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ORIGINAL PAPER

Battles of the Comfort Zone: Modelling Therapeutic Strategy, Alliance, and Epistemic Trust—A Qualitative Study of Mentalization-Based Therapy for Borderline Personality Disorder

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Abstract
We propose a model for how therapeutic strategy, alliance, and epistemic trust interact to foster or hinder therapeutic processes. Four individual mentalization-based treatment (MBT) sessions were subjected to an in-depth qualitative comparison and interpretative phenomenological analysis. Two sessions had high adherence and quality ratings, and two exemplified low evaluations. The sessions were from an MBT program for patients with borderline personality disorder. The high-rated therapists were more prone to strategically identify and investigate maladaptive patterns, were more challenging, and brought the patients out of their comfort zone. This therapeutic endeavour seemed to facilitate therapeutic alliance and a productive therapeutic process. Low-rated therapists seemed to be brought out of their own comfort zone (e.g. transferences/countertransferences), and attempted to amend the relational atmosphere by being supportive. In these sessions, the therapeutic alliance seemed weak, and therapeutic progress was not observed. When therapists strategically and competently challenged problematic patterns, despite disclosing discomfort, alliance was strengthened. It seemed that a clear therapeutic strategy, and skilfull battling of the patients' comfort zone, fostered the therapeutic process. We hypothesize that epistemic trust may develop as a product of a fruitful and persistent focus on tasks and goals in therapy.

Keywords Mentalization-based treatment (MBT) · Interpretative phenomenological analysis (IPA) · Strategic competence · Therapeutic alliance · Process research

Introduction

Mentalization refers to the ability to understand and interpret behaviours of self and others as expressions of intentional mental states such as feelings, wishes, goals, desires or needs (Fonagy et al. 2002). It develops from early infancy, through attachment relationships and care. The attachment figure is a source for physical security, emotional support, mental attention, knowledge, and culture. Recently, the concept of *epistemic trust* (Fonagy et al. 2018) was introduced to explain the relation between attachment and mentalizing. An attitude of epistemic trust, in contrast to *epistemic freezing*, implies that the listener is ready to take in personally relevant knowledge about the social world. The concepts of mentalization and more recently, epistemic trust, have particularly been advocated in treatment of borderline personality disorder (BPD). The field of psychotherapy research lacks narratives of the phenomenology of different core components and how they may work together. In the present qualitative study of BPD therapy sessions displaying very

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high and low ratings of adherence and competence, we aim to elaborate on aspects of therapist strategy, alliance, and epistemic trust.

Borderline Personality Disorder and Specifically Tailored Psychotherapy

Patients with borderline personality disorder (BPD) are characterized by insecurity in close attachment relationships, problems of emotional regulation, and a reduced ability to mentalize (Bo et al. 2017). Currently, there are eight specific, evidence-based treatments for BPD (Stoffers et al. 2012). These treatments are all extensive, highly structured, and target core aspects of BPD. One of these is mentalization-based treatment (MBT). Its efficiency for BPD is established in several studies, of which three are randomised controlled trials from UK (Bateman and Fonagy 2001, 2009; Rossouw and Fonagy 2012), and two are naturalistic comparisons replicating positive results in settings outside UK (Bales et al. 2015; Kvarstein et al. 2015). Treatment manuals specifying the style of intervention and reliable integrity measures for therapist interventions exist for both the individual (Karterud et al. 2013) and group components (Folmo et al. 2017).

The Impact of Therapeutic Alliance Across Specific Approaches

Research focusing on mechanisms of change in psychotherapy, has emphasized qualities of the therapist-patient dyad. A therapist's ability to form and maintain a therapeutic alliance (goals, tasks, and personal bond; Bordin 1979) is reckoned as a robust predictor of outcome in psychotherapy. It is known to predict more variance in outcome than the application of a technique, strategy or (*bona fide*) treatment approach alone (Wampold and Imel 2015). However, the process and outcomes of therapy are a result of a complex interplay between therapeutic factors, and specific types of therapy may differ in their involvement and dependence of aspects of alliance (Nissen-Lie et al. 2015). The therapeutic dyad clearly also depends on the patient's ability to form a personal bond to the therapist, create goals and understand the mutual tasks of therapy. Typical aspects of the relational problems in BPD are hostility, insecure attachment, and disturbed epistemic trust (Bo et al. 2017). These are factors which may severly challenge the therapeutic alliance. It is of interest to understand how a therapeutic alliance can be formed and fostered in such circumstances.

