The Cultural Change Narrative as a Core Component of Therapeutic Change

A qualitative analysis of the change narrative received from Dialectical behavioral therapy and Mentalization-based treatment for borderline personality disorder

Thea Sundal and Astrid Hermann Tobiassen

Cand.psychol Thesis
30 points

Department of Psychology
The Faculty of Social Sciences

Spring 2022

The Cultural Change Narrative as a Core Component of Therapeutic Change

A qualitative analysis of the change narrative received from Dialectical behavioral therapy and Mentalization-based treatment for borderline personality disorder

2022

Title: The cultural change narrative as a core component of therapeutic change

Authors: Thea Sundal and Astrid Hermann Tobiassen

http://www.duo.uio.no

Print: Grafisk senter, University of Oslo

Summary

Authors: Thea Sundal and Astrid Hermann Tobiassen

Title: The cultural change narrative as a core component of therapeutic change

Supervisors: Erik Stänicke (main supervisor) and Espen Folmo (secondary supervisor)

Background and objectives: Research indicates similar effect of Mentalization-based treatment (MBT) and Dialectical behavior therapy (DBT) for borderline personality disorder. However, there is a paucity in studies investigating the change narrative received from and developed in these treatments. The aim of the present study is to investigate similarities and differences in the change narratives provided by MBT and DBT, and how these narratives reflect the rationale, explanations, and procedures of the provided treatment. The present study is an independent research project, and the authors have collected the data material.

Methods: The study is a qualitative analysis of seven interviews conducted by the authors. Three of the informants had received MBT, and four of the informants had received DBT. This thesis presents an interpretative phenomenological analysis (IPA) of the change narratives received in two specialized treatments for borderline personality disorder (BPD).

Results: The main findings from the IPA were that the change narratives described by the informants reflected the treatment they received. Similarities between the two groups of informants were particularly seen in their described struggles before treatment. Differences were particularly observed in the elements of the treatments they described as important for change. The DBT informants highlighted explicit learning of a provided approach with predictable and safe therapists. In contrast, the MBT informants emphasized a long-lasting process of exploring to create procedural learning with therapists who followed their lead.

Conclusion: DBT and MBT seem to produce different changes and/or change narratives in their patients. Differences are seen in the explicit ways knowledge and skills seem to be taught in DBT, whereas in MBT a more following exploration seems to create procedural learning in a more implicit way. The informants' stories of change shed light on how the change narrative was developed, and therefore how the rationale, explanations and procedures were conveyed differently by MBT and DBT. When considering the experienced impact of psychotherapy, the culturally embedded change narrative and how it is created and conveyed, seems to influence the impact of the received treatment.

Key words: psychotherapy research, dialectical behavioral therapy, mentalization-based treatment, BPD, personality pathology, interpretative phenomenological analysis, change

Acknowledgements

We would like to sincerely thank our supervisors, Erik Stänicke and Espen Folmo, for guidance, fruitful discussions, and much needed feedback throughout the process of planning, carrying out, and writing this thesis. Our informants also deserve a huge thank you for their participation, insights, and openness. Without them this thesis could not have been accomplished.

We are also very grateful to Ina Bekkevold-Jernberg, advisor at the National Centre for Suicide Research and Prevention (NSSF), who have helped us navigating through the literature on DBT and has also been available for questions and discussions when we have needed it. In addition, we would like to thank Åse-Line Baltzersen, communications advisor at National Advisory Unit on Personality Psychiatry (NAPP), for contributing to recruitment of informants.

We would also like to show our appreciation to Nikolai and Erlend who proofread the thesis and gave valuable feedback in the last weeks leading up to submission. Finally, we would like to say thank you to our friends and each other for much needed lunch breaks, late afternoon breaks, discussions about psychology and our theses, and, particularly, conversations about anything else than psychology as well as emotional support. We are lucky to have been surrounded by our closest friends during the most stressful year of our degree.

Thea and Astrid, April 2022

Table of contents

1 Introduction

Psychotherapy research indicates that a wide range of treatments are equally effective for a varied range of disorders (Wampold & Imel, 2015). However, research on personality disorders have suggested that specialized treatments targeting personality pathology are more effective than treatment as usual for borderline personality disorder (BPD) (Cristea et al., 2017; Karterud et al., 2020; Mehlum et al., 2014, 2016; Oud et al., 2018). BPD is amongst other things characterized by unstable interpersonal relationships, impulsivity, and instability in self-image and affects (American Psychiatric Association, 2013; Karterud et al., 2020). Mentalization-based treatment (MBT) and Dialectical behavior therapy (DBT) are two evidence-based treatments specialized for BPD (Bateman et al., 2018; Karterud et al., 2020; Linehan, 1993; Mehlum, 2021). Even though the two treatments spring out of two different theoretical traditions, studies have indicated that they produce similar outcomes (Bloom et al., 2012; Choi-Kain et al., 2016; Cristea et al., 2017; Oud et al., 2018; Stoffers-Winterling et al., 2012).

A considerable amount of research has been conducted on the various common factors of psychotherapy, such as the working alliance and the therapist factor (Horvath & Symonds, 1991; Wampold & Brown, 2005; Wampold & Imel, 2015). These are important elements in all psychotherapies and are included in common factor (CF) approaches by Frank and Frank (1993) and Wampold (2001). However, other common factors proposed in these conceptualizations seem to have been less investigated. Particularly, there seems to be a paucity in studies investigating the ways in which the rationale, explanations and procedures provided by different treatments interact with the change narratives patients develop and receive in these treatments. In addition, there is a lack of qualitative studies investigating the similarities and differences in the patients' experiences of receiving DBT and MBT, and how the change narrative is formed by these experiences. The aim of this thesis is to investigate how such change narratives can be constructed based on the theories and techniques offered by MBT and DBT. This thesis presents an Interpretative phenomenological analysis (IPA) of interviews with former patients who received MBT or DBT as treatment for BPD. The results are discussed in context of current research on MBT and DBT, as well as the broader psychotherapy debate. Importantly, the current perspective of the five essential elements in psychotherapy, the common factor (CF) approach (Frank & Frank, 1993; Laska et al., 2014; Wampold, 2001; Wampold & Imel, 2015), provide the guiding theoretical framework of the thesis.

2 Theoretical and empirical foundations

In the following section, we will account for theories and concepts on which this thesis is built. We initiate by accounting for the state of psychotherapy research, and its relevance and implications for the study. Then, we aim to provide a theoretical understanding of BPD. Lastly, we will provide the theoretical and empirical foundations of MBT and DBT.

2.1 The state of psychotherapy research

"Everybody has won, and all must have prizes" was the Dodo bird's verdict in a competition in Lewis Carroll's *Alice's Adventures in Wonderland* (Carroll & Bond, 1865/2015). The Dodo bird verdict in psychotherapy research refers to the observation that a wide range of schools of psychotherapy seem to be equally effective (Rosenzweig, 1936). This has later been revisited several times (Budd & Hughes, 2009; Luborsky et al., 2002; Marcus et al., 2014). One way of understanding the lack of differences is that all psychological treatments have some shared healing ingredients (Frank & Frank, 1993, p. 39).

In a seminal article, Goldfried (1980) proposed that different levels of abstraction could provide a way of thinking about the common features of psychotherapeutic methods and their similar effectiveness. At the highest level of abstraction, theoretical frameworks and philosophical beliefs form a foundation for every major approach to psychotherapy and provide explanations for why change occurs and how this happens. At the lowest level one can find the specific therapeutic techniques belonging to the different treatments. Different schools of psychotherapy will differ at both of these levels, but somewhere between theory and technique, one can find some common change principles across different therapies (Goldfried, 1980). These change principles are often referred to as common factors, and amongst them are the working alliance and therapist factors (Wampold & Imel, 2015).

It has been demonstrated that the average effect size of psychotherapy is about 0.8, compared to no treatment, and that psychotherapy itself only contributes to 13% of outcome variance in treatment of mental disorders (Wampold, 2015). Furthermore, common factors explain 70% of this variance, whereas specific techniques or methods only explain 0-1% (Wampold, 2015). Among the common factors contributing to therapeutic change is the working alliance, which has been widely studied (Flückiger, 2022; Flückiger et al., 2018; Horvath & Symonds, 1991; Lambert, 2013; Lambert & Archer, 2006; Lambert & Barley, 2001). Studies have indicated that around 5-7 % of the outcome variance is due to the working alliance (Horvath et al., 2002; Horvath & Symonds, 1991; Martin et al., 2000). Even

though the working alliance explain only a moderate part of the variation in outcome, it is considered one of the most important predictors for outcome in psychotherapy (Horvath et al., 2002). According to Bordin's (1979) definition, a working alliance requires that the therapist and patient agree on tasks and goals for the therapeutic work, combined with the feeling of a warm and empathic bond between them. The alliance continues to be a hot topic for research to this day, which may be due to its moderate and steady effect size (Flückiger, 2022).

The therapist's contribution to the outcomes of psychotherapy is also of notable size, as it explains about 5% of the outcome variance (Lambert & Archer, 2006; Laska et al., 2014; Wampold & Brown, 2005). Research has indicated that expert therapists are able to establish an alliance with different types of patients, they are warm and relational skilled, give good explanations for the patients' struggles, are monitoring the therapeutic process, and are not avoidant towards conflicts in the therapeutic relationship (Anderson et al., 2009). Furthermore, they communicate hope, are in possession of professional self-doubt and cultural humbleness, as well as general interpersonal facilitating abilities (Anderson et al., 2009; Wampold & Imel, 2015). Additionally, therapists with a combination of professional self-doubt and positive self-affiliation seem able to evoke a higher degree of change in the patient (Nissen-Lie et al., 2017). In studies that compared the effectiveness of different treatments, results indicated a higher degree of variation within each therapeutic tradition rather than between (Luborsky et al., 1975). This could be understood as a result of the differences between therapists within each method (Nissen-Lie et al., 2010), and have led to a proposed rewriting of the Dodo bird verdict, from "Everybody has won, and all must have prizes", to "Some therapists win, and some do not, independent of the method they use" (Nissen-Lie et al., 2010, p. 628).

Research has indicated an interaction between the specific and the common factors, and that the effect of psychotherapy may stem from this interaction rather than one or the other (Nissen-Lie et al., 2013; Wampold & Budge, 2012). This interaction might already have been recognized in the 1970s as Bordin (1979) stated that the way in which the working alliance is formed will be different from one treatment method to another. This has been further elaborated by Ulvenes et al., (2012) who proposed that the working alliance may operate in different ways in different therapeutic traditions, although the significance of the working alliance might be common, the way it interacts with the particular method to facilitate change may not (Ulvenes et al., 2012). Research also suggests that treatments aimed at deeply rooted personality structures will often need a stronger emotional bond, compared

to, for example, therapies targeting specific phobias through exposure (Falkenström & Larsson, 2017; Spinhoven et al., 2007).

Although extensive research has been conducted on the general elements in psychotherapy, there seems to have been less focus on how patients make sense of the story of change in treatment. In *Persuasion and Healing* (1993), Frank and Frank proposed four effective features shared by most psychotherapies. One of these were "a rationale, conceptual scheme, or myth, that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them" (Frank & Frank, 1993, p. 42). We propose, informed by our findings that will be presented later, that this can be labelled as the 'cultural change narrative'. To our knowledge, this has been little studied. One could argue that Frank and Frank's description is a conceptualization of the change narrative as a common factor. The rationale, or myth, and explanations could be understood as embedded in the given treatment's theoretical framework. The rituals or procedures necessary for change could be understood as a given treatment's specific techniques. Furthermore, the treatment may provide the therapist with a specific language as well as indicating ways of meeting patients. Hence, all these elements could be understood as parts of what constitute the culture within a given treatment tradition. The therapist will thus be bearer of the treatment culture, which can be transferred to the patient. This may happen through the specific language used to conceptualize the healing myth, and the explanations for the patient's problems, as well as through the rituals put forth as necessary for resolving them. This conceptualization will form a foundation for our understanding going forward in this thesis.

