative and qualitative nature should be completed for these presentations. As MBT purports to be transdiagnostic in nature, future research in other types of presentations and settings would also be valuable. Lastly, due to the unique challenges that engaging with MBT-I in a prison setting can present, further research on MBT completed within a prison setting is needed, particularly with participants who have completed the full MBT program.

Conclusion

The aim of this thesis was to explore participant experience of MBT as well as the experience of mentalizing capacity development following engagement in MBT-I. A meta-synthesis of the qualitative literature and an original empirical research study were completed. This thesis has provided a deeper insight into the lived experience of participating in MBT which provided numerous

clinical implications as well as recommendations for future research with regards to developing the current evidence base for MBT.

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Appendices

Appendix A: Psychology and Psychotherapy: Theory Research and Practice (PAPTRAP) Author Guidelines

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://www.editorialmanager.com/paptrap

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2. AIMS AND SCOPE

Psychology and Psychotherapy: Theory Research and Practice is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies and Registered Reports. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in Psychology and Psychotherapy: Theory, Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

- Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for Registered Reports.

All systematic reviews must be pre-registered.

Brief-Report COVID-19

For a limited time, the Psychology and Psychotherapy: Theory, Research and Practice are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal's main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured (according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the authors. Appendices are included in the word limit; however online supporting information is not included.

4. PREPARING THE SUBMISSION

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Psychology and Psychotherapy: Theory, Research and Practice now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.

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Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

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You may like to use this template for your title page. The title page should contain:

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
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- Abstract;
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Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the Project CRediT website for a list of roles.

Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

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Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that

order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

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For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

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Author Guidelines updated 28th August 2019

Appendix B: Search strategy syntax for databases used in systematic review

Web of Science: This resource allows the user to search the world's leading scholarly journals, books and proceedings in the sciences, social sciences, and arts & humanities. **Search Syntax:** ALL=*("mentali*ation based treatment"* OR *"mentali*ation based therapy")* AND *(qualitative* OR *"mixed-method*"* OR *interview* OR *"focus group*"* OR *experience* OR *perspective* OR *view* OR *perception* OR *narrative* OR *process* OR *mechanism*)*. **Result: 187 articles**

Scopus: Scopus is the largest abstract and citation database of peer-reviewed literature, scientific journals, books and conference proceedings across all research fields which included science, health, medicine and social sciences. **Search syntax:** *("mentali*ation based treatment"* OR *"mentali*ation based therapy")* AND *(qualitative* OR *"mixed-method*"* OR *interview* OR *"focus group*"* OR *experience* OR *perspective* OR *view* OR *perception* OR *narrative* OR *process* OR *mechanism** NOT *quantitative)*. **Result: 206 results**

PsycARTICLES: is a database of full-text articles from journals published by the American Psychological Association, the APA Educational Publishing Foundation, the Canadian Psychological Association, and Hogrefe & Huber which is the leading scientific publisher for psychology, psychiatry, and mental health in Europe. **Search Syntax:** *("mentali*ation based treatment"* OR *"mentali*ation based therapy")* AND *(qualitative* OR *"mixed-method*"* OR *interview* OR *"focus group*"* OR *experience* OR *perspective* OR *view* OR *perception* OR *narrative* OR *process* OR *mechanism** NOT *quantitative).* **Result: 11 articles**

CINAHL: This resource contains a collection of nursing & allied health journals. **Search Syntax:** *("mentali*ation based treatment"* OR *"mentali*ation based therapy")* AND *(qualitative* OR *"mixed-method*"* OR *interview* OR *"focus group*"* OR *experience* OR *perspective* OR *view* OR *perception* OR *narrative* OR *process* OR *mechanism** NOT *quantitative).* **Result: 47 articles**

PsycINFO: This resource contains bibliographic citations, abstracts, cited references, and descriptive information across a wide variety of scholarly publications in the behavioural and social sciences. **Search Syntax:** *("mentali*ation based treatment"* OR *"mentali*ation based therapy")* AND *(qualitative* OR *"mixed-method*"* OR *interview* OR *"focus group*"* OR *experience* OR *perspective*

Appendix C: Summary table of the constructs identified within each study

Study	Summary of Themes/Sub-themes
Beattie et al. (2019)	Themes: (1) Mentalizing; Subthemes (i) Mentalizing self (ii) Mentalizing other (2) Treatment feedback/outcome; Subthemes (i) Improved social functioning, improved sense of self, increased assertiveness, improved relationships, decreased loneliness, insight development, acceptance.
Bradley-Scott (2017)	Themes (1) Managing complex group processes; Subtheme (i) group purpose, (ii) desire for emotional containment. Theme (2) Personalising Knowledge; Subthemes (i) Directly relating to information, (ii) self in relation to others, (iii) self within others. Theme (3) Increased understanding: the power and the fear. Subthemes (i) understanding as empowering, (ii) understanding as insufficient, (iii) sense of agency and perceived resources.
Ditlefsen et al. (2020)	(1)The group (i) participating in the group made me feel less ashamed of my problems (ii) Learning from others (iii) I felt too different from the rest of the group (2) Acquiring tools (i) I gained understanding, words and perspectives, making me more aware of my experiences and making it easier to think about them (ii) it felt good to learn something I could put into practice straight away (iii) Yes! There is actually hope (iv) it helped me avoid misunderstandings and prejudice (3) Become more prepared for longer-term therapy (i) It gave me more trust in the therapy (ii) The other therapy components felt easier and safer (iii) I felt it helped my therapy become more effective

	(4) Demands of the treatment (i) coming regularly was a challenge; (ii) keeping focused during sessions
Study	**Summary of Themes/Sub-themes**
Dyson & Brown (2016)	Superordinate theme: 'The Battle between BPD and Me' (1)Subtheme: 'I'm much better now [laughs], hopefully; (i) MBT helped but they were not 'cured'; (ii) implicit uncertainty in how it (MBT) had worked. (2) 'You've got to be ready for therapy…you've got to be able to change'; (i) willingness was essential for a positive outcome from therapy; (ii) willingness implied a sense of personal choice; (3) 'We are one [but not together]; (i) shared experience of being in a therapeutic group…[of people with BPD]…was particularly helpful, providing a sense of connection. (ii) There was also a sense the individual was lost and individuality discouraged -→increasing this felt sense of isolation and sadness
Gardner et al (2019)	(1)Being borderline; (i) Identifying with my BPD diagnosis and traits, (ii) My therapist and me, (iii) Learning the language of therapy; (2)Being in the group; (i)The power of shared experiences, (ii)The physical and emotional impact of the group, (iii)Being with other borderlines…women only please!(iv)Listen, talk, trust: learning how to be in the group, (v)There's just not enough time; (vi)The group: a necessary evil; (3)Being on a journey; (i) The point and nature of change; (ii) My mode of transport: from gentle stroll to a mental rollercoaster; (iii) my hopes and expectations: the last chance saloon; (iv)recovery markers and change catalysts; (v) Learning for life/MBT in the real world; (vi) life without MBT.
Johnson et al (2016)	Lived experience at 3 specific points identified (1) Pre-MBT; (i) Hostile and untrustworthy; (ii)roles in family or work; (iii)self(hated); (2)End of MBT; (i)self(tolerated); (3) At point of timeline; (i)Intimates; (ii) self(accepting)
Morken et al (2017)	Four themes within the main category of central inner change processes: Two psychological strategies for dealing with mental states, Two psychological strategies for dealing with personal encounters. (1) By feeling the feeling; (2) By thinking things through; (3) By walking in your shoes to see myself; (4) By stepping outside of own bad feelings in seeing you; (5) Changing step by step.
Morken et al (2019)	Five Themes identified: (1)Taking blinders off; (2)I am not alone; (3)Just say it!; (4)The paradox of trust; (5)Please follow me closely