Therapeutic Alliance and Clinical Expertise

The mere "relationship" with a therapist is, in itself, insufficient (Laska et al. 2014) for positive outcome, and therapeutic competence has considerable relevance. For unknown reasons, some therapists seem able to nurture and negotiate therapeutic alliances significantly better than others (Lemma et al. 2011). Across therapy approaches, therapists will apply "strategic competence" (Killingmo et al. 2014) to navigate and structure sessions. We understand strategic competence as the totality of the therapist's understanding of psychotherapy, knowledge of the diagnosis and the patient, and the specific relation. Rønnestad (2016) identifies a combination of a deep engagement in the client's welfare, together with a willingness and capacity to confront the client's dysfunctional behaviour as one of six important characteristics of clinical expertise. In treatment of poorly functioning patients with BPD a willingness to confront maladaptive patterns, may be crucial. However, such confrontation is challenging for both therapist and patient, may represent an interpersonal or emotional "battle of the comfort zone", and needs to be managed with care.

Therapeutic Alliance Challenged by Countertranference

Countertransference reactions may be of particular importance in psychotherapy for BPD (Betan et al. 2005), and are also relevant in structured therapies, such as MBT (Morken et al. 2014). Negative countertransferences in therapists can include feeling helpless, overwhelmed or overinvolved (Colli et al. 2014). Rønnestad (2016) has indeed called for more in-depth investigations of treatments with "difficult to treat clients". Specifically structured treatments aim to represent helpfull strategies in the management of poorly functioning patients. The specified model may then serve as a potential vehicle for the therapeutic alliance.

Therapeutic Alliance and Therapist Model Fidelity

In an MBT study of BPD patients with substance abuse, Möller et al. (2017) reported that high therapist fidelity was associated with an increase in the patients' reflective functioning (operationalization of mentalization; Fonagy et al. 2002) during therapy sessions. In this case, high competence in MBT was seen to induce a productive process of change in core pathology. Nevertheless, little research has focused on how the therapists in evidence-based treatments tailor the specific technique to the patient; how therapists using a certain method, may facilitate alliance and epistemic trust. Hence, there is a pressing call to investigate how (skilled) therapists adapt their specific therapeutic method to the individual patient and thus, integrate the potentially conflicting perspectives—specific treatments and common factors approaches (Laska et al. 2014).

The Present Study

The present study is a qualitative analysis aiming to explore therapeutic dialogues in therapy sessions in light of therapists' strategic competence, patients' indication of epistemic trust and the collaborative therapeutic alliance. For this purpose, we investigated the specific approach, MBT, as a specific treatment for poorly functioning patients with BPD. We selected therapy sessions with high and low ratings of MBT treatment fidelity (Karterud et al. 2013). In studying the transcripts, we sought to understand what influenced the therapists in the sessions, how they maneuvered the topics, how they handled difficult emotions, possible transferences and countertransferences, and the strength of the therapeutic alliance. The results of the qualitative analysis led us to suggest a model of the interaction between these different aspects—alliance, strategy, and epistemic trust.

Materials and Methods

Sessions were selected by purposeful sampling (Patton 1990). The four most deviant (extreme) sessions were sampled from a total of 108 individual MBT sessions assessed with the fidelity scale for MBT-I (Karterud et al. 2013). Ratings were done as a regular, quality ensurance service procedure provided by the Quality Lab for Psychotherapy at Oslo University Hospital, Norway (http://www.mbt-lab.no). The authors reached consensus after independent ratings of the sessions. Rater reliability (estimated on the basis of 30 fidelity ratings) was high (mean value, absolute G coefficients, adherence: 0.95, quality: 0.90). Two authors in this paper (EF and SK) were raters.

The fidelity ratings include MBT adherence and quality. Adherence ratings count the interventions compliant with the 17 items of the fidelity measure. Quality is assessed for each identified item on a 1–7 Likert scale. In addition, global adherence and quality scores are decided for the session as a whole (overall clinical judgement). The cut-off for acceptable MBT-fidelity is four or above. MBT interventions are predominantly characterized by a clear focus on exploration of mental states.

The investigated sessions were all part of MBT programs. Two sessions with high MBT ratings (Adherence: 7; Quality: 7), and two with low ratings (2/2) were selected from Norwegian, Danish and Swedish MBT teams. At the time of video-recordings, treatments had lasted various lengths of time (range 6–24 months). The four therapists were affiliated within MBT teams, were experienced psychotherapists, had advanced MBT training, and received regular MBT supervision. Therapist age-range: 37–65 years. Standard MBT includes patients with personality disorders and core BPD pathology and combine individual and group therapy, emphasize treatment formulations and initial psychoeducation (Karterud 2012; Karterud and Bateman 2010).

For the qualitative process studies, video recordings of the selected four sessions were transcribed, and personal data anonymized. Patients and therapists gave their written, informed consent to participate in the project. The study was approved by the Privacy Ombudsman at Oslo University Hospital.