Frank and Frank's (1993) conceptualization has been elaborated by Wampold (2001), who proposed the Contextual Model, a meta-theory which includes three pathways to change. The model was revisited in 2015 by Wampold and Imel. The meta-theory includes (i) the real relationship, (ii) expectations, and (iii) specific ingredients (Wampold, 2001; Wampold & Imel, 2015). In an article from 2014, Laska et al., (2014) present five common factors deemed necessary and sufficient for change, which seem to be based on the conceptualizations of Frank and Frank (1993) and Wampold (2001). This common factor (CF) approach include (a) an entrusting and curative therapeutic setting, (b) the provision of a rationale for the therapy in question, which in turn is accepted by the patient, (c) a culturally embedded explanation for the disorder which is being treated or the psychic distress the patient is struggling with, (d) an emotional bond in the therapeutic relationship, and (e) a therapeutic procedure that promotes positive and progressive behavior (Laska et al., 2014).

One of the elements highlighted by the CF approach is the therapist's ability to provide a rationale for the treatment. Frank and Frank (1993) tied the provision of a rationale to the therapist's ability to combat demoralization and inspire hope in the patient. Similarly, Wampold and Imel (2015) proposed that if therapists can provide a believable rationale that is accepted, expectations connected to the positive effects of the treatment may arise. Furthermore, the importance of expectations and hope could be illuminated by studies on the placebo effect (Enck & Zipfel, 2019; Frank & Frank, 1993; Howe et al., 2017; Wampold et al., 2007). Placebo studies' strength lie in the possibility of investigating the isolated effect of the doctor-patient interaction's effect on change, whereas the strength of psychotherapy research lies in the fact that psychotherapy is a healing practice where the treatment is administered through the therapeutic relationship itself (Wampold, 2021). One could therefore argue that the placebo effect may be an important aspect of what makes psychotherapeutic healing myths effective (Frank & Frank, 1993). Additionally, the CF approach highlights the importance of an emotional bond in the therapeutic relationship. This is described as a confiding relationship by Frank and Frank (1993), and a real relationship in the Contextual Model (Wampold, 2001; Wampold & Imel, 2015). These factors could be understood as overlapping with the concept of the working alliance (Bordin, 1979).

The relevance of the CF approach could be illuminated by a recent study by Finsrud et al., (2022). They suggested that various measures of the working alliance related to change can be explained by two underlying factors, which in turn suggest two different pathways of change (Finsrud et al., 2022). The first pathway, *Confidence in the therapist*, suggests that patients do not differentiate between various therapist qualities, such as empathy and expertise. The second, *Confidence in the treatment*, is reflecting the patient's experience of buying into the treatment. The latter could be related to the therapist's ability to provide a believable rationale, which is accepted by the patient, and thereby create expectations and hope connected to the treatment ritual itself (Frank & Frank, 1993; Wampold & Imel, 2015).

To summarize, psychotherapy research from the last decades has demonstrated how various methods are effective in treating psychological disorders, and that the alliance and the therapist effects are among the most robust mechanisms of change identified (Anderson et al., 2009; Flückiger et al., 2018; Wampold & Imel, 2015). Furthermore, different models and theories have tried to demonstrate how these similarities in effect can be conceptualized (Frank & Frank, 1993; Goldfried, 1980; Wampold & Imel, 2015). However, in regards to BPD, the evidence is clear that some specific therapies are superior to usual care (Ellison, 2020; Oud et al., 2018). These therapies have many elements in common, for instance a

highly structured treatment course (Oud et al., 2018). Mentalization-based treatment (MBT) and Dialectical behavior therapy (DBT) are two of the specialized treatment methods for BPD. However, they come from different schools of psychotherapy, where DBT has roots in the cognitive tradition (Linehan, 1993), whilst MBT is a psychodynamic inspired treatment method (Bateman & Fonagy, 2016). Yet, interestingly, they produce similar results on outcome measures (Byrne & Egan, 2018; Campbell & Lakeman, 2021; Choi-Kain et al., 2016; Cristea et al., 2017; Oud et al., 2018). One may therefore wonder how two different treatment cultures can be conveyed in a manner that is accepted and believed by the patients receiving them. Furthermore, how the patients make sense of the change narratives received.

2.2 Borderline personality disorder

BPD is by DSM-V defined as "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts" (American Psychiatric Association, 2013). BPD is a severe psychiatric disorder, traditionally seen as difficult to treat, and is characterized by pathology that affects the patient, the patient's relatives, and the society (Folmo, 2021; Karterud et al., 2020). It is suggested that an interaction between genetic, neurobiological, and psychosocial factors contribute to the development of BPD, and these factors influence brain development. Twin studies have shown that a genetic predisposition to emotional dysregulation combined with a non-supporting environment can lead to the development of BPD (Gunderson et al., 2011; Kulacaoglu & Kose, 2018; Ruocco & Carcone, 2016). The point prevalence of personality disorders in general is estimated to be around 10%, and for BPD specifically to be 1,5% (Oldham et al., 2014; Torgersen, 2009).

BPD is also strongly connected to low levels of trust, both in the traditional sense of trust, as well as epistemic trust. Impairments of epistemic trust could be understood as a core problem for patients with BPD (Bateman et al., 2018). Epistemic trust can be defined as a person's ability to evaluate information from the social world and consider its accuracy and reliability in terms of personal relevance. If that is the case, one can allow the information to be incorporated into one's existing knowledge (Fonagy, Luyten, & Allison, 2015). Epistemic trust is often discussed in the context of epistemic mistrust, a proposed evolutionary, natural human capacity to guard oneself from misinformation (Sperber et al., 2010). It has been suggested that persistent epistemic mistrust can contribute to the rigidity commonly seen in personality pathology (Fonagy, Luyten, & Allison, 2015; Orme et al., 2019). These factors

often complicate the establishment of a good working alliance in therapy (Wilberg, 2002). However, being able to form and maintain a therapeutic alliance with BPD patients can constitute a central changing mechanism for this group (Orlinsky et al., 2004; Spinhoven et al., 2007). Working with mistrust in therapy is therefore seen as fundamental in most treatments targeting BPD. Research has also shown that the impact of the working alliance for patients with BPD is up to six times higher than for patients with other disorders (Barnicot et al., 2016; Falkenström et al., 2013).

The development of specific treatments for BPD with different theoretical foundations may contribute to a lack of clear consensus among researchers on a common theoretical understanding of what personality pathology represents as a phenomenon (Wilberg, 2002). This is in contrast to the diagnostic manuals, which define personality disorders at a descriptive level (Wilberg, 2002). The complexity of personality pathology also leads to differing explanatory strengths of the various treatments. This can be exemplified by the strengths of DBT's explicit and tool-based work with self-harm, and MBT's focus on a balanced emotional temperature in the relationship between the therapist and the patient (Linehan, 1993, 2014; Muir, 2020; Paris, 2016; Skårderud, 2015; Williams, 2020).

Different treatments will inevitably target different aspects of the disorder. However, patients with severe personality pathology in the borderline range often share some core characteristics. Some of these are suicidal thoughts and attempts, and self-harm. Studies have reported a 8-10% suicide rate among BPD patients, and a lifetime prevalence of 3-4 suicide attempts (Paris & Zweig-Frank, 2001; Pompili et al., 2005; Soloff & Chiappetta, 2017; Stone, 1990). In addition, studies have shown that BPD symptoms are associated with increased risk of suicide among young adults, also when controlling for depressive disorders and substance abuse (Yalch et al., 2014). Furthermore, BPD symptoms are associated with less partner involvement, fewer adult development milestones, such as higher education, lower life satisfaction, and social functioning (Winograd et al., 2008). These factors may be reasons why the diagnosis has been researched extensively, and multiple treatment methods have been developed to treat this group specifically. While pharmacological interventions on BPD show no more than moderate effect, over half a dozen manualized treatment methods have been empirically validated for treatment of the disorder. Among those, one can find DBT, MBT, transference-focused psychotherapy and schema therapy (Choi-Kain et al., 2016; Zanarini, 2009). DBT and MBT are the two specialized methods that are most used in treatment of BPD in Norway (Karterud et al., 2020) and they will be reviewed in the following section.

2.3 Mentalization-based treatment

MBT is a manualized treatment developed by Anthony Bateman and Peter Fonagy. It was originally designed for treatment of BPD, and randomized controlled trials and naturalistic studies have shown the method to be efficient for this group (Allen & Fonagy, 2006; Bales et al., 2012; Bateman & Fonagy, 1999, 2003; Kvarstein et al., 2015; Rossouw & Fonagy, 2012). MBT consists of multiple components, as it combines weekly group therapy (MBT-G) with individual therapy (MBT-I) and 12 psychoeducational groups at onset of treatment. The structure is made with poorly functioning patients with BPD in mind. The structure can be loosened when working with patients with less loss of function (Karterud et al., 2020).

Mentalization refers to a person's ability to understand, question and be aware of one's own and others' mental state (Lonargáin et al., 2017). Furthermore, the concept refers to a core process in human social functioning and self-regulation, which is involved in the establishment of solid connections between meaningful early experiences and what they represent (Bouchard et al., 2008). It also involves the ability to understand and interpret own and others' behavior expressions, both implicitly and explicitly, as different intentional mental states. Mental states can refer to thoughts, intentions, feelings, and desires (Bouchard et al., 2008).

The development of mentalization is linked to experiences in attachment relations (Karterud et al., 2020). In other words, the environment in which attachment relationships are formed is crucial for the development of mentalization. One can distinguish between two different types of deviations in the environment: (a) inadequate input, e.g. neglect, and (b) harmful input, e.g. abuse or trauma (Humphreys & Zeanah, 2015). Fonagy and Bateman (2008) have postulated that an interaction between disturbances/traumatic events in early development of attachment, and a person's neurological development are central aspects of the development of BPD. The ability to mentalize can be weakened by insecurities in these attachment relationships (Fonagy & Bateman, 2008). Hence, the combination of the events listed above may lead to a hypersensitive attachment system, which further complicates mentalization under emotional activation (Fonagy & Bateman, 2008). Poor mentalization is also related to reduced social functioning, low quality relationships and psychopathology in general (Fonagy et al., 2002).

While the therapeutic work with mentalization is present in most treatments in one way or the other, MBT is an attempt to structuralize a way of working with the development and lack of the mentalizing ability (Karterud, 2013; Skårderud, 2015). Bateman and Fonagy (2016) have described that the goal of MBT is to restore the ability of mentalization when it is

lost, maintain it when it is present, and keep it going when it elsewhere would be lost. MBT highlights pretend mode and psychic equivalence as characteristic modi seen in individuals with BPD. These concepts are referred to as pre-mentalizing ways of organizing subjective experiences (Karterud et al., 2020). Psychic equivalence is when subjective representations feels like reality, e.g. thinking "I think I am stupid, therefore I am stupid, and everyone knows I am stupid" (Fonagy & Target, 1996), while in pretend mode, the internal experience is separated from reality. An example of pretend mode could be empty talk disconnected from affect. Consequently, experiences may seem too real or too unreal which in turn can result in the individual becoming overwhelmed or indifferent (Bateman & Fonagy, 2004). A pre-mentalizing modus is in contrast to a mentalizing mode, where the individual is able to acknowledge that their own perception of reality has a representational quality.

Many BPD patients will experience conflicting feelings towards change. In the beginning of a treatment course, this ambivalence will often be prior to the motivation for recovery (Karterud et al., 2020). One study on MBT found that BPD patients experienced change in issues related to attachment and identity, but simultaneously felt they had a long way to go (Dyson & Brown, 2016). The researchers also wondered if the patients only repeated theory about mentalization when they were explicitly asked about experiences in therapy, rather than having experienced an integrated improved mentalization. This could mean their feedback was still affected by pretend-mode. They also found that the patients appreciated direction and structure during the sessions provided by the therapist. A second study found that change in mentalization is central to an internal process of change, and that change in mentalization affected improvement on several core issues in BPD, such as interpersonal difficulties and impulsivity (Lonargáin et al., 2017). They also reported that trust was crucial for useful experiences in the group sessions, as the group sessions were perceived as challenging and intense by many of the patients. Another study reported that the experience of being understood, and therefore mentalized, helped the patients to break their cycle of self-hatred and social exclusion (Johnson et al., 2016).

In a study that investigated patients' experiences of meaningful change, patients particularly reported ways of changing their capability to deal with mental states in themselves, as well as a more adaptive and flexible understanding of others (Morken et al., 2019b). The same authors also investigated in which way MBT specifically helped them. Results indicated that the therapist's tolerance of strong emotions, the focus on negative unspoken concerns and the addressing of the relationship between the therapist and patient

were the most helpful factors in therapy. The informants also addressed the importance of the group sessions in giving them normalcy and a new mindset (Morken et al., 2019a, 2019b).