Study	**Summary of Themes/Sub-themes**
Ó Lonargáin et al (2017)	Four themes identified (1)Experiencing group MBT as unpredictable and challenging (i)beginning group MBT:initial challenges; (ii)experiencing a lack of safety; (iii)the struggle to express oneself in MBT; (2) Building trust; a gradual but necessary process during MBT; (i)building trust in individual sessions with minimal difficulty; (ii) acquiring trust in group sessions: an arduous challenge; (iii)the impact of program structure and duration of attendance on building trust; (3)Putting the pieces together: making sense of the overall MBT structure; (i) preparing for intensive outpatient MBT; (ii)individual therapy; (iii) making sense of concurrent individual and group therapy in MBT; (4) Seeing the world differently due to MBT: a positive shift in experience; (i) reflecting on personal situations and opening up to different perspectives; (ii) perceiving challenging incidents in a new way; (iii) developing a more positive outlook about others and oneself.
Thomas & Jenkins (2019)	(1)Experience of the group; (i)context; (ii)style; (iii) focus challenges; (2) Attachment; (i) secure; (ii) cohesive; (3) Learning flexibility; (i)implicit/explicit; (ii)internal/external; (iii)self/other; (iv)cognitive/affective; (4)Individual sessions; (i) individual space; (ii) expanded; (iii) safe; (5) Impact; (i) change; (ii) responsibility; (iii) effort.
Ware et al (2016)	(1)My individual care; (i)Before the room; (ii)inside the room; (iii)beyond the room; (2)Thinking about thinking; (i)own mental states; (ii)others mental states; (iii)behavioural impact; (iv) emotional states; (3) Being in here; (i)ownership; (ii) daily living; (4) Creating an offence; (i) understanding the past; (ii) victim empathy

Appendix D: The Critical Appraisal Skills Programme qualitative research checklist

Criteria	**Score** 1=Weak 2=Moderate 3=Strong
1. Was there a clear statement of the aims of the research?	
2. Is a qualitative methodology appropriate?	
3. Was the research design appropriate to address the aims of the research?	
4. Was the recruitment strategy appropriate to the aims of the research?	
5. Was the data collected in a way that addressed the research issue?	
6. Has the relationship between researcher and participants been adequately addressed?	
7. Have ethical issues been taken into consideration?	
8. Was the data analysis sufficiently rigorous?	
9. Is there a clear statement of findings?	
10. How valuable is the research?	

Appendix E: Individual CASP item scores used in the study quality appraisal in chapter two.

Paper	1. Aims	2. Qualitative method	3. Research Design	4. Recruitment	5. Data Collection	6. Reflexivity	7. Ethical Issues	8. Data analysis	9. Findings	10. Value	Total Score
Beattie et al. (2019)	3	3	2	2	1	1	2	1	2	2	22
Bradley-Scott (2017)	3	3	3	3	3	3	3	3	3	3	30
Ditlefsen et al. (2020)	3	3	2	2	3	2	1	3	3	2	24
Dyson & Brown (2016)	3	3	2	1	2	2	2	3	3	2	23
Gardner et al (2019)	3	3	3	3	3	2	3	2	3	3	28
Johnson et al (2016)	2	3	2	2	3	1	1	2	2	1	19
Morken et al (2017)	3	3	3	3	3	3	2	3	3	3	29
Morken et al (2019)	3	3	3	3	3	3	3	3	3	3	30
O'Lonargain et al (2017)	3	3	3	3	3	3	3	3	3	3	30
Thomas and Jenkins (2019)	3	3	3	2	3	2	1	2	3	3	25
Ware et al. (2016)	3	3	3	3	3	3	1	3	3	3	28

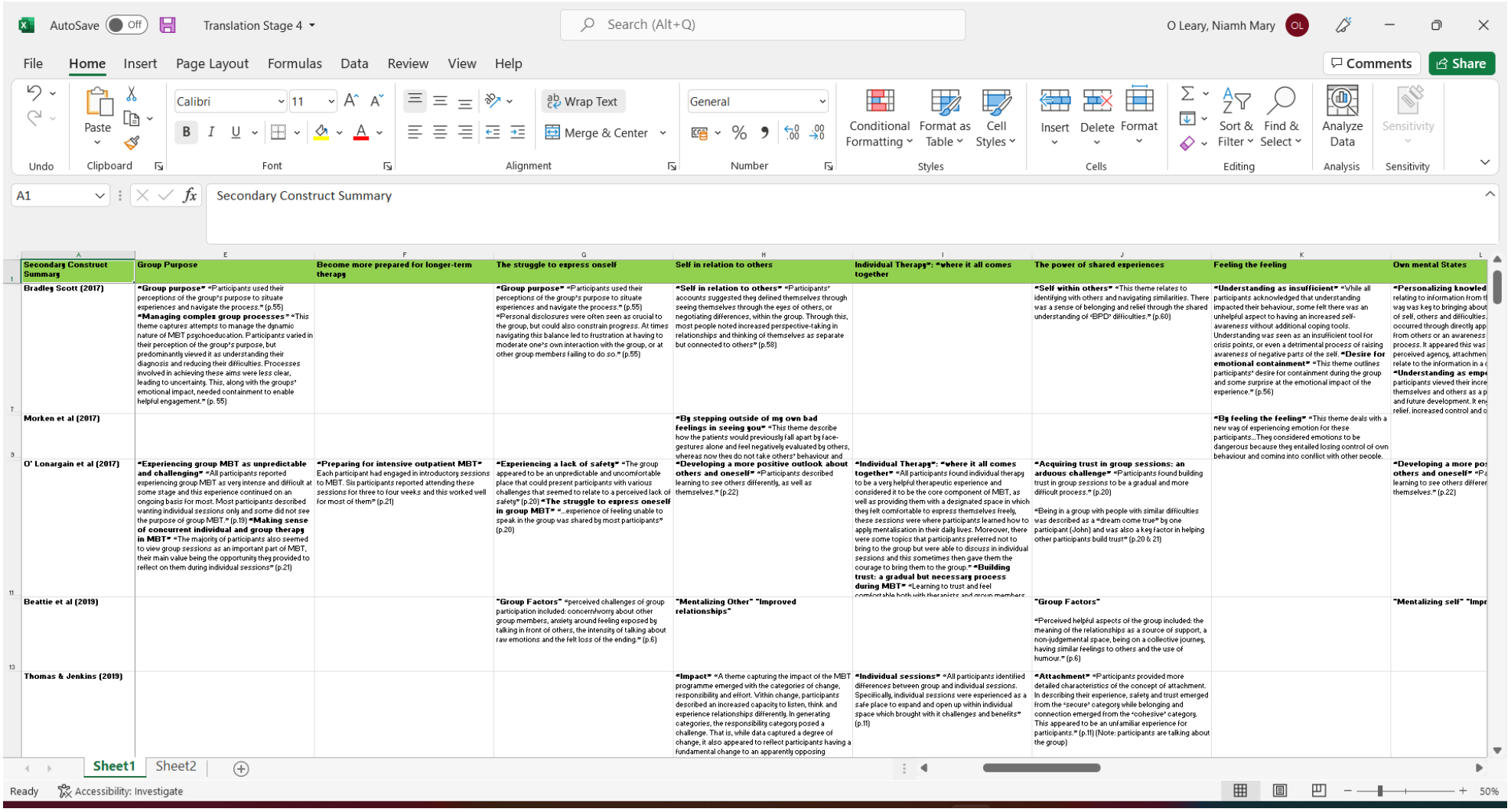
Appendix F: Sample of table used for identifying second order constructs from Thomas and Jenkins (2019).