Qualitative Data Analysis

Our intention was to investigate the phenomena beyond concepts that are defined and operationalized in existing literature. We chose interpretative phenomenological analysis (IPA; Smith et al. 2009) as it allows a fundamental investigation of phenomena like alliance and strategic competence, and has been employed in a number of papers in clinical and counselling psychology (e.g., Østlie et al. 2016; Smith 2011). The transcripts were analysed according to the IPA framework (Smith et al. 2009) in five steps:

(1) The four sessions were transcribed and studied in detail, and discussed in depth, in order to include as many viewpoints as possible (therapist, patient, overarching, synthesis). During this process the first author was in contact with all other authors, discussing transcripts in-depth with the second (SK) and fourth author (EK).
(2) The first, fourth, and last author (EF, EK and ES) sought to phenomenologically investigate the therapeutic alliance (goals, tasks, and personal bond). Agreement on goals could be identified by indications of a mutual idea of achieving improvement. Agreement on tasks was interpreted from the patient's willingness to engage in therapy, participate in a mentalizing discourse or identify, accept and process problematic themes and behaviour patterns. The personal bond could be deduced by patient expressions indicating confidence in the therapist being able to help (aspect of epistemic trust) and a degree of genuine relating, e.g., the patients' trust that the therapist really cared and understood.
(3) Emergent themes identified by (EF) were frequently discussed with the second (SK), fourth (EK) and last author (ES). We looked for possible sequential patterns, how interventions were timed, and identifiable strategies.
(4) The first (EF), fourth (EK), and last author (ES) employed different theories and concepts (e.g., alliance, common factors, strategic competence, MBT, psychoanalytic theory, attachment theory) to illuminate the perceived patterns.
(5) In a final discussion, on the basis of steps 1–5: The first (EF), fourth (EK), third (MK) and last author (ES)

decided on the major recurrent themes/patterns in the sessions.

Results

In the selected sample, the high-rated sessions were characterized by stable focus on mental states (mentalization). The interventions built logically on each other and seemed guided by an overarching strategy: If one intervention failed, the therapists pursued the same goal by another route. In the low-rated sessions, interventions were more seldom, and often lacked a clearly detectable plan or overarching pattern. The high rated sessions were characterized by the therapists being more mentally involved, more active. They also seemed able to manage their own countertransference, focus on affects, keep a mentalizing focus, and challenge the patient in an emphatic and transparent way. In particular, it seemed that the ability to tolerate negative feelings and bring up difficult themes with the patient distinguished high-rated from low-rated sessions. It seemed that high MBT fidelity implied therapies with more willingness for confrontation, and as such, a willingness from both therapist and patient to move beyond a perceivable "comfort zone". Three major recurrent themes/patterns were thus identified: (1) Alliance; (2) Strategic competence; and (3) Battles of the comfort zone. Therapeutic alliance seemed to be fostered by both strategic competence and battles of the comfort zone.

Theme 1: *Therapeutic alliance*. "Where are we headed? Do we cooperate?" Our first identified theme was well defined by Bordin's therapeutic alliance concept (goals, tasks, and personal bond; 1979). In MBT, the overall aim of therapy is to increase the patient's ability to mentalize. From the therapists point of view, the tasks in a therapy sessions is to maintain a focus on mental states, promote a mentalizing dialogue, and explore mentalizing deficits. From the patients point of view, tasks are to bring in, and be willing to explore, personal issues within a mentalizing framework. A strong alliance indicates that the patient understands that increased mentalizing is the ultimate goal, that s/he agrees to work towards this aim, and believes that the therapist can facilitate this process.

Theme 2: *Strategic competence*. "Given this patient, the goal, situation, and relation, how do we best bring about change?" Strategic competence provides the therapist the broader roadmap of how to navigate, adjust, and tailor the MBT technique to the unique patient, relation, and situation. Strategic competence partially overlaps with the quality score of MBT—it includes the timing, precision and relevance of the interventions. Skillful application of MBT includes an overarching ability to navigate (strategic competence) not defined by the MBT manuals.

Theme 3: *Battles of the comfort zone*. "How do we stay on course? Can we challenge maladaptive patterns?" The application of a specific technique, keeping it tailored to the patient, goal, situation, and relation, was a challenge for all therapists. The theme termed "Battles of the comfort zone" emerged when assessing therapist's effort to sustain strategic competence.

Battles of the comfort zone were twofold. From the *therapist perspective*, the persistence of a mentalizing focus, was in some respects, a struggle against resigning to a perhaps, more "comfortable zone", avoiding confrontation (e.g., merely providing supportive therapy). The strong impact of the patient's current mental states such as anger, pretend mode (losing the emotional grounding), teleology (taking actions as evidence for inner states), psychic equivalence (taking own convictions for reality), and possibly also the therapist's own wish for "good transferences", seemed to undermine the application of a focused technique and overall strategy. Battles of the comfort zone also include a *patient perspective*. In high-rated MBT sessions, patients maladaptive behaviors, ways of thinking or relating could be identified and confronted. Avoidance of such confrontation might be to let the patient reside within a (maladaptive) comfort zone. In low rated MBT sessions, the main therapeutic project (theme 1) was abandoned, and these sessions did not reveal relevant MBT therapeutic work. However, in a successful, and repeated confrontative process, as illustrated in the high-rated sessions, the alliance not only endured the strain, but even seemed strengthened by the mutual effort. Our two first identified themes (alliance and strategic competence) seemed to work together and result in beneficial therapeutic work.