Mentalization is also described as Reflective Functioning (RF), operationalized with the Reflective Functioning Scale, and measured by Adult Attachment Interview (Fonagy et al., 1998). RF can be used to measure the patient's ability to mentalize in an attachment context. One assumes that increased mentalization, or RF, is crucial in the recovery process for a person with BPD, and such improvement is indicated in effective BPD treatments (De Meulemeester et al., 2017). Therefore, one goal of MBT includes to increase the patient's RF. Increased RF, more secure attachment, more effective relationships, and better affect and behavior regulation are all associated factors and important elements of MBT (Ellison, 2020).

The proposed mechanism of change is an "exclusive focus on the BPD patients' current mental state while activating the attachment relationship" (Fonagy, Luyten, & Bateman, 2015, p. 21). Thus, the attachment formed in the therapeutic relationship is considered crucial. The capacity to mentalize is made up of different polarities, such as automatic versus controlled mentalization, oneself versus others, cognitive versus affective etc. Gaining a balanced way of moving back and forth between these polarities is indicative of good mentalization, and therefore as treatment effect in MBT. While restoring a balance between these polarities, the therapist is maintaining a mentalizing stance, which includes open-mindedness, a not-knowing position, curiosity and inquisitiveness (Bateman & Fonagy, 2010). The therapist is actively engaged in the regulation of the emotional temperature, which helps the patient move back and forth between the polarities (Skårderud, 2015; Williams, 2020). This relates to the pronounced goal of MBT to develop a therapeutic process where the patient's state of mind is the focus. The work is focused on situations where the patient can find out more about how they think and feel about themselves and others. Furthermore, how this affects responses, and how faults in their understanding of themselves and others lead to action in an attempt to restore stability and give meaning to incomprehensive feelings (Allen & Fonagy, 2006). Explicit work with mentalization failure is therefore at the core of the treatment, where the therapist challenges and explores the patient's experiences with mentalization failure in past and present relationships as well as in treatment (Bateman & Fonagy, 2016).

As patients with BPD have a fundamental struggle with trust, MBT assumes that working with trust in the therapeutic relationship is central to healing (Karterud et al., 2020). Furthermore, epistemic trust is at the core of MBT's recent placement of social learning at the front and center in the understanding of mentalizing (Bateman et al., 2018; Bo et al., 2017;

Fonagy, Luyten, & Allison, 2015). In 2018, Bateman wrote "The borderline mind […] may best be understood as a socially triggered outcome based on a learned expectation about the social and interpersonal environment" (Bateman et al., 2018, p. 46).

2.4 Dialectical behavior therapy

Dialectical behavior therapy (DBT) was developed in the 1980s by Marsha Linehan. In her work with self-harming women, she discovered that traditional cognitive behavior therapy (CBT) did not lead to the desired changes in that specific patient group (Linehan, 1993). The focus on change in CBT made the patients feel a lack of understanding and validation from the therapists. Hence, in the development of DBT, Linehan included a focus on acceptance and support, which complimented CBT's focus on change. She also incorporated a focus on the role of affects and relationships in treatment (Linehan, 1993). Additionally, she included mindfulness as a core skill, a greater emphasis on suicide risk assessment, focus on behavioral skills, and making patients assess their progress with diary cards (Linehan, 2014). In DBT, the extinction of patients' harmful behaviors, such as self-harm and suicidal acts, are top priorities. Furthermore, acquisition, strengthening and generalization of abilities that make the patients more resilient facing emotional dysregulation, stress and difficult relationships are core focus areas (Linehan, 1993).

The dialectical philosophy is the basis for DBT (Linehan, 1993). The dialectical philosophy emphasizes the synthesis between strategies that promote both change, and acceptance (McMain et al., 2001). This is indicative of how the therapist should relate to the patients, however, it is equally as important for the way the patients relate to themselves. The focus on acceptance and change in DBT is inspired by Zen Buddhism, which emphasizes mindfulness, self-observation and avoidance of judgement (Linehan, 1993). Central change mechanisms in DBT are motivating the patients to recognize and accept their affective states, and at the same time encourage them to apply different tools to reduce the intensity of emotions to a bearable state (McMain et al., 2001). The dialectic perspective in DBT also refers to working towards a change in dichotomous, rigid, non-dialectical thinking within the patient to achieve more nuanced perspectives (Linehan, 1993).

DBT's biosocial theory of BPD suggests that emotional dysregulation, originating from emotional vulnerability, and emotion regulation deficits are core themes of BPD (Linehan, 1993). According to Linehan (1993), dysfunctional behavior such as deliberate self-harm or violence, could either be a way of regulating intense and overwhelming emotions, or

it could be an outlet for such emotions. As an illustration, a woman could purposefully cut herself to redirect attention from internal pain, or she could feel overwhelmed with anger and therefore lash out towards another person (McMain et al., 2001). Thus, emotional, interpersonal, and behavioral dysregulation, and especially the extinction of self-harm, are important targets in DBT (McMain et al., 2001). It has been suggested that individuals with BPD have a stronger activation in response systems for emotions, which can be a consequence of a biological vulnerability as well as events in early childhood. Childhood events like neglect or traumas can lead to changes in the development of neural structures important for emotion regulation (Feigenbaum, 2007). As a result of this, it is thought that BPD patients have an emotional system that reacts stronger and faster to cues from the environment than others, which makes them more prone to behavioral and cognitive dysregulation (Feigenbaum, 2007).

DBT is a highly structured treatment and consists of four components: (i) The individual therapy seeks to enhance the patient's motivation to create a life worth living; (ii) in group skills training the focus is on acquiring tools and skills to enhance the patient's ability to cope; (iii) between session telephone coaching offers the patients support when putting to use new skills in everyday life to promote generalization; (iv) a therapist consultation team seeks to enhance the therapists' ability and motivation to treat BPD patients (McMain et al., 2001). One of these components, the DBT skills training, is a manual based group with a highly educational and pedagogical format (Linehan, 2014). It consists of several modules that skills trainers will work through with the patients in the group, and it includes rehearsing skills and discussion points. The group practices *General skills*, such as chain analyses, where situations are broken down into a series of linked components. The manual also includes *Mindfulness skills*, where the goal is to learn different mindful techniques, such as attending to the breath and *Interpersonal effectiveness skills* where participants practice skills such as validation. During the module *Emotion regulation skills*, patients practice observing, describing, and naming emotions and strive to see situations objectively by trying to check the facts of a situation neutrally. While learning *Distress tolerance skills*, the group practices different forms of distraction and crisis survival skills, for example when in danger of harming themselves and skills for accepting reality as it is (Linehan, 2014).

Furthermore, participants are taught that the mind can be divided into three parts: 1) Emotion mind dominates when emotions are completely in control over the choices a person makes, and the outside world is interpreted in line with the person's own emotional and

mental states; 2) reasonable mind is in control when choices are completely ruled by reason and pragmatics, and feelings such as love, or grief are overlooked; 3) wise mind could be understood as the integration of these opposites and therefore an ability to tap into "the inner wisdom that each person has" (Linehan, 2014, p. 167). Another central component of DBT philosophy is the use of metaphors and stories that can promote motivation and understanding by creating vivid imagery. For example, when explaining the wise mind, the skills trainers can tell a story of how the "wise mind is like a deep well in the ground" (Linehan, 2014, p. 170).

The skills manual for DBT (Linehan, 2014) reads: "Suppressing emotion increases suffering. Mindfulness of current emotions is the path to emotional freedom" (p. 403). However, if the emotional pain reaches dangerous/extreme levels, Linehan proposes that skills trainers "[s]ay: 'Splash your face with cold water or put your face in a bowl of ice water or cold water on your eyes and upper face (this will reduce arousal for a brief time)'" (p. 402). Linehan reports that this simple technique will calm you down and is incredibly effective. The theory here "might seem counterintuitive, but research has shown that immersing your face in very cold water while holding your breath causes your body to turn on the nervous system's relaxation response and slow your heart rate" (McKay et al., 2019, p. 181).

Studies indicate that DBT is an effective treatment of BPD (Bloom et al., 2012; Stoffers-Winterling et al., 2012). More specifically the effects of DBT include improvement in overall functioning, less inappropriate anger and reduced self-harm (Stoffers-Winterling et al., 2012). Moreover, studies of mechanisms of change in DBT for BPD have shown a link between an increased capacity to regulate emotions and to gain more behavioral control (Mehlum, 2021). Additionally, central change mechanisms that have been identified are the use of concrete skills, the therapeutic alliance, and investment in the treatment (Rudge et al., 2020). In a study by Axelrod et al. (2011) the association between DBT and reduced frequency of substance use was mediated by improvement in the ability to regulate emotions in females with comorbid BPD and substance dependence. Another study indicated that DBT led to a decrease in general psychopathology through improvement in mindfulness skills such as acceptance without judgement and distress tolerance, two important components of DBT skills training (Zeifman et al., 2020).

Furthermore, research suggests that DBT is an effective treatment for suicidality and self-injurious behavior (DeCou et al., 2019; Linehan et al., 2006, 2015; Mehlum et al., 2014, 2016, 2019). One study indicated that a higher frequency of practicing DBT skills was associated with less self-harm (Barnicot et al., 2016). Another study indicated that acceptance

without judgement – one of the core features of DBT – mediated the relation between DBT group skills training and the frequency of self-harm (Krantz et al., 2018). Linehan (1993) proposed that working with chronic suicidality should be based on what functions the suicidal thoughts have for the patient, while Paris (2016) stated that working with chronically suicidal patients presents a paradox. The therapist is trying to treat the suicidality, but simultaneously must respect that the patient might choose death rather than remission (Paris, 2016).

Furthermore, qualitative studies have indicated that patients who receive DBT report positive outcomes. One qualitative study reported that patients described that the skills they acquired in DBT led to an increase in coping mechanisms, such as handling the urge to self-harm (McSherry et al., 2012). They gained more control over their feelings, and their interpersonal relationships improved. As a result, their self-esteem also increased. The study also reported that patients perceived some of the concepts in DBT as more intricate than needed, particularly the complex therapeutic language (McSherry et al., 2012). Another qualitative study indicated that patients experienced DBT as having a positive effect on their lives (Gillespie et al., 2022). Participants reported gaining more control over their lives, healthier relationships, and resources to handle setbacks after receiving DBT. However, the study also indicated that the patients had further need for support in spite of the subjective experienced positive effects (Gillespie et al., 2022). Furthermore, a systematic review of qualitative studies on patients' experience of DBT highlighted the development of self-efficacy as an outcome of therapy (Little et al., 2018). This was further specified by learning skills to manage emotions and taking responsibility. The study also emphasized how patients valued a shift in perspectives, both regarding themselves and the future, through insights, acceptance, and hope (Little et al., 2018). To summarize, the research above suggests that DBT is effective in producing positive outcomes for BPD in line with DBT theory.

2.5 Aims of the study

The aim of the study was to openly investigate how patients who have received MBT or DBT experienced change in the treatments they received. When we looked closer at what the informants spoke about in the interviews, we became more and more interested in the systematically different change narratives they received from MBT and DBT respectively. Furthermore, we wished to investigate how the similarities and differences in change narratives could be understood in light of the treatments' rationales, explanations, and procedures.

3 Methods

3.1 Participants

The sample consisted of seven informants all of whom are given fictional names. Four received DBT, Sara, Lisa, Eva, and Anna. Three received MBT, Daniel, Miriam, and Amanda. Six of the informants were female, and one of them male. The informants' age ranged from the mid-twenties to the mid-forties. According to themselves, all the informants met the inclusion criteria for the project. Inclusion criteria included that they at some point had met the criteria for F60.3 Emotional unstable personality disorder according to ICD-10, they had gone to either DBT or MBT, they ended their course of treatment at least three years ago and that they felt they could speak freely of their experience of receiving MBT or DBT. Two of the MBT informants, Daniel and Amanda received the regular MBT program, with three years in MBT-G and MBT-I. Miriam was part of a 16 weeklong MBT group, as well as receiving individual therapy. All the DBT informants received the regular DBT program.