Second order constructs	Explanation	Raw Data illustration	Notes for potential 3rd order constructs
"Experience of the Group"	"Participants talked about practical characteristics of group. This included; duration, where all participants valued the length of the group retrospectively; location, in relaying that 'trying things out' in the community was easier than in prison and finally that the programme was voluntary, which was perceived as a positive element and different to that of other groups attended." (p.10) "Themes capturing the style of the group reflect elements that are consistent with the MBT model; curiosity, listening, understanding, transparency and not being judged." (p.10) "This is also the case with regards to the focus of the group that explores emotion, relationships and 'me'" (p.10) "In contrast, challenges were noted particularly in the early stages of the programme (early experience) including where questioning was experienced less as curiosity, rather more distressing with an implied ulterior motive and an apparent lack of faith that the programme would be able help" (p.10)	"You learned them [tools] yourself. That's why the group was so long. I realise that now. I used to think a year? That's a bit excessive!" (p.10) "I didn't have to do it . . . it was voluntary . . . I can get up and go . . . You know what I mean, it's very important. Never force anyone to do anything." (p.10) "People don't get me it's hard, it's hard to get your point across, group felt like people got me, I felt happy there as it was the real me." (p.10) "It was helpful, I wanted to see it from another person's point of view as well, to see if they hated me or disagreed with me." (p.10) "Learning to deal with my emotions." (p.10) "To work out what happens in my relationships" (p.10) "In the start . . . scared to do it [come to group], even coming to probation" (p.10)	
"Attachment"	"Participants provided more detailed characteristics of the concept of attachment. In describing their experience, safety and trust emerged from the 'secure' category while belonging and connection emerged from the 'cohesive' category. This appeared to be an unfamiliar experience for participants." (p.11)	"It was like my safety box, where I didn't have to watch what I was saying . . ." (p. 11)	

		"When I didn't go for a week, it was like something was missing, it was a part of my life at the time and it meant a lot to be part of something" (p.11)	
"Learning flexibility"	"The theme of learning flexibility appeared to describe a capacity to shift along continuums that related to the MBT dimensions; internal/external, implicit/explicit, cognitive/affective and self/other" (p.11)	"I know that I react on the emotions, I do this without thinking and it is really quick and instinct based a survival part of the brain." (p.11) "Without realising it you listen to what is actually being said and the situation and the behaviour and realise you can assume things and be wrong." (p.11) "I never thought about it from your [therapists] perspective . . . so that was interesting . . . it changed how I felt." (p.11) "I thought all anger was like red rag to a bull and to nip it in the bud but now I realise I can be angry and deal with it in my head without hurting people." (p.11)	
"Individual sessions"	"All participants identified differences between group and individual sessions. Specifically, individual sessions were experienced as a safe place to expand and open up within individual space which brought with it challenges and benefits" (p.11)	"You could talk to X if there were issues you didn't want to bring up in front of the boys [other group members]… you could talk about anything." (p.11) "It was harder than the group, all about you" (p.11)	
"Impact"	"A theme capturing the impact of the MBT programme emerged with the categories of change, responsibility and effort. Within change, participants described an increased capacity to listen, think and experience relationships differently. In generating categories, the responsibility category posed a challenge. That is, while data captured a degree of change, it also appeared to reflect participants having a fundamental change to an apparently opposing position – i.e. from a rigid sense of accountability where organisations and authority figures are to 'blame', to a more flexible acknowledgement of the participants contribution to interactions with others. Finally, participants reported on the effort it takes to	"It makes you understand what is right and wrong, you look at more detail, it makes you step back and realise what you have said and why that might be a problem." (p.12)	

	engage in the programme but also the challenges of mentalizing" (p.12)		

Appendix G: Illustrative screenshot of the spreadsheet used to translate the studies into one another. This process is described in Section 2.5.3



Secondary Construct Summary	Group Purpose	Become more prepared for longer-term therapy	The struggle to express onself	Self in relation to others	Individual Therapy*: *where it all comes together	The power of shared experiences	Feeling the feeling	Own mental States
Bradley Scott (2017)	***Group purpose*** *"Participants used their perceptions of the group's purpose to situate experiences and navigate the process." (p.55) ***Managing complex group processes*** *"This theme captures attempts to manage the dynamic nature of MBT psychoeducation. Participants varied in their perception of the group's purpose, but predominantly viewed it as understanding their diagnosis and reducing their difficulties. Processes involved in achieving these aims were less clear, leading to uncertainty. This, along with the groups' emotional impact, needed containment to enable helpful engagement." (p. 55)		***Group purpose*** *"Participants used their perceptions of the group's purpose to situate experiences and navigate the process." (p.55) "Personal disclosures were often seen as crucial to the group, but could also constrain progress. At times navigating this balance led to frustration at having to moderate one's own interaction with the group, or at other group members failing to do so." (p.55)	***Self in relation to others*** *"Participants' accounts suggested they defined themselves through seeing themselves through the eyes of others, or negotiating differences, within the group. Through this, most people noted increased perspective-taking in relationships and thinking of themselves as separate but connected to others" (p.58)		***Self within others*** *"This theme relates to identifying with others and navigating similarities. There was a sense of belonging and relief through the shared understanding of 'BPD' difficulties." (p.60)	***Understanding as insufficient*** *"While all participants acknowledged that understanding impacted their behaviour, some felt there was an unhelpful aspect to having an increased self-awareness without additional coping tools. Understanding was seen as an insufficient tool for crisis points, or even a detrimental process of raising awareness of negative parts of the self. ***Desire for emotional containment*** *"This theme outlines participants' desire for containment during the group and some surprise at the emotional impact of the experience." (p.56)	***Personalizing knowled*** relating to information from t way was key to bringing about of self, others and difficulties. occurred through directly app from others or an awareness process. It appeared this was perceived agency, attachmen relate to the information in a ***Understanding as emp*** participants viewed their incre themselves and others as a p and future development. It en relief. increased control and c
Morken et al (2017)				***By stepping outside of my own bad feelings in seeing you*** *"This theme describe how the patients would previously fall apart by face-gestures alone and feel negatively evaluated by others, whereas now they do not take others' behaviour and*			***By feeling the feeling*** *"This theme deals with a new way of experiencing emotion for these participants...They considered emotions to be dangerous because they entailed losing control of own behaviour and coming into conflict with other people.	
O' Lonargain et al (2017)	***Experiencing group MBT as unpredictable and challenging*** *"All participants reported experiencing group MBT as very intense and difficult at some stage and this experience continued on an ongoing basis for most. Most participants described wanting individual sessions only and some did not see the purpose of group MBT." (p.19) ***Making sense of concurrent individual and group therapy in MBT*** *"The majority of participants also seemed to view group sessions as an important part of MBT, their main value being the opportunity they provided to reflect on them during individual sessions" (p.21)	***Preparing for intensive outpatient MBT*** Each participant had engaged in introductory sessions to MBT. Six participants reported attending these sessions for three to four weeks and this worked well for most of them" (p.21)	***Experiencing a lack of safety*** *"The group appeared to be an unpredictable and uncomfortable place that could present participants with various challenges that seemed to relate to a perceived lack of safety" (p.20) ***The struggle to express oneself in group MBT*** *"...experience of feeling unable to speak in the group was shared by most participants" (p.20)	***Developing a more positive outlook about others and oneself*** *"Participants described learning to see others differently, as well as themselves." (p.22)	***Individual Therapy*: *where it all comes together*** *"All participants found individual therapy to be a very helpful therapeutic experience and considered it to be the core component of MBT, as well as providing them with a designated space in which they felt comfortable to express themselves freely, these sessions were where participants learned how to apply mentalisation in their daily lives. Moreover, there were some topics that participants preferred not to bring to the group but were able to discuss in individual sessions and this sometimes then gave them the courage to bring them to the group." ***Building trust: a gradual but necessary process during MBT*** *"Learning to trust and feel*	***Acquiring trust in group sessions: an arduous challenge*** *"Participants found building trust in group sessions to be a gradual and more difficult process." (p.20) "Being in a group with people with similar difficulties was described as a "dream come true" by one participant (John) and was also a key factor in helping other participants build trust" (p.20 & 21)		***Developing a more pos others and oneself*** *"P learning to see others differe themselves." (p.22)
Beattie et al (2019)			***"Group Factors"*** *"perceived challenges of group participation included: concern/worry about other group members, anxiety around feeling exposed by talking in front of others, the intensity of talking about raw emotions and the felt loss of the ending." (p.6)	***"Mentalizing Other" "Improved relationships"***		***"Group Factors"*** *"Perceived helpful aspects of the group included: the meaning of the relationships as a source of support, a non-judgemental space, being on a collective journey, having similar feelings to others and the use of humour." (p.6)		***"Mentalizing self" "Impr***
Thomas & Jenkins (2019)				***Impact*** *"A theme capturing the impact of the MBT programme emerged with the categories of change, responsibility and effort. Within change, participants described an increased capacity to listen, think and experience relationships differently. In generating categories, the responsibility category posed a challenge. That is, while data captured a degree of change, it also appeared to reflect participants having a fundamental change to an apparently opposing*	***Individual sessions*** *"All participants identified differences between group and individual sessions. Specifically, individual sessions were experienced as a safe place to expand and open up within individual space which brought with it challenges and benefits" (p.11)	***Attachment*** *"Participants provided more detailed characteristics of the concept of attachment. In describing their experience, safety and trust emerged from the "secure" category while belonging and connection emerged from the "cohesive" category. This appeared to be an unfamiliar experience for participants." (p.11) (Note: participants are talking about the group)		

Appendix I: Sample of exploratory noting and experiential statements from the first 4 pages of transcript 1 (Rob).