Four Case Examples

Below we present our analysis of the three themes in the sessions.

Diane and Her Therapist: Losing Authority and Losing Battles

Diane was a woman in her late 20 s. Her therapeutic project (in the session) was not clear, and she displayed a wide repertoire of strategies to avoid working on her problems in therapy. By attacking, putting down, refuting, appealing to, rejecting, and directly contradicting her therapist, she focused her narrative on several themes, mostly in a pseudo-mentalizing way. She blamed others and her life-situation for her problems, and wanted the therapist to support this view.

Diane opened the session by inquiring whether the therapist had sent a health statement on her behalf: *"Yes. Did you send the statement?"* Her tone was harsh and judgemental. When the therapist turned defensive and uncertain, she

immediately followed up by saying: *"It should have been sent two weeks ago"*, in a way which indicated frustration with the therapist. Next, Diane confronted the therapist for mislabelling her feeling of anger in the previous session: *"Last session, I got angry with you. You said I was irritated, but I wasn't, I was angry!"* The therapist misunderstood her, laughed, and again underestimated her feelings. Diane moved on to say that her problems stemmed from other people, and not from herself. After a while, the therapist vaguely suggested that the patient's views were not necessarily the only reality. Diane immediately refuted this perspective, stating that she took no responsibility for her problems: *"… you made it only my experience and not an actual reality… then you are kind of placing responsibility on me for a situation that is really not my responsibility."*At the end of the session the therapist offered Diane an extra session. Diane turned down this offer, saying that it would not help.

Alliance The patient exhibited little confidence in the therapist and statements explicitly demonstrated a lack of alliance. The emotional level was high. Diane was not able to understand or consider most of the therapist interventions. Interventions did not address the actual relationship or therapeutic project (alliance level). In this case, the possibility for battles of the comfort zone were lost on the alliance level.

Strategic Competence The therapist's initial attempt to laugh away the theme of the patient being "angry and not irritated with him/her" was out of tune with Diane, and the entire session was coloured by a lack of therapists' direction, authority and clarity. Interventions were vague, often only initiated, but not followed up. Possible therapist strategies were outmaneuvered. The therapist missed several opportunities to explore how Diane's statements made sense, or confront non-mentalizing. The most frequent intervention was *"Ehm"*, suggesting an attempt to be warm and supportive. Increasingly, the therapist seemed to strive for a pleasant climate (which often resulted in an even lower interpersonal temperature). At one crucial moment, Diane displayed personal vulnerability in a relational context, but at that point, the therapist missed the invitation to explore mental content, and instead pursued a concrete detail. Diane: *"Ehm… Because… I really felt that I wasn't… seen, in a way, at all. By her. Ehm… Therapist: When did you…?"* Diane: *"Saturday. Therapist: Saturday, OK. Yes, you said that. Yes"*.

Battles of the Comfort Zone Early in the session, the therapist seemed outplayed by their own countertransference (e.g., feeling overwhelmed, helpless, and fearing Diane's anger) and the therapists mentalizing capacity seemed effected. Less able to guide, challenge or question the patient's mental states, the therapist gradually retreated to a supportive and submissive stance. The therapist attempted to challenge Diane when she talked about the other students at her school being the cause of her problems: "*Mm. You kind of.. yes. Because what I was interested in understanding, was something like why it is a bigger problem for you than for others, that is what was maybe… that is what was…"*. However, in response to Dianes confronting style, the therapist gradually started to excuse him/herself for questioning her position: "*Yes. No, I was also thinking… it wasn't right… it was foolish to say that… negative attitude and that, so… but I still think that, OK, maybe other people have different…"* Towards the end of the session, Diane said she really needed to finish a paper over the next few days. The therapist then suggested that they should have kept the content of the session more superficial. Diane strongly rejected this argument, leaving the therapist bewildered, still out of touch. Therapist: *"We could have kept it a bit superficial here, but…* Diane: *What's the point of that? Therapist: Yes, what's the point of that. Right. More superficial or… More focused on the concrete, or… yes. I think it was very important that we spoke about this.."*. The dialogue in this session, indicates that Diane was winning a battle of the comfort zone without resolving her maladaptive, prementalistic, modes of experiencing (pretend mode, psychic equivalence and teleology). Diane: *"This is not something I can do much about. And… I don't see any point in having a positive attitude to something negative."*

Monica and Her Therapist: Protecting the Patient from Therapy

Monica, a woman in her early 20 s, had suffered a violent sexual assault and subsequently missed several sessions. The session was her first since the incident. She conveyed that she lacked energy and did not sleep well. In the session, she seemed uninterested in resuming psychotherapy. The therapist did not challenge the patient. The therapeutic strategy was resigned early in the session. The session included some enquiry, information and continued with a sequence about Monica's wish to buy a new dress. The patient finally wanted to end the session five minutes early, "*as they had nothing important to talk about*". The therapist agreed.