3.2 Recruitment and data collection

Before initiating recruitment of participants, we discussed what the inclusion and exclusion criteria for the participants in the project should be. The inclusion criteria are described above. Furthermore, it was decided that potential informants who had been in DBT or MBT less than three years ago would be excluded because of the recency of therapy, and only possible participants who ended therapy three to five years ago would be included. This increased the possibility of the participants feeling comfortable talking about their experiences of therapy, and for the therapeutic process to have settled. Furthermore, given the time gap between the end of treatment and the interviews, one could argue that enough time had gone by for the potential informants to have had time to reflect on their experiences in treatment, as well as them being able to articulate these experiences. The details concerning the content of the invitation letter were also discussed, such as how to convey information about the goals of the study and the ways to make participation simple and comfortable.

The informants were recruited through two different Facebook groups. In these groups, the invitation letter was posted. The letter asked for people who had been to MBT or DBT about three to five years ago. It also contained information on the set-up and structure for the interview, and what the results would be used for. For further information about the invitation letter, see Appendix A. Potential informants then contacted one of the authors by e-mail or SMS. This abled us to contact the potential informants by telephone, and further

information about the project were given. The informants were asked if they had any questions, and the whereabouts of the interviews were planned. After the telephone contact, the informants were sent a digital letter of consent (Appendix B) they could sign by using an electronic identification system, like BankID. The signed letters of consent were registered by the authors before each interview. Five of the interviews were conducted via Zoom, and two were conducted in the premises of the Psychology department of University of Oslo.

The interview guide (Appendix C) was developed in April 2021 to suit a qualitative in-depth interview. The questions were categorized as *before therapy*, *during therapy,* and *after therapy*. The interview guide was later modified and designed to better suit the IPA framework as it is presented by Smith and colleagues (2009). For instance, to reduce the number of questions in the interview guide, some of the questions were changed to probes that could be used if the main questions were perceived as too broad by the informant. The focus of the interviews was the informants' lived experience of therapy, in accordance with IPA. To achieve this format of the interviews, the preparations for the interviews were loosely inspired by the Life-mode Interview developed by Haavind (2019) as we tried to capture concrete experiences in the informants' everyday lives. The interviews were conducted during a period of three weeks in November 2021.

The interviews were recorded using the mobile application Nettskjema Diktafon. The application encrypted the interview file. It was therefore impossible to listen to the recordings via the application. The audio files were sent in an encrypted format from the application to our secure project area in TSD (Services for sensitive data). TSD is a platform that fulfills the law's requirements for collecting, storing, and analyzing sensitive research data. The letters of consent, audio recordings of the interviews, and the de-identified transcriptions of the interviews were stored in our area in TSD.

During the interviews, we tried to articulate our understanding of the experiences the informants put forward. As a form of double hermeneutics, the informants tried to make sense of their own experience, and we attempted to make sense of what the informants were saying. The informants could then correct, explore, and confirm the articulated understanding provided. We used the interview guide in a flexible way and attempted to follow the informant's story as closely as possible by moving between questions and skipping the ones already covered. After each interview, the authors discussed associations, non-verbal communication, verbal and interpersonal style, emotional climate, and the overall experience of the interview. Once every interview was conducted, the process of transcribing the

interviews started. We agreed to transcribe the interviews we did not conduct, to get a sense of what these interviews were like for the other through the audio files.

3.3 Interpretative phenomenological analysis (IPA)

Interpretative Phenomenological Analysis (IPA) has been used as the fundamental method throughout the study. IPA is a qualitative method particularly suitable when seeking to understand an individual's experience of their own lived experiences, and the meaning they relate to those experiences (Smith et al., 2009). IPA is commonly used in psychology research; however, it is increasingly used in other disciplines as well. The development and framework of IPA is informed by concepts and debates from multiple philosophical traditions which attend to the philosophy of knowledge – phenomenology, hermeneutics, and an idiographic approach (Smith et al., 2009).

Both the phenomenological and the hermeneutic perspective is essential in IPA, as well as insights from the combination of these two. Phenomenology can be defined as the philosophical approach to the study of experience. IPA is phenomenological because it is concerned with exploring a person's experience in its own terms. Using IPA, the researcher strives to make sense of what the participant is trying to make sense of, namely what has happened, or is happening, to them (Smith & Osborn, 2015).

Hermeneutics was originally referred to as the theory and practice of interpretation but has later been expanded to incorporate a theory of understanding. Hermeneutics' position in IPA is particularly the idea of double hermeneutics; meaning the informant is trying to make sense of their own experience, and the researcher is trying to make sense of the material the informant puts forward in an interview (Smith et al., 2009). Hence, the use of double hermeneutics is central for understanding the dynamic process between the material, the researcher, and the informant. The hermeneutic circle is a useful idea as it describes the process of meaning making and can influence the way one approaches data analysis in IPA (Smith et al., 2009). The circle symbolizes the movement back and forth between parts and the whole at multiple levels. To make sense of one part, one must take in the whole, and to take in the whole one must make sense of the single parts. This creates a dynamic and non-linear way of understanding and is a key tenet in IPA. One moves back and forth through the material in question and allows for different ideas to influence ones thinking.

As stated by Smith et al., "Without phenomenology there would be nothing to interpret, and without hermeneutics the phenomenon would not be seen" (Smith et al., 2009,

p. 37). The phenomenological position guides the researchers to try to position themselves as close as they can to the participant's experience of life, while the hermeneutic position informs the researchers that this effort is unavoidably an interpretative one, for the participant as well as the researchers (Smith et al., 2009; Smith & Osborn, 2015). Phenomenology is about seeking to understand the phenomenon, whilst hermeneutics concern which methods and for what purposes this is done.

IPA is also an idiographic approach, meaning the researcher is committed to understanding how *this* informant experiences *that* experience in detail. The aim is to reveal something of importance for these specific informants. This also gives researchers the opportunity to investigate how one informant differs from another. In our study we have both payed attention to the differences and similarities between informants that have attended MBT on the one hand, and informants that have attended DBT on the other, as well as similarities and differences between informants within the same group.

Before starting this project, we discussed different qualitative methods with our supervisors, that would be most suitable for research where the material is in-depth interviews of informants' personal experiences. Two methods were discussed, IPA and thematic analysis. The discussion concerned, among other things, the degree to which we could allow ourselves to interpret the material and apply meaning to the informants' stories. Although interpretation is a central part of most qualitative methods, IPA allows for more in-depth interpretations and an analytic attitude towards the material. Therefore, the choice ultimately fell on using IPA.

3.4 Data analysis

The data analysis was guided by Interpretative Phenomenological Analysis (IPA) developed by Smith et al., (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research* (Smith et al., 2009) was used to guide the steps from creating the interview guide to writing up the results as seen later in the thesis. During the interview process and the data analysis we strived to be reflexive regarding our position as psychology students at the psychodynamic clinic at the university, but also as women born and raised within a liberal Western culture, and how this may affect our research.

The data-analysis consisted of several steps, in line with Smith et al., (2009). The first step was reading through the interviews several times. We also listened to the recordings of the interviews and attention was particularly paid to the interviews conducted by the other

author. The second step consisted of writing summaries for each interview, including repeating ideas, important preliminary codes, and what impressions we were left with, as well as the shape, flow, and rhythm of the interviews. We first discussed these impressions with each other, then later we discussed them with our supervisors. This process was conducted according to the ideas of phenomenology and hermeneutics in the sense that we strived to get as close to the informant's experiences as possible, by reading, rereading, listening, and discussing impressions, but at the same time unavoidably interpreting the informants' stories in accordance with pre-excising knowledge. The first and the second step were inevitably intertwined.

The third step consisted of identifying emerging themes and categories from the material. The material was firstly organized into broad categories, such as the working alliance, and functioning before and after therapy. After doing this on all seven interviews, the categories seemed too broad. The selected quotes from the interviews were therefore coded even more descriptive, e.g., 'Learning that feelings eventually will pass'. These codes emphasized what the informants spoke about in the interviews, rather than what meaning we applied to the quotes. At the completion of initial coding, we sat together and discussed findings of these descriptive codes, and which emergent themes could be found both within and across the interviews. The analysis across was made between each of the MBT interviews, between each of the DBT interviews, and between the MBT and the DBT interviews. This step of the analysis was strongly inspired of the hermeneutic circle, where the material was pulled apart and put together several times through lengthy discussions, between each other and our supervisors.

During the fourth step of the analysis, we attempted to search for connections in the material of each interview. This involved making sense of the codes and placing them into a hierarchy. All the initial codes were therefore printed and cut apart from each other, leaving us with a great visual overlook of the material. As a part of step five, moving to the next case, this process was applied to each interview. Step six consisted of looking for patterns across the cases, whereby the process of abstracting super-ordinate themes, or meta-themes, started. Firstly, the initial codes and transcriptions were sorted into six selected broad themes for both the MBT interviews and the DBT interviews – before treatment, during treatment, after treatment, self-harm, the therapist, and the diagnosis. The descriptive codes for each interview were clustered into sub-themes, which then were abstracted to themes, and this led us to the meta-themes. Subsequently, the meta-themes, themes, and sub-themes of the DBT interviews were put together into a single DBT hierarchy. The same process was applied to the MBT

interviews, leaving us with two separate hierarchies. We decided to divide all the meta-themes in both hierarchies into two topics: Before MBT or DBT and during/after MBT or DBT.

The hierarchies with associated transcriptions were then presented to the supervisors. The names of meta-themes, themes and sub-themes were discussed, and some were re-labeled, merged, and moved in a process of trying to make the hierarchies as close to experience as possible. Quotations from the interviews were then selected to illustrate the final themes and sub-themes. The final versions of the hierarchies are presented in Appendix D, and the quotes selected are presented in the results section below. The table below aim to illustrate the process from quote to meta-theme.

Quote	**Preliminary code**	**Sub-theme**	**Theme**	**Meta-theme**
"Learning that it's not dangerous even though it hurts, it will pass. It helped me a lot when I learned that [the feeling] will always pass. And I hadn't thought of that before, I was so preoccupied with how painful it was"	Learning that feelings eventually will pass	Learning about feelings	Learning new ways of understanding myself and others	Explicit learning of a provided approach specific to my struggles

Table 1

The analysis process consisted of moving back and forth between the material as a whole and its parts, in accordance with the idea of the hermeneutic circle. The supervisors were also consulted throughout the analysis process to secure validity to our findings. Throughout this process, we have discussed ways of going forward, as well as emerging thoughts with each other. This has made our progression through the steps of the IPA less linear than the description given in this section. In addition, the analysis was a lengthy process where the results have emerged more and more clearly with time. At the end of the analysis, we were able to see the findings in the hierarchy, rather than descriptive labels on emergent themes. The process is described accurately by Smith and colleagues (2009): "There is a phenomenon ready to shine forth, but detective work is required by the researcher to facilitate the coming forth, and then to make sense of it once it has happened" (p. 35).

3.5 Personal and epistemological reflexivity

Reflexivity is seen as "a process of a continual internal dialogue and critical self-evaluation of a researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger, 2015, p. 220). Some researchers argue that reflexivity is not a choice within the framework of IPA, but rather an integrated feature of the research process (Engward & Goldspink, 2020). Engward and Goldspink (2020) also argue that there is neither a specific time nor a single activity during the research process where reflexivity is applied; reflexivity is rather a way for the researcher to 'be' with the material in which IPA is applied.

Before starting this project, we discussed what topics we were interested in researching and what subjects motivated us. After some debate, it was clear that personality pathology was the main interest of both of us. As a result, we contacted Espen Folmo, who at that point was the head of the MBT quality lab at the Norwegian National Advisory Unit on Personality Psychiatry (NAPP). After fruitful and inspiring discussions with Folmo, he agreed to be our external supervisor. Espen Folmo is closely connected to MBT through his clinical and academic work; however, he has also completed a course in DBT and possesses a wide range of interest in psychology and beyond. Folmo suggested Erik Stänicke, psychologist and associate professor at the Institute for Psychology at the University of Oslo, as the internal supervisor. Erik Stänicke's affiliation lies in the psychoanalytic theory and method, as well as holding a master's degree in philosophy.