	Interview 1 (Rob)	
Experiential Statements	Original Transcript	Exploratory Comments
The initial period in prison was one of instability.	**I: I firstly just wanted to ask you how you first heard about the MBT group** P: Em…When I got sentenced I was in *REDACTED* Prison and ah…like I got a sentence of 15 years and I wasn't expecting to get a sentence of 15 years and a chief…a chief officer introduced me to the psychology service in *REDACTED*. and maybe I think I did not attend them in *REDACTED*	bringing it back to the start of his time in prison, the beginning of the story in prison length of sentence was a shock/surprise to him (why?-reflection; could the sentence have been a catalyst for internal change or something else-period of turbulence?) the psychology service was something new, no prior experience with psychology (or possibly other mental health service) did he make the decision not to at the time? (reflection-maybe seems unsure of why he made this decision at the time); period of instability, lots of change, unsettled being moved a lot (reflection-I wonder why was he getting transferred?)

	but I got transferred from prison to prison	something clicked in this prison, this is where he settled, possibly another description of point of change or point of development; more surprise? this seemed to just come out of the blue;
The introduction to psychology was casual and informal	and I found my feet down here in *REDACTED*	didn't question it, (reflection: was there a degree of passiveness there? maybe he was just bored that morning and decided to go?); so had asked about it previously, curious, interested about psychology (reflection-why?);
	and I just.. eh I got referred to them one morning,	introduction to psychology was casual, informal
Has had significant Interaction with the psychology service	I didn't even ask them but it was probably on file from me asking to see them in *REDACTED*	I've done a few…a load of one to ones'-(reflection-hesitates? Maybe he's reflecting while talking)-describing a lot of input from psychology;
	and they just called me over	lots of input from psychology in terms of groups possibly but calls them courses-psychology as education (reflection-does he see them as education like school instead of therapeutic?-does he need to frame this way for them to be acceptable to do in the prison context/in his personal/historical context).

Psychology is conceptualised as education	and I've done a few…a load of one to ones and I done a few ah…a few courses …eh mentalization courses and you know and that like	(reflection: he has done group twice but is he talking here about courses that might overlap with topics covered in mentalization group? E.g. emotion regulation/anger management?); emphasis on very-does this indicate that he got a lot out of them-new knowledge that landed/changed his perspective perhaps? making a connection with the interviewer? Would he say this in conversation with someone who maybe didn't know about MBT-related to explaining his experience? is he hesitating here; maybe he's reluctant to admit that he did it twice (context-in this prison they sometimes ask people to do the group again if they think it will be of benefit to the individual but also so that the individual can scaffold the learning of the other group members). distinguishing it from the longer term MBT group; making a distinction between the two groups that he has completed. was he surprised that he was asked to do it a second time-(how did he interpret that-how was it explained to him?

Experience of surprise at how much he learned from doing the course a second time	and I found them very…very very interesting with psychology courses you're always learning you know? **I: mmhmm** P: you know and eh… I done that mentalization group twice the…the… ten week one, I've done that twice. xxxx	wasn't on board with doing it a second time-he had drawn a line under it, that's done with; I've learned all I can learn about mentalization; indicates that there was some sort of process as he went through the group; revealing that he felt he was incorrect to say 'there's no more to learn'-surprised about how much more there was to learn (or how well he got on in the group in terms of contributing etc the second time?) see above-surprise at how much more there was to learn-or was prior learning just further consolidated; the second time around was almost like revision, reminded of things that he had forgotten previously, consolidated his previous learning.

Appendix L: Table of Group Experiential Themes from the completed data analysis

Group Experiential Themes
1) Making sense of difficulties with emotions in the context of early life experiences Making sense of his emotions in relation to his past *"…cause like…I was born in* ****REDACTED**** *like yeah? ya get me like? We rarely showed our emotions, well I never like*" (Marty). Not receiving support to learn about emotions as a child "*The only emotion that you were left to feel was anger, d'ya know? And that was justified because that made you a man. If someone pissed you off and you got angry, you box the head off them. And that's the way it was, but you can't feel upset, you can't feel sad, d'ya know what I mean? Or any of these emotions going on like coz then you're weak, d'ya know?"* (Eric) Not receiving support to learn about emotions as a child *"I'm not gonna hold my parents up on a pedestal and say they weren't the best of parents like, d'ya know what I mean. I was never taught about all those things like…I never knew about emotions or anything…but…like if they done it…"* (Eric) Life before prison *"I hadn't got a good upbringing"* (Rob) Life before prison *"I've seen a lot of violence down through my years myself"* (Rob) Opening up and sharing personal information *"like opening up and all about my past…like I knew it wasn't gonna be easy"* (Lorcan) Learning from other group participants *"I just kinda took in more about what they were saying about how to control ourselves and how to deal with emotions rather than blurting out my life story"* (Lorcan)

Opening up and sharing personal information

"like and there was a good group of lads there as well so I didn't really feel, do ya know, upset about bringing up things from the past or anything like that." (Lorcan)

2) Learning to feel and manage emotions

Making sense of his emotions in relation to his past
"I'd leave them build up and leave them build up until all of a sudden someday like it was all too…and the wrong person would push that button and then all hell would break loose like…" (Marty)

Learning and understanding his own emotions
"Now I can just like stop it before it even gets to that point, right? Like do something, get active, read a book, go to the gym, play football, you know?" (Rob)

Coping with emotions
"*the gym is my kind of release."* (Lorcan)

Coping with emotions
"Nah I just…I got distracted by the television then after that really (laughs)*"* (Lorcan)

Identifying and understanding emotional triggers
"It was just that I could understand it more, like process it more in my head it was just, d'ya know, a technical fault like whereas the first time it was it was a person like..." (Lorcan)

Experiencing emotions in his head rather than his body
"it was always a head thing for me like. It was never here (points to chest)…it was always up here (points to head)." (Eric)

Learning to feel emotions

"So, right we can see that…the negative thoughts are associated with the sad emotion, d'ya get what I'm saying? So I'm having good thoughts then you realise I feel happy, so you know that happiness comes with good thoughts. So it's about learning the patterns like…". (Eric)

Learning to feel emotions

"…the more you practice it like, the stronger the connection gets. The link between mind and body, it gets stronger." (Eric)

Making sense of the experience of emotion

"They're all in my head like. Where before I used…things used to just build up inside of my stomach". (Marty)

Making sense of his emotions in relation to his past

"…like I do be scared to snap because I know what I'm capable of doing like yeah?" (Marty)

3) Keeping other minds in mind

Thinking about others

"I wouldn't have thought about a person, d'ya get me? All my life, I'd have never thought about anyone in my life d'ya know what I mean, d'ya know? Family alright maybe yeah but all the rest of them I didn't think like yeah?" (Marty)

Making sense of the emotions of others

"the biggest part of the course was putting yourself in someone's shoes before you act and I found myself doing that a lot more. I suppose even towards officers as well. If I was told 'no' or if I was told to do something I just did it and if someone was being angry towards me I kinda thought, right what are they feeling? Put myself in their shoes." (Lorcan)

Inferring the mental states of others from their behaviour

"like 'so let's just check it like so he's being aggressive…'why is he being aggressive' so I'd be more curious about the other person, d'ya get that kind of way like? Maybe there's something going on in his life or…whatever it is I don't know but clearly there is like because he's shouting and screaming at me for no reason like". (Eric)

Making sense of others and their behaviour

"if they're having a bad day and you know, they're having a bad day…you'd go over and you'd talk to them like. If you see them all slumped over and if you see them all on their own or, you know, if you see them not talking to anyone or, you know, you would go over and try to talk to some of them like but before that if I seen all that I wouldn't have a clue." (Rob)

Changing tack: learning how to work with/manage emotions in the context of violent behaviour

"…if someone came into me and started roaring 'you this that, you this that', I'd just walk away. I'd just bite my tongue and walk away because they are obviously having like a bad phone call or a bad day, you know?" (Rob)