Alliance Most interventions aimed for a positive personal bond. The relationship or therapeutic project was not addressed directly. Monica had one utterance addressing alliance to the group *"No, I am actually quite excited about getting back there, because it has been pretty much... a lot happening there."* However, she did not seem enthusiastic about the ongoing individual therapy session and took the opportunity to end the session early. The alliance seemed weak.

Strategic Competence Monica's therapist sought a warm, gentle, considerate atmosphere throughout the session, asked practical questions, validated responses, but largely avoided exploration and refrained from challenging the patient. Brief inquiries included details after the assault (had the rapist been caught: *"You don't know, or do you know that he hasn't*

been caught?"; was support from health care and judicial system sufficient), on post-traumatic symptoms (dreams/nightmares; fear of walking alone in the dark), and functioning (was coming to two group sessions too much at the moment, was she able to continue at school: *"Have you managed to get back on your feet with regards to … school and… or have you…"*; how was her social network,*"Who is close by you now?*"; and how were other things in her life, e.g., *"What else is happening to you?")*. The therapist provided news from the group, advice on sleep medication, and normalized symptoms in light of the recent incident.

Battles of the Comfort Zone The therapist had a strategy of not confronting the patient too much in the current situation—it is unclear what was the patient's perspective as she had difficulties with elaborating on her own mental state. This is captured by the therapist. Therapist: *"But those thoughts that are coming in lots... those thoughts, what are... I would have liked to hear."* Monica: *"Well, this is what I have been telling you"*. Therapist: *"Yes. But are there any more?"* Monica: *"No."* Therapist: *"No.. no...?.. content, no kind of depressive... no kind of wish that you were... no kind of...?"* Monica: *"No. I am more kind of indifferent, really."* Therapist: *"Indifferent."* Monica: *"Yes"*. Nevertheless, countertransference appear to be present, effecting the quality of the session. The fact that Monica had not turned up to therapy for a while was brought up. However, the question was framed so it could be precieved rather as difficult for the therapist, who had been worried, than care for the patient. The therapist also brought up missed sessions of group therapy, but abandoned the theme when Monica explained her total lack of energy after the traumatic event. The therapist often seemed to lack curiosity for the answers to own questions and in one example, the therapist gave a conclusion on behalf of the patient. Therapist: *""Who is close by you now?"* Patient: *"Right now it is S and Y, family."* Therapist: *"Yes. But you are a little lonely…."* The struggle of the comfort zone in this case seems to end up with a dialogue devoid of any exploration of mental states, both parts avoiding discomfort, which nevertheless seemed to be present. The therapist becomes increasingly careful, avoidant of emotional themes, oversupportive perhaps, and the patient increasingly unmotivated, but possibly, left in a vulnerable state. Implicitly, the therapist may have conveyed compassion, but coupled with possible unresolved countertranferences of helplessness or resignation.

Elsa and Her Therapist: Leaning on the Alliance in the Battle of the Comfort Zone

Elsa was a woman in her early 50 s. She was also a former heroin addict. Recently, she had felt hurt in a group therapy session, and had avoided coming for 4 weeks. This was the most salient subject in the session. The underlying theme of returning when someone had hurt her was painful for Elsa. She tried several strategies to avoid talking about the group in the session.

Alliance Elsa made seven statements that directly addressed the alliance in highly positive terms. The second one occurred about 10 min into the session: *"Yes, but. Fucking good. How competent you are. Thank you."* From the context, it suggests a genuine sense of being helped (bond part of alliance) and it may indicate an aspect of epistemic trust. One utterance captured some of her inner representation of the therapist's persistent stance: *"Yes but I see, I see what you're saying, I see what you know you see. YES."*Later in the session, Elsa gave a statement concerning the appreciation of new learning: *"It's good that others see things as well, that I don't see."* By the word "others" it is clear in this context that it was the therapist she denoted, although she chooses a less personal and more general phrasing. Elsa's announcement also expresses gratefulness. She recognized her therapist as competent and appreciated his help. In this session the therapeutic dialogue between patient and therapist indicates that the alliance relates closely to patients confidence (experience of new interpersonal learning about herself stemming from the therapy) and enables the therapist to keep a focused strategy.