Furthermore, our positionality in the research field is psychology, and more specifically, advanced students completing the clinical psychology program at the University of Oslo. During the last ten months, both of us have been student therapists at the psychodynamic clinic at the university. We are aware that this may have given us a natural bias towards psychodynamic theory and understanding, and how the choice of supervisors could be more balanced in terms of more cognitive oriented influence. Furthermore, aspects of the authors, such as pre-existing knowledge and work experience, will inevitably have affected the way the material was interpreted as well as our choices regarding the parts of the material we decided to highlight. However, neither of us had particular knowledge of MBT or DBT beforehand. We have therefore tried to let our informants and the research process guide our perception of the two treatment methods. Furthermore, we believed that as both Stänicke and Folmo have broad interests in psychotherapy research, philosophy, literature and more, we would not be stuck with one point of view. Instead, we would be able to speak openly

about our biases and could check each other when our perspectives narrowed so that our research could profit from fruitful discussions.

Considering our bias towards dynamic theory, and hence MBT, we decided that in the comparison of MBT and DBT we would not focus on what method worked best. In light of research on allegiance effects (Dragioti et al., 2015), we knew that this would mean an unconscious favoritism of MBT, which could make our findings less useful. Instead, we wished to focus on why two methods, with such different theoretical anchoring, could display such similar results on outcome measures. Furthermore, we were interested in understanding how these treatments were experienced by the people who had received them. During the data collection and data analysis period we strived to take the position of the DBT therapists as an exercise to see if our understanding and descriptions of the DBT material could be justified. For example, we decided not to use MBT language, such as mentalization, in the results when describing what the DBT informants learned in therapy. As a way of further counteracting our potential dynamic biases we contacted the National Center for Suicide Research and Prevention (NSSF), where a lot of research on DBT has been done. We contacted an advisor at NSSF, Ina Bekkevold-Jernberg, who has provided us with useful literature on DBT as well as inspiring and informative discussions about the method. This has proved very useful as it has been a way of checking if our perceptions of DBT, and our interpretations of the DBT informants, resonate with those who research this method daily.

The discussion of this thesis is mainly based on psychotherapy research on common factors which could be understood as neutral in terms of allegiance. However, our discussion will also inevitably be influenced by some dynamic and MBT frameworks as this is the main interests for both the authors and the supervisors. We believe that this will not reflect negatively on DBT. Instead, we wish to highlight both the strengths and weaknesses of both methods based on the material we have collected.

3.6 Ethical considerations and evaluations

The Norwegian Regional Committees for Medical and Health Research Ethics (REK, Appendix E) and National Center for Research Data (NSD, Appendix F) have approved the study. The participants received written and oral information from the authors about the project and its purposes. All participants signed a letter of consent before the interviews were conducted. The participants were free to end participation if they wanted to.

During the whole length of the project, careful consideration of the BPD patient group in general, and the informants in particular, has been important. Patients with BPD often experience stigma, both in psychiatric health care, somatic health care, and in society in general. Attending to the informants' well-being as well as maintaining respect for the informants have been at the forefront of our consciousness since the very beginning of the project. The potential benefits of the study have been compared to potential costs for the informants and the patient group. Measures have been taken to minimize risk throughout the whole project, but especially in the making of the interview guide and in carrying out the interviews.

As mentioned, a lengthy discussion was held before initiating recruitment. Ethical evaluations were made regarding who would feel comfortable talking about their experiences, while simultaneously having the experiences relatively close to them in time. These evaluations were continued from the process of creating an interview guide throughout the last interview. Firstly, the interview guide was made with careful consideration of the informants, where curiosity and openness guided its development. Secondly, we made running evaluations during the interviews on how the informants seemed to be dealing with the questions about their lives and their struggles. This gave us a sense of how insisting we should be on follow-up questions. Some of the informants seemed to experience the interviews as somewhat stressful. This was taken into consideration during the interviews to minimize potential harm. All the informants were asked to give feedback on the interview, and the setting in which the interview was conducted, at the end of the interviews to ensure their opinions were heard.

4 Results

In the following chapter, the results from the analysis will be presented. Firstly, the meta-themes of the first topic regarding the informants' lives before therapy will be presented. Secondly, the meta-themes of the second topic regarding their experiences during and after therapy will be presented. The meta-themes hierarchically organize associated themes, which in turn organize the sub-themes. The themes and sub-themes are not discussed separately. However, the whole hierarchy of the analysis can be found in Appendix D. The informants are given fictional names when examples and quotes are used.

4.1 First topic: Before treatment

4.1.1 First meta-theme DBT: I lacked an understanding of myself, and coped with my struggles destructively

The first meta-theme of DBT seeks to capture the informants' stories of how they felt inside, and the extent to which they did not feel connected to, or in control of their inner states. Furthermore, it highlights the different ways the informants tried to handle their emotions before DBT. All four informants described emotional intensity and instability, and Lisa and Anna talked about overwhelming emotions. Anna explained: "*It was the experience of being overwhelmed, that came with the emotional instability, when I was tired, shameful, or felt insulted.*" Furthermore, both Sara and Eva talked about emotional chaos and not being able to understand what they really felt.

As a result of an overwhelming emotional chaos, some of the informants described a desire to change the way they felt and take control over their inner state without having the ability to do so before DBT. When Eva looked back on her difficulties before DBT, she explained: "*I couldn't get myself up or change my mindset. To get up and out of bed. Life just felt hopeless and over*." This inability to change her way of thinking made her feel like she could not control what happened to her. Eva looked back on her struggles before DBT with an understanding of how her mindset impacted her life. This may imply that because of DBT, she now believes it is possible to change the way she feels by changing how she thinks. Similarly, Anna talked about her emotional life before DBT, "*It was very unstable, and I didn't know how to make it stop*". This may imply a belief that with the proper knowledge, feelings can be controlled and changed. Furthermore, it may suggest that Anna learned some tools in DBT that abled her to control her emotions to a greater extent.

All the informants described self-harm as a way of handling these painful emotions that felt out of control. Self-harm became a way of changing focus and relocating their pain as well as a relief of internal pressure. In the interview Lisa talked about when and why she would harm herself, "*It was under strong frustration or despair. And it was because [the frustration or despair] got an outlet somewhere. The pain was moved from one place to another*." Anna also highlighted relief and relocation of internal pain as a result of self-harm. Similarly, Sara described the function of self-harm, but at the same time she reflected on the negative aspects of it: "*To cut oneself is a huge stressor. You sort of don't want to do it, but it's the thing that works. To calm down the thoughts that you don't understand.*" In the interview Eva described another function self-harm had for her if she was afraid her mother would not help her. She said, "*[..] I was terrified that that she would go away and not be there for me. So, I increased the intensity [of self-harm]to keep her. Because I knew she would come at some point."* Eva described a feeling of terror over the fact that her mother might not help her anymore and how important it was to keep her. Hence, all four of the informants had a clear picture of how self-harming felt like and the function it had for them. They spoke about it quite freely and openly, which could be interpreted as a sign that the informants had become comfortable addressing this topic.

4.1.2 First meta-theme MBT: My life lacked coherence

The first meta-theme of MBT seeks to capture the informants' descriptions of their lives before they received MBT, both in terms of symptomatology and coping mechanisms. They all described lives that lacked coherence, in terms of self, understanding of others, and their coping mechanisms. Daniel and Miriam described their everyday functioning as limited. Daniel said, *"A typical day consisted of either sleeping all day or going to the activity center. Very little was happening. Very navel-gazing, one can say,"* and Miriam said, "*Get the kids to kindergarten, go home, lay and stare at the wall"*. The way Daniel described his life before MBT as naval gazing may imply that he got a new perspective of himself during therapy, where he was able to consider how other people might have perceived him. All three informants described a chaotic inner state, in one way or another. For Amanda it was strongly psychosomatic. She said, "*Inside me, it was huge. It is extremely psychosomatic. It's like it's burning inside. Your head gets warm, you can't think straight. It's a feeling of being totally overwhelmed. […] It was an existence in chaos*". Miriam described how she withdrew due to her chaotic internal experiences, while Daniel described his life as a rollercoaster, meaning his life was unpredictable and unstable. Amanda described how she managed to keep a

façade, with an education and a job she was good at. However, her private life was troublesome. She said, "*I had enormous problems in my personal relationships. I have self-harmed since my early teens, but I hid it from everyone. The self-harm and how I actually was doing"*.

All the informants dealt with the lack of coherence in harmful ways. Miriam developed a severe eating disorder, which became a way of gaining control. Daniel struggled with suicidal ideation when things got hard, and often expressed a wish to die to others when it all became too much. He also said, "*I understand now that such expressions ["I just want to go and hang myself"] can trigger reactions in others*", implying in therapy, he reached an understanding of how his actions could have a direct effect on other people. Daniel mentioned his struggles with self-harm by cutting, Amanda said she struggled with self-harm throughout therapy, and Miriam mentioned she had several suicide-attempts behind her. Neither went further into detail about the circumstances of the self-harm or suicidal behavior.

4.1.3 Comparison of the first meta-themes of the first topic

Both the MBT and the DBT informants described a chaotic inner state and a feeling of being overwhelmed. The DBT informants highlighted how they were not able to change their mindset, and consequently not able to make the pain stop. This could be interpreted as something they learned in DBT which may have affected the way they looked back on their struggles. The MBT informants did not talk about wanting to change their mindset or make feelings stop, but rather took the perspective of the other in their descriptions. This could mean that increasing the capacity to take the other's perspective in therapy is also reflected in the way they understand themselves retrospectively. Furthermore, the MBT informants described their experiences with self-harm with few details and did not elaborate on specific situations and feelings connected to the self-harm. In contrast, several of the DBT informants provided more detailed description of the function of self-harm as well as elaborating on the circumstances in which the self-harm occurred.

4.1.4 Second meta-theme DBT: My struggles with seeing the situation from an outside perspective

The second meta-theme of DBT concerns how the informants were sensitive to what they believed other peoples' opinions of them were, and how this led to difficulties in close relationships as well as in interaction with the outer world in general. Both Eva and Anna

talked about how they felt ashamed of what they believed other people thought of their behavior. Eva described how shame led her to withdraw from others: "*If I woke up on a Wednesday, was tired and didn't have the energy to go to work, then the shame was too bad for me to go back to work on Thursday.*" Furthermore, Sara, Lisa, and Eva all talked about their fear of being rejected by the people they cared about. In the interview Lisa said, *"I was extremely affected if [my psychologist] cancelled our appointment. I remember one time she cancelled our appointment because she had a lot to do in her other job. I remember I got furious."* They all described how small things could make them feel like people did not like them or care for them, and how painful this could be. This speaks of the extent to which the informants had trouble looking at situations from an outside perspective.

The tendency to interpret other people's behavior towards them negatively was described by all four informants as a core difficulty. Eva said, "*I often misinterpreted other people. I could believe they were criticizing me when they were just … I don't know, trying to correct me […] I always thought they meant to hurt me, not that they were trying to help."* This quote describes how easily Eva felt criticized and how her interpretations led to a belief that other people were trying to be unkind and hurt her. Lisa, Anna, and Sara also described how they would interpret small things, such as a look or a glance, negatively, and how they quickly jumped to the conclusion that people did not like them.

4.1.5 Second meta-theme MBT: How my problems with mentalization affected myself and others

This meta-theme of MBT seeks to capture how the informants' internal pain also affected their relationships. Both Amanda and Daniel had challenges with boundaries. For Amanda, it was also connected to her inability to tell others what she needed and meant. She said, "*It was often something that was bothering me about a person, but I couldn't tell them*. *Instead, it became a very forceful reaction, so it becomes almost impossible to sort it out. In the end, you end up burning all your relationships*". This may imply that Amanda's lack of understanding of own inner state made it difficult to know her own and others' boundaries. Daniel described aggression as one of the only ways to communicate his boundaries to others. He said, "*When something made me angry, I knew it wasn't necessarily rooted in reality, but it was aggression towards everything and everyone. The whole world, in fact*". Daniel also struggled with differentiation of affect, he only knew happy and angry. His lack of understanding of his own feelings and own reactions led to internal pain and great struggles in his relationships. He only knew how to express his boundaries through anger.

The informants also talked about how they had little room internally for others. Misinterpretation was particularly common, and they connected this to their lack of understanding of themselves. Amanda said, "*When you do not know what is happening inside, it gets hard to interpret external signals, and it becomes a mess. And then there might be strong reactions to little stimuli. I misinterpreted*". Daniel connected his lack of mentalization to how he over-analyzed his environment, while Miriam talked about how difficult and incomprehensible it felt to receive criticism from her former husband, leading to an argument lasting for hours. Miriam also talked about how she was afraid of what other people thought about her. That is, her fantasies about what an imagined other might have thought of her struggles if they knew. She said, "*That shame, the defeat you carry, you cannot tell others because people are going to laugh. You go around thinking, no one feels this way, and you must try … society expects you to be normal".* This fear became less prominent during and after therapy, which may imply that an increased capability to mentalize not only affected her close relationships, but also how she interacted with her environment.