Making sense of the emotions of others

"like if an argument was likely to pop up…I kinda stepped away from it…em…d'ya know when you can feel an argument brewing like when you're on a phone call like…em…just took a step back and just thought of how they were feeling" (Lorcan)

4) Mentalizing in practice

(i) Keeping mentalizing 'in mind'

Impact of Covid-19

"I suppose over the lockdown…d'ya know my way of thinking has changed a bit, obviously like it's not an easy time and all so it would be no harm for me to do a group again just to keep it fresh in mind. If you get me like? The good thing about the course is that it kept it, d'ya know it kept things in mind like." (Lorcan)

The battle to change

"Like…that course was only on for 8 weeks like d'ya know what I mean. So like I'm ****REDACTED**** *years of age like, so I'm living my life like that. The way I'm living it like that since I been…since I been…since I been about 12 or 13. I:* ***yeah yeah*** *P: Do you know like, so like, I just find it really hard like. I know like, I can understand, do ya get me, t's just very hard for a person like who didn't know any…who doesn't know any different ya know that kind of way like?"* (Marty)

The experience of attending the MBT-I group

"I was thinking to myself 'what's the point I've already done it there's no more to learn and as I done it, and like I was actually surprised at myself with the things that I did learn as well from the second one that I forgot from the first one you know so…". (Rob)

Reflecting on mentalizing ability

"…look you're not gonna get it perfect all the time, that's what I realised like and sometimes you're like 'g'way fuck off man' but you'd kinda stop and you'd say…like even the psychologist said that to me like…it's a skill and you need to work on it like so…" (Eric)

Reflecting on mentalizing ability

"So you go round the prison then and that's when…like at the start I would have been rusty but you get better. You do become better". (Eric)

(ii) Mentalizing in prison

Culture of not talking about emotions in prison

"And…as I said just being able to sit down and just…be in touch with your emotions, d'ya know, it makes a big difference but…its it's good for me but you cant really talk to much people in here about that kinda of thing, d'ya know what I mean because in prison they'd say, 'what the fuck you on about emotions, what are you a woman?' D'ya know what I mean like?" (Eric)

Managing conflict in prison

"you go into that environment where you cannot let people like…step on your toes, you know?" (Rob)

Managing conflict in prison

"you hear people saying 'no you can't like let people say this or you can't let people do that or…" (Rob)

The battle to change

*"for a bloke like who's trying to change his life around like that it's a hard place to do like anything in jail like yeah? You know that kind of way like? Because *REDACTED* you see I've been around people that I know my whole life like that play nothing and it's easy to get dragged back into things like."* (Marty)

The battle to change

"There was just a situation and I'd no choice really, do you know what I mean? I: Okay P: D'ya know like that's the way life is d'ya know like? D'ya know like…I'd like to walk away but I can't walk away." (Marty)

Identifying and understanding emotional triggers

"arguments on the phone, your head wouldn't be right for a few days because you've nothing else but time to be thinking about things like that, especially in here so…" (Lorcan)

Appendix N: Irish Prison Service Research Approval Form

Irish Prison Service

Research Approval Form

This form must be completed in respect of applications to carry out research within the Irish Prison Service.

Part A – Personal and Research Details

1. Personal Details			
Name(s)	Niamh O'Leary		
Address	*redacted*		
Landline		**Email** *redacted*	**Fax** n/a
Mobile	*redacted*		

2. Title of Proposed Research
An exploration of the experience of mentalization capacity development and the impact on reflective functioning and alexithymia following group mentalization based therapy (MBT) within an Irish prison service (IPS).

3. Description
Provide a brief description (approx. 200 words) of the research proposal, including aims and objectives.
MBT is a structured therapeutic program which aims to increase the resilience of an individual's mentalizing capacity (Bateman & Fonagy, 2016). Recently there has been emerging evidence to

suggest that individuals who exhibit aggressive behaviour and engage in violent acts often have a limited capacity to mentalize (Bateman & Fonagy, 2016). Few studies have investigated mentalizing processes in those who have been charged with violent crimes and held in prison. This study aims to address several gaps in the MBT research literature by exploring how individuals with a history of violent behaviour make sense of their mentalizing capacity following an MBT-I group in the Irish Prison Service. This study also aims to measure the impact of MBT-I on reflective functioning and alexithymia in a wider sample of those who have completed the group while in custody with the IPS.

4. Research Methodology

Indicate the research methods, including samples, instruments, measures, procedures, analysis, personnel and the likely time scale of the research project.

4.1 Design:

This is a mixed-methods study exploring the experience of developing mentalizing capacity following participation in an introductory Mentalization-Based Therapy (MBT-I) group in the Irish Prison Service.

4.2 Participant Sample:

The quantitative aspect of this study will involve the analysis of pre and post MBT-I group questionnaires which have previously been collected within the Irish Prison Service. All participants have provided consent for their anonymised data to be analysed as part of a group and used in presentations or publications considering MBT (see Appendix vi). This data will be anonymised before being shared with the researcher in accordance with GDPR policies. The questionnaire measures that will be used in the quantitative aspect of this study have been collected from across a number of prison psychology services across Ireland who offer the MBT-I group. To date, the database contains questionnaire measures from approximately 40 participants. However, this number is likely to increase before the completion of the current study as measures are being collected on a continual basis.

The participants in the qualitative aspect of the study will be comprised of individuals who have completed the MBT-I group in Cork Prison. The researcher will aim to recruit between 6-8 participants who have completed the MBT-I group within the last year. Among those that have completed the group, some are currently serving the remainder of their custodial sentence within

Cork Prison while others may have been transferred to another prison service in Ireland. The MBT-I group runs twice annually and typically has 8 participants per group. As a result, there will be a pool of approximately 16 people from which the sample for the current study can be recruited from.

4.3 Participant Inclusion and Exclusion Criteria:

To maintain homogeneity of the sample, this study will aim to recruit participants who are male, and fall within a similar age-range and sentence duration.

For inclusion in the study participants must:

(i) be 18 years or over

(ii) have completed the MBT-I group in the 12 months prior to the scheduled interview

(iii) be able and willing to provide written informed consent.

(iv) have attended at least 75% of the MBT-I group sessions.

Exclusion criteria for participation in the study include:

(i) A history of severe traumatic brain injury, moderate-severe learning disability or other significant cognitive impairment

(ii) inadequate English to participate in informed consent and group therapy

4.4 Questionnaire Measures:

The measures which will be used for this study are the Reflective Functioning Questionnaire (Appendix iv) and the Toronto Alexithymia scale (Appendix v).

i) *Toronto Alexithymia Scale-20 item* (TAS-20; Bagby, Parker & Taylor, 1994)

The TAS is a self-report measure of alexithymia. It consists of three subscales: difficulty identifying feelings; difficulty describing feelings and externally oriented-thinking. The TAS-20 is reported to have good test-retest reliability (r = 0.77) and high internal consistency (cronbach's alpha =0.89).

ii) *Reflective Functioning Questionnaire*-8 item (RFQ-8; Fonagy, Luyten, Moulton-Perkins, Lee, Warren et al., 2016).

The RFQ-8 is a screening measure of reflective functioning and mentalizing and measures the degree of certainty or uncertainty of knowledge about a respondent's own and others' mental states. There are currently no articles published on the reliability and

validity of the RFQ-8. However, the eight items included in the RFQ-8 were all part of the original RFQ, with findings providing preliminary evidence for its reliability and validity (Badoud et al., 2015; Fonagy et al., 2016).

Qualitative data will be collected through conducting interviews with individual participants. A semi-structured interview schedule (Appendix ii) has been constructed for this purpose and was guided by an interpretative phenomenological methodology as specified by Smith, Flowers and Larkin (2009). All questions in the interview schedule are open and non-leading in order to facilitate each participant to talk about each topic at length.