Strategic Competence The therapist kept a persisting mentalizing stance insisting to talk about Elsa's attendance to group therapy—a part of the MBT program. The therapist's core strategy was close to the MBT manual, with curiosity about mental states, keeping focus on mental content, and being transparent about their own mind. The therapist often started by exploring and clarifying a topic, summarizing or connecting to a larger framework of understanding, and then employing a more challenging stance. For instance, after Elsa had agreed to return to the group, her therapist concluded the theme by highlighting her own responsibility and agency: *"No, and when I asked you about this, it was not to criticize you, but to emphasize the problem with it. There is something that is making it difficult when we talk about it. But the only one who can persuade you to go to the group is you, yourself."* In this session the focused therapeutic strategy seems to relate closely to the therapists specific MBT competence.

Battles of the Comfort Zone The session revealed Elsa's discomfort and her relational issues. She (quite correctly) expected her therapist to challenge her, and tried to avoid such interventions by laughing, distracting and opposing. Elsa's strong appraisals of her therapist could also be interpreted as a defensive strategy, (implicitly) implying that the therapist should be gentle with her, as she was nice to the therapist. However, Elsa's therapist was not led astray by her avoidance strategies. After several interventions, persistently, negotiating a need for talking about the theme, e.g., *"I think we should talk about it now, and then we can*

return to what we were talking about, all right?", the therapist finally succeeded in this first step. In creating this situation the therapist leaned on the therapeutic bond, which seemed good enough to allow the persistence. S/he was then able to say more about why the group is so important for the patient, and how s/he felt somewhat stupid for "nagging about it for the hundredth time", when the patient did not attend the group even though she promised. The following is an example of alliance and strategy working together. The therapist is open about countertransferences. Therapist: *"At the same time, I think like this: Now that we're talking about it, I try in a way, well..it...it is quite difficult, because I can't hide that I think it's good for you to go there. Just because I happen to think so?! But at the same time, I feel that I nag you about this a lot. And then I think like this: Is it because I keep nagging you, that you say yes, that you want to go there? Because you don't go there. And then I feel...well, what am I doing..... and I feel disappointed in a way. We talk about it and you say you will go there and then you don't...."* Elsa and her therapist seemingly agreed on the goals and tasks in the therapy, even though the patient resisted them. In this session, in contrast to the former examples of Diane and Monica, the personal bond (established trust) enabled an explicit battle of the comfort zone, and Elsa, who accepted the struggle, thus achieved a therapeutic focus on her core relational problems. In treatment of patients with severe relational problems, the concept "battles of the comfort zone", depicts a two-way tension within the therapeutic dyad.

Maria and Her Therapist: Using Empathic Focus to Carefully Battle Affect Avoidance

Maria was a woman in her early 30 s. She harboured strong resistance to the conjoint group therapy. When she eventually turned up in the group, she experienced skepticism. This urged her to leave the group. The therapist asked if some of her thoughts and feelings about this could be shared with the group. Maria responded that strangers should have no access to her inner life. This reactivity echoed other relations in her life, and she had lately become rather isolated. The therapist explored various barriers Maria raised in relation to the group in an empathic and steadfast way, which finally allowed Maria's underlying sadness to emerge.

Alliance Maria provided 20 statements concerning alliance. Six of these were connected to a plan of education. If it proved impossible to combine with treatment, she stated that she would choose treatment: "*Yes. Yes, yes, and I am also prepared that, if it should be, that I cannot, so if it should be, that, that my teacher does not want to give me dispensation, then I am fully aware that I will have to drop the education."* We interpreted this statement as reflective of Maris's commitment to the treatment she was receiving. Maria felt diagnostic assessments had been helpful: *"Ehm... but I have only just become really aware of my feelings and my…everything after I got my diagnosis."* Maria indicated that she was not used to be challenged: *"Ehm...so I haven't…I haven't necessarily had to face a lot of…anything in reality."* Inferably, Maria nevertheless, here can be seen to accept this aspect of therapy. An important contributing factor may be that the therapist seemed highly emotionally attuned. Throughout the session she was able to accurately identify the patient's feelings. Consequently, it is likely that the patient felt held and understood in a contingent and congruent way. The treatment was in its beginning, but the alliance already appeared strong.

Strategic Competence The therapist was highly adherent to the manual, had an impressive range of MBT interventions, and awareness of the conjoint therapy aspect. The therapist validated, encouraged, and kept a steadfast focus on mental states throughout the session. This process seemed to stimulate the patient's ability to mentalize others, and facilitated Maria in exploring the experience of the other group members: *"Mm. Do you think that the others notice the feeling you have, that it doesn't concern them?"* and *"What do you think made her say something like that?"* In a playful and gentle way, she further encouraged Maria to mentalize her emotional reactions to the others in the group: "*Did you get a little irritated by her not trying to see it from your perspective… viewpoint? Maybe? The fact that it also could be difficult for them? Do you think that is what made you most irritated?"* The therapist balanced being challenging and supportive, and explored the patient's resistance to the group therapy in great detail, while she semeed to validate Maria's different difficulties in a transparent and clear way: "*Because it, I think, it could also be really difficult to be the new one and kind of have to get in to a group, that already is going, and… try to find one's feet there, and find a place in the group, and I suppose, that too can be really difficult"*. She also normalized Maria's trouble in choosing themes for the group, and actively encouraged her to talk about this in her individual therapy: "*If there is any situation… well how, you could bring something into the group. So we could try to look at that… what could be relevant for you. There are a lot of people who feel like that, that… what exactly do I bring up… what kind of event one should talk about,… that is when you can use our sessions to look at, whether there could be some relevant situations…"*