4.1.6 Comparison of the second meta-themes of the first topic

The DBT informants particularly talked about misinterpretation of others, and fear of rejection because of such misinterpretation. They connected this to a struggle with seeing the situation from an objective perspective, and how they rather interpreted others in line with their own emotional and mental state. Their basic assumption was that other people were out to hurt them, or that other people did not mean well. The MBT informants also highlight misinterpretation of others as a problem; however, they connected this to their limited understanding of themselves as well as the subjective mental state of others. The MBT informants also put a greater emphasis on their problems with boundaries, and not having the capacity to contain the other when their chaotic inner states dominated their daily lives.

4.2 Second topic: During and after treatment

4.2.1 First meta-theme DBT: Explicit learning of a provided approach specific to my struggles

The second topic is concerned with the informants' experience of change during and after therapy. The first meta-theme incorporates different ways the informants, alongside their therapist or their group, learned new ways of understanding themselves and their struggles through the concrete information and skills that DBT offered. This included an understanding

of the past, as well as an experience of empowerment connected to their own abilities and impact. One central aspect of change the informants spoke of was how they learned to look at a situation more objectively. They explained how they learned to take an outside perspective of a situation, rather than to rely on their own thoughts, feelings, and interpretations. This made them see that their interpretations of situations did not necessarily coincide with what was happening, and this provided new meaning to situations. In the interview Lisa described how DBT dramatically changed the way she viewed the world and her own contributions.

> Lisa: It was almost like a … paradigm shift. Because I felt like everything I thought and believed was pulled out from under me, and I was like oh, so that's how it is! And now I can see that everything I'm thinking, feeling, and reacting to has to do with me and my background. It's not objectively connected to what's going on out there in the world. So, the part of DBT that worked the best for me was that […] it changed my way of thinking about my own contribution, and to take responsibility for my own contributions. What I do, think, and say and stop blaming others. Just not interpreting stuff into other people and situations.

Like Lisa, both Anna and Eva explained how DBT taught them to pause and try to figure out what was really happening in a situation and understand what other people were actually saying. This became a way for the informants to work against and overcome their tendency to misinterpret.

In addition to new perspectives on situations, the informants highlighted the value of the knowledge they gained about different emotions in DBT. In the interview Eva talked about the valuable experience of learning how one feeling can conceal another, such as anger concealing vulnerability. This enabled her to better understand and put into words how she felt. Sara and Anna also described the importance of learning about the different categories and sub-categories of emotions, and in which situations they could arise. They spoke of an increased capacity to connect feelings to situations, which made their own feelings more understandable. Anna also emphasized the importance of knowing that feelings are not permanent. She said, "*Learning that it's not dangerous even though it hurts, it will pass. It helped me a lot when I learned that [the feeling] will always pass. And I hadn't thought of that before, I was so preoccupied with how painful it was*". Thus, explicit learning about feelings were central in the informants' stories of change.

Furthermore, both Anna and Eva highlighted how information and knowledge about why they struggled made them more accepting towards themselves. Eva explained some important aspects of DBT, "*Understanding why I react as I do. Not feeling crazy, thinking*

there's something wrong with you. And when there's a reason and cause, you can do something about it. […] That made a huge difference. There's hope not just hopelessness". In this quote, Eva spoke of how knowledge about feelings and reactions helped her create a sense of meaning, and that this normalized her experiences. Furthermore, she demonstrated an ability to balance her focus between acceptance of herself and a hope connected to the possibility of change.

In combination with learning new information and knowledge, all four of the informants talked about the importance of the specific tools and skills they learned in DBT which enabled them to cope with emotions. This in turn made them believe that it was possible to feel better. In the interview Sara said, "*It takes a while before you see, okay, I'm able to tolerate these feelings, and then you're maybe able to tolerate them for one, two, three minutes, and then you take a walk and you're suddenly gone for two hours*". Sara described how she managed to tolerate painful emotions through distracting herself by taking a walk. Similarly, Eva explained the tools she learned to use when she felt like harming herself, "*You postpone it a little. It's like an impulse, the feeling is strongest in the beginning. After a while it's easier to regulate when your head works a little. […] For me, counting something worked. It still does; it happens automatically*". In this quote Eva explained how she could change the way she felt by using concrete techniques to regulate herself when emotions were strong. Some of the informants also highlighted the importance of practicing and repeating these tools so that it was possible to make use of them automatically when needed.

> Anna: I've practiced DBT every day since DBT. After a while it felt natural. You can't just attend DBT skills training for a year and expect everything to be solved. Because the truth is, the difficulties you face when you have this diagnosis were probably created early in life, in most cases. They're rooted deep inside you, so it takes a lot of hard work and repetition. And the more you practice the easier it gets.

Anna explained how the tools she learned in DBT became important parts of her process of change and her coping mechanisms after DBT. Lisa also valued the tools she learned; however, it was not as natural for her to continue practicing them after the therapy ended. As the skills were not automated, they became difficult for Lisa to use in later times of struggle.

Furthermore, the informants described how they developed a greater sense of agency. Lisa, Eva, and Sara all talked about how DBT taught them to believe that they could affect situations themselves. Lisa said, "*I experienced that more was up to me. Before, I felt like a victim of my circumstances. In DBT I learned that it was a consequence of how I see stuff, and*

react, it's not necessarily related to what's happening". In this quote Lisa explains how her experience of change in agency is closely linked to what she learned in DBT.

All the informants described how DBT was more helpful than previous treatments, and some also explained how it changed their lives. Eva and Anna talked about trying many different therapies and psychologists without much effect before DBT. In the interview Anna said, "*Before DBT everything was about therapy, hospitalizations, medication. Starting school, leaving, starting a job, quitting. […] I tried everything, and it wasn't until DBT I noticed things got markedly better. I can't say it enough, it has changed so much*". In unison with Anna, Eva described how DBT helped her getting to know herself and how she acquired and learned to use concrete tools. She also spoke about how this format fitted her personality. One of Eva's most important goals in treatment was to stop self-harming, and specific skills she learned in DBT helped her do this. This was one of the reasons why she felt like DBT worked. Lisa said she wished she had been referred to DBT earlier. Similarly, Sara talked about how DBT spared her of suffering: "*I don't know where I would have been without DBT. Still a lot of chaos*". All four of the informants described how DBT seemed to represent an important turning point in their lives regarding their healing process.

As much as the informants emphasized the importance of learning tools, they differed in whether they found the specific ones helpful. Sara and Eva both described how they did not like mindfulness, because it only amplified the chaos of thoughts and feelings they had inside. In the interview Sara said, "*I think you should be more mindless […] it's not that I need to be more present, sometimes you just need to shut everything out*". Even though the informants reported a greater acceptance of themselves overall, some of them still seemed to have difficulties accepting painful or racing thoughts and feelings in the moment. As the quote above indicates, Sara might not have wanted to accept her inner state but rather shut it out. In contrast to Eva and Sara, Anna described what mindfulness meant to her: "*Especially mindfulness has helped me a lot. […] Being able to take a pause, breathe for a second and try to see a situation for what it actually was".* Anna further explained how she began to use mindfulness daily after DBT as a way of connecting to her inner states.

4.2.2 First meta-theme MBT: A long-lasting process of exploring to create procedural learning

The first meta-theme of the second topic for MBT seeks to understand the informants' experiences of making sense of their world during treatment, and how this continued after treatment ended. One aspect that seemed important for all the informants was the integration

of relational experiences, from past to present. By reaching an understanding of relational experiences and their own suffering, they also gained a sense of self-acceptance regarding themselves and their reactions. Amanda was able to understand that her experiences with domestic violence in her childhood and in her relationship gave her a certain perspective of the world. Moreover, she understood how these perspectives might not have corresponded with the things that happened around her. Her turbulent relationship with her mother also became more understandable. Similarly, Daniel developed a greater understanding of his childhood's contribution to his functioning before MBT. Integration of past and present relational experiences thus seemed to have been a core focus during therapy and therefore became important aspects of the informants' experience of change.

The informants also emphasized the importance of enough time for change to happen. Amanda talked about how it took several years for the changes to sit. Daniel pointed out how therapy is not a quick fix, but a way of unlearning your old habits and establishing new ones. Daniel said, "*If you walk the same route over and over, it's easy. But if this route always leads you to a mountain wall, it's not very productive. So, you have to make your own route. It's really heavy, but when you walk that trail again and again, that one eventually also becomes easy*". This quote demonstrates how hard and long-lasting a recovery process can be. However, it also says something about Daniel's increased acceptance of his struggles, and his increased feeling of agency, because he realized he could do something about status quo. He also said, *"It was not until the end I managed to reflect on how my anger affected others"*, which underlines the importance of time in the process leading up to such reflections. Even though Miriam received a shortened version of the MBT program, she also stressed the importance of time. This was particularly related to how establishment of trust and safety in the group can take time, and how recovery from BPD symptoms needs time.

Through the lengthy process described above, the informants spoke about how a greater understanding of their own feelings through an increased capability to mentalize were crucial elements in their healing. With increased mentalization came greater stability and understanding of self and others. Daniel talked about how therapy helped him deal with his pain, and how increased awareness of his struggles and feelings led to him gaining more stability in his daily life. He said, "*I connected with other feelings than anger, and to a certain degree I managed to be with the pain and my struggles. And I was assured that it was not dangerous to have such feelings*". In the description of Daniel's life before therapy, he talked about a life on a rollercoaster. About his life at present, he continued: "*I have my ups and*

downs, but my life is more stable, I've landed in myself. Most of the time I know my triggers, and my life is generally more stable".

Amanda talked about how a wider perspective of herself and others helped her recover. She emphasized how she slowly managed to widen her perspective in different situations. She said, "*Pausing between situations and the reaction. Thinking, what is happening, what am I feeling, what is she feeling, what did she mean. That process was non-existent before therapy. [My therapist and I] didn't talk about it, but I believe that is the effect of mentalization*". Amanda also described a troublesome relationship with one of the group therapists, however, she eventually realized that this person reminded her of someone else. Amanda said, "*It was helpful, understanding that my struggles with her had more to do with me than her. It was a good experience".* This implied that Amanda gained a greater perspective of her own contributions to relationships with others, which she in turn ascribed to a greater ability to mentalize. In addition, the more she understood of her own reactions and feelings, the more comprehensible others became.

Daniel also described how increased mentalization made him able to deal with situations that would have been hugely problematic before therapy. He said, "*Other people can have a really shitty day without saying anything. I understood how others' negative or positive feelings didn't necessarily have anything to do with what I had said or done".* Miriam also gained a greater understanding of her attribution of feelings and thoughts to others, by looking at the way in which she interacted with others from a new perspective. She described this awareness of own patterns as an epiphany. During therapy she gained an understanding of how she was allowed to feel the things she felt, and that yelling at herself did not make the situation any better. Miriam's increased tolerance and acceptance of own feelings also made her realize that she was a whole person who had needed the maladaptive coping mechanisms to deal with her illness.

> Miriam: [Before therapy] I felt I had to give up my personality. But later [during therapy] I found out, the things I was doing were not my identity. I am still the same mum, the same wife. The way I am overthinking and ascribing feelings to others, it has nothing to do with my identity. It was just tools I needed in a period of my life to survive. It was an aha experience. I am not my struggles.

Daniel and Miriam, who both had 'careers' in psychiatry since childhood, described how MBT gave them something that previous therapies had not. They both emphasized how MBT enabled them to connect with their feelings. They both gained a sense of stability, that in turn enabled them to work through traumas and gave them hope for an actual recovery process

from psychological struggles. Miriam also spoke about how MBT enabled her to begin a different treatment for her traumas. In addition to highlighting the positive sides of MBT, Daniel mentioned how he missed a focus on personal resources, and felt it was little room in the group therapy to talk about positive experiences. Amanda talked about how she missed a focus on her internal states, rather than just a focus on understanding others, and mentioned how she could have benefited from more explicit learning about emotions.