The interview schedule was comprised of three sections. The 'Opening' section is designed to allow the participant to become accustomed to the interview setting. The opening questions include; asking the participant to provide a descriptive account of how they came to hear about the MBT-I group and what their overall experience of the group was like. The questions in the second section are designed to address the research question of "How do people make sense of their capacity to mentalize after completing MBT-I within a prison setting?" and aim to serve as prompts to facilitate participants to reflect on their experience of developing their mentalizing capacity. This section of the interview schedule is informed by the definition of mentalizing as outlined in the literature, specifically, that mentalizing relates to how a person recognises and imagines their own internal mental states as well as the internal states of others (Allen, Fonagy & Bateman, 2008). It was also informed by what is known about some of the difficulties experienced by those with poor mentalizing capacity such as emotional dysregulation, impulsive behaviours, dysfunctional relationships, aggressive behaviour and violence towards self and others (Jorgensen, Freund, Bøye, Jordet, Andersen D & Kjølbye, 2013; Møller et al., 2014). The third and final 'Closing' section has two final questions which allows the participant the opportunity to add any further information that they feel is important It also allows for the researcher to determine what the experience of the interview was like for the participant and to ascertain whether the participant needs further debriefing around feelings or emotions that may have arose during the course of the interview.

After the interview has been completed, participants will also be asked a series of demographic questions (Appendix iii) to allow the researcher to describe the sample in the write-up of the research report.

4.5 Procedure

Participants will be invited to participate in the research by one of the assistant psychologists (AP) working in Cork Prison. Those who meet the inclusion criteria will be approached and informed of the research by an AP. The AP will explain the nature of the study and what is involved to anyone who expresses an initial interest in participating or finding out more about the research. If interested, participants may also be provided with a copy of the information leaflet (Appendix i). The AP will also offer to read through the information leaflet with anyone who may have literacy difficulties. The AP will then provide each person with an expression of interest form (Appendix vii) and inform the

person that they are being asked to indicate whether or not they are interested in taking part in the research. Each person will complete their response out of the view of the AP and enclose their response in the envelope provided so that the AP will not be aware of their decision. All envelopes will be returned to the research supervisor in the prison psychology service. The research supervisor will then open all of the envelopes. Those who have expressed an interest in taking part will have an interview scheduled with the primary researcher at a time and day that is suitable for them. No further action will be taken with those who have not expressed an interest in the research and their decision will not impact any future opportunities to engage with the prison psychology service.

Participants who express an interest in participating in the research will be invited to attend an interview with the primary researcher by the research supervisor at a time and day that is suitable for each person. At the outset of this interview, the researcher will go through the information leaflet and consent form with each person. Each person will be provided with the opportunity to ask any questions they may have in relation to the purpose of the research or their participation. Participants will also be reminded that they can decide that they don't want to take part in the research at this point, and do not have to provide a reason for doing so. If, following a review of the information leaflet and consent form, the person agrees to participate, they will sign the consent form and will be invited to participate in a 1-1.5 hour interview with the researcher (Appendix ii). All participants will be provided with the opportunity to discuss how they feel after the interview and will be asked if there was any further information to add, if they are happy to include all of the information discussed or if they have any further questions regarding the study or their participation. At the end of the session each participant will be thanked for their contribution to the study and will be reminded that if they have any further questions or concerns that they can discuss these with a member of the Irish Prison Psychology service.

4.6 *Personnel*:

This study will be facilitated by the psychology team within Cork Prison. As the quantitative data has already been collected it is envisioned that, apart from navigating the researcher to the current database, that this will require limited further input from the IPS psychology staff. Participants for the qualitative study will primarily be recruited by assistant psychologists working in Cork Prison. The sample size for this aspect of this study requires 6-8 participants, and the participant pool consists of approximately 16-20 people. It is estimated that the duration of time required to complete the initial recruitment (ie inform each potential participant of the research and provide a brief explanation of what would be involved if they choose to take part) will take no longer than 20 minutes per person. The primary researcher will carry out the more time-extensive procedures of going through the information leaflet with those who have expressed interest and will ensure to answer any questions or queries asked by potential participants. The transcription, analysis and write-up of the project will all be completed by the primary researcher and will not require further time from IPS psychology staff apart from the supervisor's input on the final drafts of the report.

4.7 Data analysis

The pre-MBT-I and post-MBT-I measures of the RFQ-8 and TAS-20 will be analysed using a repeated measures t-test. If the data are not normally distributed, the Wilcoxon Signed-Rank Test will be used.

All participant interviews will be transcribed and analysed using Interpretative Phenomenological Analysis (IPA). IPA is concerned with the detailed examination of personal lived experience, the meaning of experience to participants and how participants make sense of that experience (Smith, 2011). Mentalizing capacity develops as a consequence of an individual's early life experiences and develops while undergoing MBT in conjunction with the unique opportunities that may arise in their everyday life to practice their mentalizing skills. Therefore, it is appropriate to look at the lived experience of each individual participant in attempting to broach the research question which asks: 'how do people make sense of their capacity to mentalize after completing MBT-I within a prison setting?' IPA as a methodology was also chosen due to its inductive nature which may contribute to a greater understanding of the idiographic experiences of men who undergo MBT within a prison setting, a population which has largely been neglected within the research literature.

Data analysis will be carried out as an iterative process according to the procedures outlined by Smith and colleagues (2009). Each transcript will be read and re-read to allow the researcher to become fully immersed in each participant's experience. During each reading of the transcript, the researcher will take note of arising codes in the data. Initial codes will then be incorporated into themes for each individual transcript. Emergent themes will subsequently be explored for convergence and divergence across all completed transcripts which will result in the development of superordinate and subordinate themes for the data obtained from the overall sample. All themes will be reviewed by the academic research supervisor to ensure credibility of the analysis and finalised themes. In the discussion section, the themes identified as part of the current study will be related to those themes identified in similar studies within the existing research literature.

The researcher will maintain a reflective diary from the outset of the research project which will be utilised to note any thoughts or reflections that arise through each stage of the project (Interviews→Transcription→Data analysis). Researcher reflexivity and bracketing of any preconceptions related to any stage of the research will be considered in a supplementary chapter in the final project submission.

4.8 Estimated Timeline of the Study:

It is estimated that:

-data collection for the project will run from approximately April 2020-July2020.

-transcription of the data will be completed by Dec 2021.

-data analysis will be completed by March 2022

-write-up will be completed by April 2022.

Please note that the gap between the data collection and data analysis is due to researcher maternity leave.

5. Outcomes

Indicate the expected value of this research (i) for society in general and (ii) the Irish Prison Service specifically.

This study will investigate each participant's experience of developing their mentalization capacity and will contribute the evaluation of this therapeutic intervention within the IPS. It will also provide further information on individuals' experiences relating to the development of mentalizing processes. As a result, this may contribute to advancements in this therapeutic approach in the future, both in prison service populations and beyond. To date, the evidence base for MBT has primarily focused on the full structured 18 month program of MBT. There has been limited research on the individual components that make up the full MBT program such as MBT-I. If it is demonstrated in the current study that short-term MBT (MBT-I) is beneficial in improving mentalizing capacity, it may be a way of increasing access to MBT across a variety of settings. This is of particular relevance to the IPS and as longer term MBT is not accessible to those with shorter sentences or to those who may be transferred to different services within the prison system.

Part B – Research Ethics

6. Ethical Considerations

Outline the ethical considerations that you consider relevant to this proposal and provide details as to how you have addressed them. Please attach the Code of Ethics and Professional Practice Guidelines which is guiding your application.

The ethical considerations outlined below have been guided by the *Psychological Society of Ireland's Code of Professional Ethics* (PSI, 2010), the *Research Ethics Guidance* Document published by the Irish Prison Service (IPS, nd), the *World Medical Association Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects* (WMA, 2013) and the *UCC Code of Research Conduct* (UCC, 2018). Only the considerations of each document that are deemed relevant are addressed below.

The Research Ethics Guidance Document published by the Irish Prison Service (IPS, n.d) outline the below ethical principles which must be accounted for when seeking to complete research within the IPS.

1) **"Prisoners are vulnerable to exploitation and abuse by research because their freedom for consent can easily be undermined, and because of learning disabilities, literacy**

difficulties and language barriers prevailing within prisoner populations." (IPS, n.d., p. 1).