Battles of the Comfort Zone The main part of the session was spent exploring and gradually challenging Maria's concerns about the group, and reasons for not finding it fruitful. The therapist was steadfast in her focus on mental states and mentalizing of Maria's attachment to and beliefs about the group. This increasingly activated the patient, and resulted in her being "irritated" at the therapist for being "poked". As Maria was brought out of her emotional comfort zone the therapist asked: *"But I'm wondering, what can you notice*

right now, when you are sitting here telling me these things? What are you in contact with now?" Maria said she felt "irritated". The therapist investigated this further by saying: "*So me asking about things, and trying to understand some things, and examining some things together with you, can actually be experienced as irritating?"* Maria confirmed that being "poked" like this by the therapist annoyed her, and then admitted that it was "*not too comf… fantastic*" to say this aloud to the therapist—but she said it with a big smile. It was a relief for Maria to have ventilated her feelings towards the therapist. It seemed to strengthen the bond. Her experience of being different and lonesome filled the last part of the session, now with tears and sadness. She seemingly felt seen, met and held by her therapist and her narrative became more open, personal and in contact with emotions.

Discussion

This qualitative analysis of therapy sessions with high and low-rated MBT fidelity including poorly functioning patients with BPD, highlights interactions between therapeutic alliance and therapists' strategy. We suggest a model where alliance and strategic competence work together, and enable focused, but challenging work with highly sensitive patients and their psychopathology. Further, we postulate that such a process may have the potential of increasing the patient's epistemic trust. A central theme was depicted in the concept "battles of the comfort zone".

Battles of the Comfort Zone: Expanding the Front Line of the Therapeutic Relationship

The low rated MBT sessions highlighted how counter-transferences of being useless, judged/criticized, not knowing enough (incompetent), not being liked, or strong feelings of sympathy, may result in a therapeutic style with too little confrontation. In the low rated sessions, therapists seemed to be avoiding difficult contents or trying to accommodate or please the patient. Therapist interventions included concrete/practical advice or offering extra sessions. The low rated MBT therapists seemed for various reasons to be brought out of *their* comfort zone and their competence was outplayed. These sessions displayed a lack of mentalizing on behalf of the therapist in terms of few MBT interventions and abandonment of the overall therapeutic strategy.

The high rated MBT therapists seemed to have kept their ability for mentalizing during the session, and were able to focus more explicitly on the alliance, and explore possible transference reactions in a transparent manner with the patient. The therapists remained steadfast and committed to the overall goals of trying to increase the patients' mentalizing abilities and seemed to tolerate the patient's anger, depreciation, abstruseness, or stubbornness as well as the more austere atmosphere that arose when they pursued the patient's problems.

Our analysis suggests that the high rated clinicians were willing to challenge the patients, even though it would temporarily disharmonize the therapeutic relation. High rated therapists identified, investigated, and confronted the patients' problems in a clarifying process, which in turn, further promoted therapeutic alliance. In the low rated sessions, the therapeutic alliance was interpreted as weak, and no positive progress was observed. Low rated therapists were brought out of their own comfort zone (e.g., by transferences and/or counter-transferences), and attempted to amend the atmosphere by being overly agreeable and accommodating.

It seemed that a positive alliance and clear strategic competence were two necessary, coacting components allowing for what we conceptualized as "battles of the comfort zone". The therapist needs a willingness and capacity to confront the client's dysfunctional behaviour (Rønnestad 2016), and a willingness to tolerate the discomfort (e.g., transferences and counter-transferences) this may cause in the session. We propose that, when administered with skill, such "battles of the comfort zone" may evoke an even stronger alliance.

In our sessions, the more there was a sense of genuine warmth (personal bond) in the relation, despite struggles, the more it seemed possible for the therapist to challenge the patient even further. This general sense of a "warm climate", similar to what Sandler (1960) termed background of safety, in the high-rated sessions seemed to enable work on sensitive, but core relational or personal issues. In our analysis, a crucial part of this warmth or background of safety is most accurately seen as trust: It is reasonable that such trust is an accumulated asset built from assimilated experiences of the therapist being able to help.