4.2.3 Comparison of the first meta-themes of the second topic

The DBT informants emphasized the importance of learning about the different emotions and the situations they could arise in. Furthermore, they highlighted learning to take an outside perspective of situations to become aware of their own and other peoples' contributions as well as acquiring new and concrete tools to try out. In contrast, the MBT informants emphasized how the process of change was a long-lasting endeavor of exploration of past and present as well as self and others, with a slowly developing capacity to mentalize. This in turn led to greater self-understanding and better relationships overall.

4.2.4 Second meta-theme DBT: A predictable program felt safe but less flexible

The second meta-theme of DBT explores the informants' experiences with the structure of DBT as well as their experiences with their therapists and their groups. Both Eva and Sara talked about how the educational format of DBT was essential to their recovery process. Eva said, "*DBT gave med concrete things to go out and try*", and Sara said, "*I don't think you can do it [recover] without the education, you need something systematic, you need to learn it on a child's level*". These quotes demonstrate to a certain extent how the informants valued the pedagogical format of DBT.

However, Eva, Sara, and Lisa explained that some aspects of the specific format of the DBT skills training were challenging. Eva described how she felt like the therapists in the group skills training could be inflexible about what worked for whom. Eva said, "*Not everything works for everyone. Like mindfulness, it didn't work for me".* Similarly, Sara experienced that the skills trainers occasionally presented advice as if behavioral change was easy. As a result, Sara felt that not all the advice from the group skills trainers were useful, when it was not adapted to the individuals in the group. Both Lisa and Sara explained how some of the other group members did not contribute to the group, either by not showing up or by being quiet. Lisa explained the consequence of participants not showing up: "*[…] I felt it*

ruined both the dynamic in the group and what I could get out of it when I had no one to work with. One time it was just me alone with two therapists, no one else showed up". Similarly, Sara described how the lack of participation from quiet group members affected her progress in the group because it made learning interpersonal skills difficult.

All the informants highlighted the importance of genuine therapists. Both Anna and Eva felt like their therapists cared for them. In the interview Anna spoke of her therapist's importance for her recovery, "*Having a person who genuinely wishes the best for you, but at the same time sets boundaries and all that stuff… She means a lot to me*". Lisa in contrast described her relation to the therapists as more ambivalent, as she shifted between admiring and disliking them. Lisa felt like it was hard for the therapists to say they were sorry after a thoughtless comment, and she described how this affected their relationship negatively. About the skills trainers Lisa explained: *"Sometimes I felt like they validated me to death […] It was like, you shouldn't believe that it gets any better when you confirm that it has been difficult for me, because I know that".* Similarly, Sara mentioned that she did not like being validated by her therapists, without elaborating further.

Lisa and Sara both highlighted the importance of how their therapists could share their reactions and emotions. About her individual therapist, Lisa said, "*I remember it was something I appreciated about her, when she said something, because I could see, wow the woman reacts, she has feelings!".* Sara and Anna also emphasized how their therapists felt predictable and safe. They spoke of not feeling judged no matter what they said or felt. In the interview Anna described what she valued with her therapists: "*The fact that they were concrete, and that it was easy to understand what they meant made me trust them a lot. I knew they were there, and I knew they would tell me the truth"*. Sara highlighted the importance of being introduced to the skills trainers and being prepared for what she was going into. For Sara, this predictability was positive. Both Anna and Lisa were also given information about DBT before therapy which made them believe that DBT could be helpful.

4.2.5 Second meta-theme MBT: The therapist followed my lead, which made therapy relevant but challenging

The last meta-theme explores the informants' experiences with the therapists and the group members. For Daniel and Miriam, a safe attachment and emotional bond to their therapists were valuable. Daniel emphasized how the therapists made use of his way of expressing himself, which in turn strengthened the emotional bond. He said, "*She gave me an image of my way of being near others. She said, "if you imagine a cactus in the desert, who wants to*

hug a cactus?", and suddenly I realized how others perceived me". This implies that Daniel felt seen and understood by his therapist, who managed to tune into his use of language and ways of understanding the world. In other words, the therapist's openness to the use of relevant language strengthened the therapeutic relationship. He also experienced this with one of the group therapists, who understood the need for a normal rather than a clinical language. For Miriam, the safe relationship was strongly based on the therapists' self-disclosure, and how this made them more approachable and less mystic. Miriam also talked about how the other group members became internal objects she could evoke to comfort her in times of pain. For Daniel, it seemed like he experienced an emotional correcting relationship in a therapeutic dyad that contained all parts of him.

Amanda in contrast experienced how her therapists could be perceived as passive. For example, she experienced the group therapy as immensely intense and challenging, due to the group members combined emotional instability. She said, "*Everyone is unstable, it's so volatile, because no one is stable, except the therapists, and you can feel the intensity and … it's like matches always being in flames*". She continued on how conflicts often arose, and how she felt that the therapists were not authoritative enough when a group member did something mean to another. For her, the therapists did not do enough to make the intensity bearable. Amanda also experienced that her individual therapist did not understand what she needed or took her concerns seriously enough. She perceived him as passive, and to a certain degree, dismissive, particularly regarding her experiences with domestic abuse.

4.2.6 Comparison of the second meta-themes of the second topic

The DBT informants highlighted the importance of the therapists being predictable, clear in what they meant and telling the truth. Furthermore, they also emphasized the importance of the educational format and concrete approach to working on their struggles. Although the DBT informants highlighted how the predictability made them feel safe, they also spoke about how this could lead to reduced flexibility. For some of the informants this affected the relevance of some aspects in the skills-training, and possibly the attendance and participation from other group members. The MBT informants, on the other hand, spoke about the positives of having a therapist that followed their lead and spoke their language. However, they also described how a more following therapist could lead to a perception of the therapists being too passive or unauthoritative. Furthermore, this could make the group feel intense because the participants were emotionally unstable, and the therapists seemed to let the group members decide the content.

5 Discussion

The IPA indicated similarities and differences in the stories of change told by informants who received DBT or MBT for BPD. Similarities between the two groups of informants were particularly seen in the content of their struggles before they received MBT or DBT as well as in how they regarded the treatment as a big contributor to their healing process. Differences were observed in the ways the informants described their lacking coping mechanisms before treatment and in the aspects of the specific treatments highlighted as important for their recovery process. These findings, when seen as a whole and complete story, might shed light on how a change narrative is developed during and in the aftermath of receiving MBT or DBT. Hence, this is one of the first studies we are aware of, that specifically target the cultural change narrative received from two treatments specialized for BPD. The change narratives described by the informants seem to reflect the content of the treatments.

In the following, we will discuss how we best can understand our findings when taking into account the current theories and research on MBT and DBT. Furthermore, we will discuss how our findings might shed light on how the rationale, or the healing myth, the culturally embedded explanations, and procedures connected to the treatments are conveyed differently in MBT and DBT. Lastly, we will discuss our findings when contemplating the current state of psychotherapy research, which was outlined in the introduction.

5.1 Different explanatory models for similar symptoms

The IPA indicated both similarities and differences in the groups of informants regarding how they understood themselves prior to treatment. They all spoke about how life could be chaotic and overwhelming, which may be attributed to symptoms related to the diagnosis (Kulacaoglu & Kose, 2018). However, differences could be seen in how they described their lack of coping mechanisms. The DBT informants spoke about not being able change their mindset, hence not being able to change the way they felt. This may represent a way of thinking that is influenced by the cognitive behavioral tradition DBT springs out of, where working with changing thoughts is an important way of regulating emotions (Linehan, 2014). In contrast, the MBT informants spoke about their lives before therapy from the perspective of the other, which may indicate a mentalizing stance (Fonagy & Target, 1996; Karterud et al., 2020).

There was also a striking contrast in the representation of self-harm in the informants' stories. Most of the DBT informants provided detailed descriptions of self-harming experiences, whereas the MBT informants did not elaborate on the subject to such an extent.

This may be understood as a result of the focus on self-harm in DBT and MBT respectively. The former uses tools and skills training actively to replace self-harm as a coping mechanism (Linehan, 1993), whereas the latter has less focus on such skills, and believes the frequency of self-harm will be decreased with an increased capacity to mentalize as well as reduced attachment avoidance (Karterud et al., 2020).

Furthermore, informants in both groups highlighted a tendency to misinterpret others and being sensitive to rejection and judgement cues from the environment. However, these tendencies were described differently to a certain extent. The DBT informants were particularly concerned with how they were not able to take an objective perspective in their interaction with others and the world in general, and how this led to misinterpretation. Meaning, they put an emphasis on the objectiveness of a situation. This may be understood in the context of a DBT skills training module, emotion regulation skills, where checking the facts of situations is one of the tools practiced (Linehan, 2014). These descriptions provided by the informants may also be an indication of DBT's concept of emotion mind, where assumptions are made in an emotional state without checking the facts (Linehan, 2014; Ritschel et al., 2015; Swenson & Choi-Kain, 2015).

The MBT informants rather emphasized how they were not able to understand their own inner states as well as not being able to comprehend the subjective experiences of the others. This may be attributed to the way in which MBT works with mentalization failures and psychic equivalence (Bateman & Fonagy, 2016; Karterud et al., 2020). The ability to consider the mental state of the other may be difficult if you are overflowed with your own pain (Karterud et al., 2020). Some of the MBT informants also spoke about how this could lead to challenges with boundaries, inwards and outwards. An assumption in MBT is that struggles with boundaries is linked to identity due to disturbance of normal mirroring in childhood (Karterud et al., 2020). Hence, building a greater capacity to mentalize will also affect one's ability to set boundaries (Karterud et al., 2020). The MBT informants also connected these struggles to how their relationships suffered. One could therefore argue that receiving MBT not only helped them form better relationships going forward, but also gave them a better understanding of why their past relationships had been so turbulent. In MBT, one assumption is that the poorer one's ability to mentalize is, the more one misunderstands (Balestrieri et al., 2015). Consequently, their own and others' lives become harder to make sense of. In light of the similarities and differences accounted for above, one might argue that the ways in which the informants described their lives before MBT and DBT could indicate how these stories became influenced retrospectively by the treatments they received.

5.2 Explicit and implicit ways of facilitating the change narrative

The main findings from the second topic concern what the informants gained, learned, understood, liked, and disliked in the treatments they received, as well as how they experienced the therapeutic relationship and the group. Furthermore, how these factors contributed to therapeutic change. Regarding the treatment itself, the DBT informants indicated an explicit learning of a provided approach, and the MBT informants' stories concerned a more implicit or procedural process of change. Elements from their stories represent both the theories of psychopathology as well as specific techniques used in the healing process.

The DBT informants' description of what they gained from DBT could be understood as ways of resolving what they perceived as their core struggles before treatment. For instance, they spoke about learning to look at situations more objectively and understand their own contributions to such situations. According to the DBT perspective, as mentioned, you can change an emotion if you change your interpretation of a situation to fit the facts (Linehan, 2014). This abled the DBT informants to understand how their interpretations were affected by their emotions and their background, which made it possible to separate misinterpretations from the actual situation. The DBT informants also spoke about the importance of the educational format of the treatment, exemplified by the pedagogical approach to learning about different emotions. This could be ascribed to the DBT skills training program consisting, in part, of observing, describing, and naming emotions, but also to a pedagogical approach to emotions in the individual therapy (Linehan, 1993, 2014). Furthermore, the concrete approach to therapy, consisting of tools to practice, was highlighted as important for therapeutic change by the DBT informants. Thus, change in therapy might have been experienced through an explicit and educational learning process where new meanings were developed through acquiring the knowledge and tools offered by DBT.

The MBT informants in contrast, emphasized the importance of having enough time for change. This coincide with MBT theory proposing that being able to distinguish between fantasies and the real world takes time (Karterud et al., 2020), which could also be applied to how the MBT informants spoke about overcoming their mentalization failures in close relations. Additionally, the integration of past and present, and how early relational experiences may have affected the present were stated as important for therapeutic change by the MBT informants. This is aligned with the MBT assumption that an individual's ability to

interpret mental states and intersubjective transactions are affected by early attachment relations (Karterud et al., 2020). Lastly, the MBT informants emphasized the importance of implicitly developing and strengthening their ability to mentalize. One informant even referred to it as gaining a superpower. This seems reasonable considering that one of the goals of MBT is to restore, maintain, and keep mentalization going when it would otherwise be lost (Bateman & Fonagy, 2016).