To address the above principle, exclusion criteria regarding language barriers and learning disabilities have been considered. Participants will be reminded that their participation in the study is entirely voluntary. The researcher will review the information leaflet and consent form (Appendix i) with each potential participant and provide an opportunity to ask questions or clarify any terms used. The researcher will ensure that all information and consent materials are written in plain English. Materials will include some words which would be considered jargon, e.g. 'mentalizing' or 'mentalization'. However, it is anticipated that these terms will be familiar to all participants as a result of taking part in the MBT-I group which explains and discusses these terms in detail. However, to ensure that this is the case, a definition will be provided to each potential participant. If an individual has literacy difficulties, the researcher will read the information leaflet and consent form to them. The researcher will also ensure to answer any questions or queries regarding all aspects of participation and data collection, storage and usage thereafter.

To address any concerns about perceived repercussions of refusing to participate in the study, it will be clearly stated on the information leaflet and will be reiterated at all stages of the research process that refusing to participate or withdrawing their data at a later stage will not impact their current or future opportunities to engage with the prison psychology service. It will also be stated that they do not have to provide a reason for why they may have chosen not to participate or make the choice to withdraw their data.

The AP who will be completing the initial recruitment procedure and the primary researcher will not have worked in a therapeutic capacity with any of the potential participants. It will also be emphasised that the research is independent from treatments/interventions provided by the psychology service at all stages of the research process.

2) **"Individuals have a right to keep a part of their lives free from intrusion, and information privacy is an area of particular importance. A fundamental requirement of ethical research is that information disclosed within the context of a research relationship be kept confidential." (IPS, n.d. p. 3)**

As the researcher will not be directly recruiting the participants from this study, access to individual information or files that are held in the prison is not required. Participants will be reminded that they can refuse to provide information or answer specific questions that are asked by the researcher. Therefore they have greater autonomy over which information relating to their background or experience that they may or may not choose to share. Procedures around maintaining confidentiality pertaining to the data obtained as part of the proposed study is addressed in Section 7 below.

3) The *Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects* item 20 states that:

"Medical research with a vulnerable group is only justified if the research is responsive to the health needs or priorities of this group and the research cannot be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that result from the research." (World Medical Association, 2013, p. 2192).

It is necessary to complete this research on MBT-I within a prison service as the development of mentalizing capacity within a prison setting may indeed be more difficult due to the inherently stressful experience of being held in custody. Therefore, it is necessary to build the evidence base with this specific population as evidence gathered from community samples may not be comparable. Furthermore, this research will contribute to the knowledge base in this area which will allow for further developments relating to clinical practice and the tailoring of this framework of intervention to this specific population.

7. Confidentiality

(a) Describe procedures for maintaining confidentiality.

7.1 Exceptions to confidentiality

Participants will be informed that the information that is disclosed within the context of the research will be kept confidential but is subject to the limits of confidentiality as outlined in the Prison Psychology Service 'exceptions to confidentiality' protocol with the exception of items 1, 10, 11 and 12. These items are applicable to clinical and therapeutic work carried out as part of the IPS psychology service, as per IPS policy, but are not a requirement for the purposes of IPS research. As such, they have not been included as part of the participant information leaflet and participants will be informed of this distinction. The researcher will have a copy of this protocol on their person while carrying out the research. Participants will have already signed a copy of this protocol prior to their participating in the MBT-I intervention.

7.2 Data Confidentiality

The audio-recordings from the participant interviews, signed consent forms, electronic transcripts obtained from the interviews and hard copies of the demographic questionnaires will be stored.

7.3 Data Storage

The audio-recordings will be stored on Share-file, a secure file sharing and transfer service which is currently used by the Irish Prison psychology service for sharing and storing video files for

supervision purposes. These recordings will only be accessible to the researcher and staff of the Irish Prison psychology service in Cork.

The researcher will be able to access Share-file in order to complete the transcripts remotely. For the purposes of this research project, the share-file in use for the project will only be accessed remotely through a HSE encrypted laptop. Anonymised transcripts will be saved securely on the UCC google drive and not on the laptop locally. Following the removal of all identifying information, transcripts will also be shared with the UCC research supervisor and UCC data repository for storage following completion of the research.

The consent forms and demographic data forms will be stored in a locked filing cabinet in the psychology office of Cork Prison.

The audio-recordings will only be stored on the Share-file for the duration of time it takes to complete each transcript. When each transcript is complete, the associated audio-recording will be deleted from the Share-file. The transcripts from which the data will be analysed will be stored for a minimum period of ten years after the completion of the research project in line with UCC's *Code of Research Conduct (2017)*.

7.4 Data Sharing

Anonymised data will be shared with the UCC academic research supervisor and staff of the Irish Prison Service Psychology service. The supervising psychologist in the IPS will act as a second reviewer to ensure that all information that could be considered as identifiable has been removed. This may include any name the person uses, any reference to where they are from or locations of incidents described, descriptions of physical characteristics e.g. scars or tattoos, or any information that is unique to that person that they may describe during the interview process (e.g. ownership of a model of car, favourite type of music etc). Once all of the identifiable information is removed, the person in the transcript will be referred to by their chosen pseudonym for the remainder of the research project. However, as the data for this project will be analysed using IPA, it will be necessary to quote participants' own words within any written reports or publications in order to illustrate the extracted themes. As a result, a selection of the raw data will be available to all consumers of the research report.

7.5 Consent for Data Sharing and Storage

The above procedures for the sharing and storage of confidential data are outlined in the information leaflet and consent form (Appendix i) and participants will sign their name to indicate that this has been explained to them and that they agree to have their data shared and stored as outlined.

(b) Describe procedures that you will follow if confidentiality is breached.

If the situation arises where a breach of confidentiality or personal data occurs, the procedures set out by the IPS *Data Processing Agreement* will be followed. This agreement will be signed by the primary researcher and the UCC research supervisor who will act as 'data processors' on behalf of the IPS for the duration of the research project.

The following is the appropriate section of the Data Processing Agreement which will be applied in the event of a data breach:

4.9 Data Breach

4.9.1 The Processor shall notify the Controller as soon as it becomes aware but no later than 24 hours of becoming aware of a personal data breach affecting the personal data processed in accordance with the placement agreement and shall provide the Controller with sufficient information to meet any obligations of the Controller to inform the data subjects and the relevant data protection authorities. The processor shall, at a minimum:

- *describe the nature of the personal data breach, the categories and numbers of data subjects affected and the categories and numbers of personal data records concerned;*
- *describe the cause or suspected cause if not known of the breach;*
- *describe the likely consequences of the personal data breach;*
- *describe the measure taken or proposed to be taken to address the personal data breach, and*
- *communicate the name and contact details of the processors data protection officer and any other relevant contact persons.*

4.9.2 The Processor shall cooperate with the Controller and take such reasonable steps as are necessary to assist in the investigation, mitigation and remediation of any personal data breach.

4.9.3 The Controller shall determine whether or not to inform the data subjects and/or the relevant data protection authority(ies) and the Processor shall cooperate with the Controller in notifying the relevant authorities and/or data subjects.

8. Risk and Risk Mitigation

Outline the risks associated with your research proposal and the associated risk mitigation which you have included:

What will happen if a participant discloses that they are thinking about harming themselves or threaten to harm themselves during the research interview?

If the situation arises whereby a participant experiences distress during the interview process or discloses information that would indicate that they may have intentions to harm themselves the researcher will immediately inform a psychologist in charge. They will ensure that this person is reviewed by the prison health-care service which is accessible 24 hours a day. If for any reason a

psychologist is not available, the researcher will contact the prison medical team directly to inform them of this information.

What will happen if a participant discloses that they have recently self-harmed?

If the situation arises whereby a participant discloses that they have recently self-harmed during the research interview the researcher will immediately inform a psychologist in charge. They will ensure that this person is reviewed by the prison health-care service which is accessible 24 hours a day. If for any reason a psychologist is not available, the researcher will contact the prison medical team directly to inform them of this information.

What will happen if a participant threatens to harm another person or at risk of being harmed themselves (e.g. assault, kill) during the research interview?

In the event that a person discloses that they are at risk of harm to or from another person, the researcher will inform the psychologist in charge. If for any reason, a psychologist is not available, the researcher will contact the governor of the prison directly to inform them of this risk.

What will happen if a participant discloses information that would indicate that a child is at risk sexual, emotional, physical abuse or neglect during the research interview?