In the two high-rated sessions, trust evolved through repeated experiences of the therapist being able to guide, reflect, explore, understand, challenge, and/or interpret (help the patient connect specific situations to a larger dysfunctional behavioural pattern) the mental content. It is conceivable that improvement in epistemic trust could evolve from the therapists' willingness to address and confront maladaptive patterns according to an overarching strategy. We postulate that such a process may have the potential of increasing the patient's epistemic trust, which is crucial because therapy then works through three levels. First, the patient's trust in the therapist allows her to learn new content about mental states of self and others. Secondly, the therapy foster mentalization through a process of reflecting mental states. Thirdly, the new content and reflection relaxes a hypervigilance in social situations, which in turn opens for new social learning (Fonagy et al. 2018).

A different conception could be that such battling of the comfort zones induces what Davanloo (1990) refers to as an

"unconscious alliance". This means that the patients' unconscious trust (alliance) is built by the therapists' willingness to directly confront the patients' defences (battle the comfort zones) in order to be helpful. McCullough (1991) found that patients seemed more able to digest the painful information contained in a therapist's confrontation or interpretation when it was paired with a statement that reflected consideration or care—it was detected that confrontations made along with a supportive or empathic statement by the therapist resulted in a greater probability of affective activation.

As we assume that epistemic trust can be gained or regained, the alliance need not be high in all sessions. A treatment may be efficient as a whole, despite some low rated sessions. Consequently, it is more important to negotiate the alliance than to have a positive personal bond at all times (Safran and Muran 2000; Zilcha-Mano et al. 2015).

In the low rated sessions, the patients seemed to command the battles of the comfort zone. In our selection of four sessions, the high rated therapists built on the personal bond and managed to pull the patient towards their common goal. The personal bond appeared as an asset allowing the therapist to challenge the patients' sensitive subjects. The high rated therapists were selective about what s/he wanted to battle (strategic competence). Both Diane and Monica (low rated sessions) displayed low trust in receiving help from their respective therapists. In the session with Monica, the atmosphere was difficult to interpret, her mental state was described as "indifferent", and an increase in mentalizing could not be observed. In the session with Diane, the atmosphere was tense, and the therapist struggled to improve it, but lost focus on the overall therapeutic project in the session. In the high-rated sessions, the general atmosphere was not uncomfortable, but had the distinct quality of the patient both protesting, but gradually working with and accepting challenges. The atmosphere was coloured by the patient's content.

Strengths and Limitations

In line with recommendations for purposeful sampling, we selected the most extreme or deviant sessions in order to illuminate possible themes or patterns (Patton 1990). The logic and power of purposeful sampling lies in selecting in formation-rich sessions, those from which one can learn a great deal about issues of central importance to the purpose of the research, for in-depth analysis. Hence, our findings depend on the assumption that the four most deviant sessions will inform us about alliance in MBT. One could argue for a larger sample, or for selecting more average sessions.

Smith et al. (2009) underscore that the purpose of IPA is to attempt to gain an insider perspective, while acknowledging that the researcher is the primary analytic instrument. The researcher's beliefs are not seen as biases to be eliminated, but as a necessity for interpretation of the qualitative data. It may thus be regarded a strength that the researchers are experts in the field they investigate (Binder et al. 2012). However, in order to balance possible biases towards MBT, the last author is a psychoanalyst, and had no formal MBT education.

The study focused on aspects of alliance. Alliance may be assessed in a variety of ways, often by quantitative methods such as self-reports, and is shown to predict positive outcome across several measurement methods (Martin et al. 2000). This suggests that trained clinicians should be able to evaluate qualities of therapeutic alliance by observation of in-session processes. Our phenomenological analysis was based on the assumption that alliance could be analysed as the phenomena of the relational process (Henry and Strupp 1994). Built on this fundament, the three aspects of alliance were investigated phenomonologically on the basis of the transcripts. The study is nevertheless limited by a lack of quantitative data which could support our interpretations of alliance.

Conclusion

Based on MBT therapy sessions for poorly functioning patients with BPD, we suggest a model where alliance and strategic competence work together, enabling focused, but challenging work with highly sensitive patients. We postulate that such a process may have the potential of increasing the patient's epistemic trust, which is crucial because therapy then works through the three levels described by Fonagy et al. (2018).

The tension within the therapist-patient dyad was clearly illustrated in all the therapies, challenged therapeutic strategies, and was termed "battles of the comfort zone".

However, within a framework of a trusting alliance, therapists were able to keep a focused strategy and address problems. We suggest that this fruitful interaction, nurtured epistemic trust, and a willingness to manage sensitive topics within the therapeutic dyad. Conversely, poorly demonstrated therapist strategies were coupled with low confidence and lack of alliance in patients, and possibly further enhanced by activation of therapist countertransference. Such interaction implied severely restricted possibility for managing sensitive topics within the therapist-patient dyad. The study raises the question of how not only the bond, but also the task aspect of alliance, may be a crucial factor in treatment of poorly functioning individuals.

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Compliance with Ethical Standards

Conflict of interest None of the authors have any financial disclosure/conflict of interest related to this manuscript.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent: Informed consent was obtained from all individual participants included in the study.

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