If a person discloses a child protection risk during the interview, the participant will be informed that it is mandatory that child protection concerns are reported to Tusla. The researcher will then inform the psychologist in charge and will contact the duty social worker regarding the information and complete a Tusla child protection report relating to the disclosure.

What will happen if a participant discloses information regarding a retrospective report of physical, emotional, sexual abuse or neglect during the research interview?

If a person discloses information regarding a retrospective report of physical, emotional, sexual abuse or neglect during the research interview, the participant will be informed that it is mandatory that retrospective reports of abuse are reported to Tusla. The researcher will then inform the psychologist in charge and will complete a Tusla retrospective abuse report relating to the disclosure.

What will happen if a participant discloses information regarding a previously undisclosed crime, during the research interview?

If a participant provides information regarding a previously undisclosed crime during the research interview, the researcher will inform the supervising psychologist of this information as this is considered as one of the limits to confidentiality as specified in the ‘exceptions to confidentiality’ protocol.

What will happen if a participant discloses that they are in possession of a prohibited item (e.g. drugs, weapon, mobile phone)?

If a participant provides information that they are in possession of a prohibited item during the research interview, the researcher will discuss this information with the supervising psychologist. In the case that a research participant discloses that they are in possession of a weapon and the supervising psychologist is unavailable the researcher will inform the governor directly due to the risk of safety to the person themselves and others within the prison service.

What will happen if there is risk to the physical safety of the researcher?

The risk of physical distress to the researcher is low. In the unlikely event that there would be a risk of physical distress to the researcher: two alarms are located in the room in which each interview will take place and interview sessions are monitored intermittently by 2-3 prison guards who will be located in one of the rooms adjacent to the interview room. The rooms used for the purposes of the research interview have a window through which the session can be monitored externally. Items of furniture within each room are kept to a minimum to reduce the likelihood that a person in custody can use these items as a barricade or potential missile. The researcher has also completed professional management of aggression and violence (PMAV) training and will ensure this training is up to date for the duration of the research project.

If a research participant appears to become distressed or agitated during the interview, the researcher will discontinue the interview. If it is felt that discontinuing the interview suddenly may agitate the participant further, the researcher may leave the room under the guise of 'fetching something from another room' in order to exit safely. Should this situation arise, the researcher will be cognisant of not engaging in behaviour or body language that could be perceived as confrontational or threatening to the other person. The researcher will then inform the supervising psychologist or prison governor and inform them of this person's agitated state as they may pose an increased risk of harm to themselves or others in the period of time afterwards.

9. Conflict of interest

Please give details of any potential conflict of interest, including employment with Irish Prison Service or membership of any bodies.

The proposed researcher is a member of the Psychological Society of Ireland, is enrolled as a student of University College Cork and is employed by the Health Service Executive. However it is not envisioned that these associations create a potential conflict of interest in the context of the proposed current research study.

10. Informed Consent

Specify who will give consent and procedures for obtaining same. Please attach a copy of the consent form and subject information leaflet. (Note that (i) if a subject has literacy difficulties the researcher must read the material to the subject) and (ii) if a consent form is not required, a description of the study, specifying all the elements of consent, must be given to participants.
Participants will be reminded that their participation in the study is entirely voluntary. The researcher will review the information leaflet and consent form (Appendix i) with each potential participant and provide an opportunity to ask questions or clarify any terms used. The researcher will ensure that all information and consent materials are written in plain English. Materials will include some words which would be considered jargon, e.g. 'mentalizing' or 'mentalization'. However it is anticipated that these terms will be familiar to all participants as a result of taking part in the MBT-I group which explains and discusses these terms in detail. However to ensure that this is the case, a definition will be provided to each potential participant. If an individual has literacy difficulties, the researcher will read the information leaflet and consent form to them. The researcher will also ensure to answer any questions or queries regarding all aspects of participation and data collection, storage and usage thereafter.

Part C – Academic Background

11. Please insert below any personal and or professional competencies that you have that would assist you in carrying out this research
The researcher is current undertaking the Doctorate of Clinical Psychology course in UCC. As part of this course, the researcher has gained professional experience in working with vulnerable populations in a therapeutic context and therefore can adequately manage any discussions of a sensitive nature (e.g. disclosure of abuse, self-harm) or emotive disclosures that may occur during the interview process. In addition to the above, the researcher has previously been employed as a researcher on numerous previous research projects and in addition has been awarded a PhD by research in the field of developmental psychology, all of which ensure that the proposed research will be carried out in an ethical manner with the utmost scientific rigour.

12. (a) Academic Supervision	
Supervisor:	Dr. Philip Moore

Contact number:	Phone: 021 490 4685; Email: philipmoore@ucc.ie

12. (b) If this research forms part of an academic course, please indicate the following	
Academic Institution:	University College Cork
Qualifications for which you are aiming for	Doctor of Clinical Psychology

13. Dissemination of research findings
Outline plans for the dissemination of research findings and/or publication.
It is proposed that the research findings will be published in a peer-reviewed journal and presented at an academic conference. Feedback will also be provided to participants of the study. The research report and additional publications or conference proceedings will be sent to the Irish Prison Service Research officer.

14. Is your research being funded? **Yes** [ ] **No** [x] **If yes:**	
Funding Body	n/a
Please attach confirmation of funding	**n/a**
Funder Contact Name	**n/a**
Funder Contact details	n/a

Part D – Consent and Declaration

15. Consent to be Contacted		
I agree to being contacted the Irish Prison Service from time to time about the progress of the research and to provide relevant information when requested. (Note that agreement is a condition of approval)		
	Yes	**x**
	No	

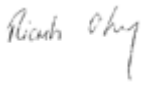
16. Output Agreement		
I agree to submit Reports / Findings / Conference Papers to the Research Officer, Irish Prison Service College for their appropriate use and dissemination. (Note that agreement is a condition of approval)		
	Yes	**x**
	No	

17. Security Clearance		
I declare that the information I have provided above is true. I understand that a false declaration will result in my application being refused. I understand that a security check will be conducted by the Irish Prison Service with An Garda Síochána if I require entry to a prison and I hereby give my consent to this being done.		
	Yes	**x**

No	

18. Access
Please indicate the IPS facilities which you are looking to access.
The sample will be primarily recruited from Cork prison but the study is hoping to recruit anyone who has participated in the MBT-I group in Cork that may have been transferred elsewhere since completion of the group. Therefore access to all IPS facilities is being requested.
19. Ethics
I declare that as a researcher I will act in accordance with this guidance and act ethically to protect the wellbeing of prisoners at all times (Note that agreement is a condition of approval)

Yes	**x**
No	

20. Signature
Signature: 
Date: 17th February 2020

Applicants should be aware that final approval for research resides with the Director General of the Irish Prison Service, and access to prisons is a matter for individual governors for operational and security reasons and in light of available resources in the institutions.

Note:

* The Irish Prison Service advises that you refer to the appropriate sections of the Declaration of Helsinki1[v] and give due consideration to the ethical principles/guidelines of your own discipline regarding research.

Please return this completed form with the IPS Security Clearance Application Form and direct enquiries to the contact details below.

Research Officer

Irish Prison Service College

Brian Stack House

Portlaoise

Co. Laois

Email: researchoffice@irishprisons.ie

Appendix P: Irish Prison Service Psychology Service Information Sharing Consent Form

Psychology Service Information Sharing

When can a psychologist share my private (confidential) information without my consent?

Appropriate information might be shared for sentence management and release planning. Psychologists can (or must) break confidentiality if:

1. You threaten to harm yourself (e.g., suicidal).
2. You threaten to harm another person (e.g., assault, kill).
3. You are involved in a prison incident that threatens the safety of yourself or others.
4. You are a serious risk to the public on release.
5. The court asks for a report and/or access to your psychology record
6. You say something that your psychologist has to report (e.g., child abuse and neglect, vulnerable adult abuse, undisclosed crime).
7. You self-harm – this information with your initials and unique PRIS Number will be given to the National Suicide and Harm Prevention Steering Group.
8. You die by suicide (in prison or two weeks after release) relevant information might then be released by your psychologist to the Inspector of Prisons.

I have read the above. It has been explained to me. I can ask questions about it. I understand what it means and how it might affect me. I understand that I can ask questions again.

Name of client (print):_____

Signature: _____

Date: _____

Psychologist: _____

_____