Both groups reported having experienced therapeutic change as a result of the content of the treatments they received, but the process or ways of creating change could be understood as different. One interpretation could be that the DBT informants acquired a map or learned an approach already made specifically for their problems, whereas the MBT informants created the map or explored new approaches along the way. However, the differences between the two treatments are not as clear cut as the results may imply. For example, MBT is also a manualized treatment with concrete focus points and interventions (Karterud, 2012; Karterud et al., 2020; Karterud & Bateman, 2021), and automatization of skills in DBT (Linehan, 2014) may also create procedural learning. The differences might therefore be more apparent in the explicit and declarative ways the knowledge and skills seem to be taught in DBT, whereas in MBT a more fluid and following exploration seems to create procedural learning in a more implicit way (Fonagy & Target, 1996; Garred & Gough, 2021; Karterud et al., 2020; Linehan, 1993, 2014).

The explicit and implicit procedures indicated above were also reflected in the ways in which the informants spoke about the therapeutic relationships. The MBT and DBT informants brought forward different aspects of the therapeutic relationship that could facilitate or challenge progress. This could reflect how the therapeutic relationship unfolds differently in different treatments (Bordin, 1979; Falkenström & Larsson, 2017; Garred & Gough, 2021; Spinhoven et al., 2007; Ulvenes et al., 2012). The DBT informants emphasized predictable, safe, and structured therapists and how this promoted a feeling of safety which was important to their healing process. They also spoke about the importance of the therapists being genuine, and how the therapists' self-disclosure, which is an encouraged intervention in DBT (Linehan, 2014), promoted trust. However, some of the DBT informants experienced a lack of flexibility in the group skills training. This might have been due to the structure of the DBT skills training manual (Linehan, 2014). As the structure may be similar for most DBT skills training groups, flexibly adapting tasks to the specific participants may not be a part of what is provided. This could also relate to how some of the informants spoke about lack of attendance and participation from other group members, which they felt negatively affected

the effect of the treatment. One way of interpreting this could be that some participants experienced the topics as either unengaging or less relevant, hence the motivation to discuss the topics and attend the group might have suffered.

The MBT informants' spoke about differing experiences in the therapeutic relation, which could possibly be related to the not-knowing position in MBT (Bateman & Fonagy, 2010). For instance, one informant, Daniel, emphasized how the therapist followed his lead by making use of metaphors and therefore speaking his language. On the other hand, one informant, Amanda, perceived the therapists as passive and not authoritative enough, thereby contributing to a feeling of insecurity or lack of safety in treatment. Amanda particularly experienced the group as intense. It could be argued that these factors contributed to a weaker emotional bond to her therapists. However, she gained a greater ability to mentalize regardless, which may imply BPD patients can be on a recovering path even though the emotional corrective experience is not as powerful. This might be attributed to the presence of epistemic trust, as Amanda seemed to believe in what her therapists communicated about the social world and may have trusted its relevance for her (Fonagy, Luyten, & Allison, 2015).

The informants' descriptions of the therapists and the group highlight experiences of both the positive and the negative aspects of two highly different therapeutic traditions. The findings from this thesis may indicate that in a group treatment like MBT-G, which is less structured than DBT skills training, and where group members decide the agenda, the therapists can either seem too passive or it may seem like they follow the group members lead. Similarly, the content of the group may either seem emotionally relevant or it can make the group feel unstable and uncontrolled. As an interesting contrast, the therapists in the DBT skills training group may be perceived as both predictable and safe, and more rigid and inflexible in the educational and pedagogical format. Similarly, the group may either feel safe, controlled, and relevant, or irrelevant, and unengaging to some.

These results converge with the findings in a thesis by Garred and Gough (2021), who studied the therapeutic relation in MBT and DBT. Their results indicated that a therapist's project could be described along the dimension from a *leading* (DBT) to a *following* (MBT) strategy, and along the dimension from a *held* (DBT) to a more *fluid* (MBT) format. This is in line with the findings of the present study where the informants described both the positive and the negative sides of these dimensions. This could be understood considering the two therapeutic traditions that DBT and MBT springs out of, namely cognitive behavioral therapy and psychodynamic therapy (Allen & Fonagy, 2006; Linehan, 1993). In the cognitive behavioral tradition, it is more common for the therapist to explicitly educate the patient and

rehearse new and concrete skills to handle or relieve the patient's symptoms (Berge & Repål, 2015). In psychodynamic tradition the therapist, to a greater extent, seeks to follow the patient's lead in developing a new understanding and gaining insights. In psychoanalysis, this is often referred to as evenly suspended attention or the analytic attitude (McWilliams, 2004; Schafer, 1983). These findings also support the claim made by Bordin (1979) and Ulvenes and colleagues (2012) that the alliance may operate in different ways in different therapeutic traditions. Several of the aspects that facilitated positive outcomes for the informants are in line with how the therapeutic relationship typically unfolds in the two treatments respectively.

As accounted for above, the findings from the IPA indicate that the informants' stories of change were told from a perspective situated in the therapeutic traditions they were socialized into, as the descriptions seem to be congruent with the theories and techniques provided. Furthermore, these elements coincide with other qualitative studies investigating patients' experiences of DBT or MBT (Dyson & Brown, 2016; Gillespie et al., 2022; Johnson et al., 2016; Little et al., 2018; Lonargáin et al., 2017; McSherry et al., 2012). These studies have accounted well for the various helpful elements, such as the quality of the working alliance and the usefulness of specific interventions. One may therefore argue that the separate elements demonstrating the effectiveness of talking cures have been major suspects in the detective story about what makes psychotherapy work. However, the complete stories of change, the cultural change narrative, has to our knowledge been less investigated.

5.3 Change through the internalization of a specific narrative

Our results indicate that change can come about differently in two different treatments specialized for BPD. Moreover, there seem to be a paucity in studies investigating ways the cultural framework of a treatment – the cultural change narrative – is explicitly or implicitly transmitted from therapist to patient. The change narratives presented in this thesis contained descriptions of why the informants had struggled heavily in the past, what they gained from receiving treatment, and how this was done through experiences with therapists and the groups. To explore the change narratives presented by the informants in this study, we will discuss the development of expectations, how the rationale, or healing myth, is accepted and communicated, the plausible explanations for the informants' symptoms, and the rituals and procedures for resolving them, as conceptualized in the CF approach (Frank & Frank, 1993; Laska et al., 2014; Wampold & Imel, 2015).

In Western societies psychotherapy could be understood as an acknowledged healing myth for psychological suffering, trusted and believed in the culture (Frank & Frank, 1993). In Norwegian public mental health care, however, there is a variety in psychotherapeutic methods provided, resulting in a variety of healing myths offered. Patients accepted to a regular District Psychiatric Centre (DPS) may not be aware of the theoretical background of their therapist. In this study however, the informants were aware of the specific treatment in advance. One could therefore argue that the socialization into the treatment already began before the treatment started, and thereby the internalization of the cultural change narrative. This might have influenced the development of expectations (Wampold & Imel, 2015). Freud himself argued that, "Expectation colored by hope and faith is an effective force with which we have to reckon … in all our attempts at treatment and cure" (Freud, 1905/1953, s. 289). Several decades of psychotherapy research have suggested that the patient's belief in the treatment, in addition to motivation and expectations, is associated with positive outcomes (Finsrud et al., 2022; Frank & Frank, 1993; Wampold, 2001, 2021; Wampold & Imel, 2015). This is also evident in the interviews, where the informants consistently referred to treatment as either DBT or MBT, and previous treatment they received as just therapy. This might be due to the nature and focus of the project, but it could also reflect an unconscious affiliation or association with the method itself.

The development of a patient's hope and expectations towards a given treatment could also be related to the therapist's ability to provide a rationale for the treatment in question, which in turn is accepted by the patient (Frank & Frank, 1993; Laska et al., 2014; Wampold & Imel, 2015). Through the stories brought forward by the informants in the present study, their change narratives seemed to have been shaped and influenced by the treatment they received. Several of the informants also spoke about how they felt that DBT and MBT helped them to a greater extent than previous treatments. This may imply an acceptance and integration of the rationale provided, and the possibility that they had their expectations met or exceeded. However, the change narratives described by the informants indicated differences in the rationale provided by MBT and DBT respectively. In DBT one rationale could be the importance of addressing the emotion dysregulation, central to BPD pathology, and how it can lead to harmful behavior, such as self-harm or interpersonal difficulties. Emotion regulation could be developed, for instance, by practicing the ability to observe and accept emotional states through skills such as mindfulness and distress tolerance (Linehan, 2014). In the present study, using mindfulness or distress tolerance skills were described by the DBT informants as important in their recovery from emotional distress as well as being

vital for the ability to quit self-harm for some. In MBT, one assumes that a patient's healing process relies on an increased capability to mentalize, and that increased ability to learn from interpersonal situations outside of treatment is facilitated through the therapeutic relationship. These differences support the claim that the common factors, here exemplified by the rationale, must be put into the context of the specific therapeutic techniques (Nissen-Lie, 2013).

The interaction between common factors and the specific techniques can also be related to why different rationales for the treatment of the same disorder can potentially be equally effective. One explanation might be that the particular content is not of highest importance, but rather whether the rationale is believable, accepted and considered relevant to the patient. This could be seen in the light of epistemic trust, a concept embedded in the theoretical frameworks of MBT, as the informants' seemed to have considered the rationale's information and knowledge about the world as relevant to them (Sperber et al., 2010). One may therefore argue that epistemic trust could be important when a therapist is attempting to convey the healing myth to a patient. To further investigate how this might be done differently by different treatments, one may look to Fonagy and Allison (2014), who have proposed three communication systems that contribute to the development of epistemic trust, and therefore perhaps the ability to accept a treatment's rationale.

Communication system 1 refers to the teaching and learning of content, and concern, in part, how different treatments will offer different rationales. System 2 refers to the re-emergence of robust mentalizing, and system 3 consider the re-emergence of social learning (Fonagy & Allison, 2014). According to this conceptualization, all treatments make use of communications system 1 to convey their rationale as well as for communicating the fact that the therapist possesses knowledge and personal characteristics that could prove valuable to the patient (Fonagy et al., 2017). However, based on our findings, it could be argued that DBT, to a greater extent than MBT, makes use of explicit teaching and learning throughout the treatment as a way of fostering epistemic trust. This is because the rationale, as well as its relevance for the patient, seems to have been communicated pedagogically through an educational format. Although MBT also consists of psychoeducational groups, it could be argued that important elements of MBT is lacking in concrete and explicit operationalization (Sharp et al., 2020). Explicit learning also seems less prominent in the change narratives of the MBT informants. However, recent studies of MBT have indicated an interest in developing a pedagogical stance as well as incorporating more of an explicit educational format more clearly seen in treatments such as DBT (Folmo, 2022). Psychopedagogic

interventions suited to MBT are suggested to be information about emotions, attachment, and social rules (Folmo, 2022).

Communication system 2 concerns the different ways therapists can aid in the development of a patient's epistemic trust by exploring the content of the patient's mind rather than offer new knowledge (Fonagy et al., 2017; Fonagy & Allison, 2014). For example, if the therapist marks the patients experiences and emotional states, mentalizes the patient, and responds sensitively "the patient takes a step back from epistemic isolation, and the patient gradually begins to exercise his/her mentalizing skills" (Fonagy et al., 2017, p. 9). However, according to this conceptualization, "mentalizing is not its main goal, but the improved mentalizing that results from it enables the patient to start to approach and learn from their wider social context" (Fonagy et al., 2017, p. 9). An experience of improved mentalizing, and thus an ability to learn from and consider the perspective of others, was especially emphasized in the MBT informants' change narratives. Moreover, this was referred to as a long-lasting process of exploring self, others, past and present, with their therapists.

Despite the emphasis on mentalization in MBT, one could argue that some of the explicit techniques in DBT has overlapping qualities with communication system 2. For instance, the wise mind in DBT involves taking a pause and consider the possibility that other peoples' intentions could be different from the patient's own emotional mind (MacMillan, 2020; Swenson & Choi-Kain, 2015). This precisely was highlighted by several of the DBT informants; learning that their perception of a situation did not always coincide with the actual situation. This could possibly suggest that the DBT informants' therapists explored and marked their emotions and experiences, which could have led to an understanding of how emotions affected their interpretations. One might therefore argue that this DBT concept, emotion mind, may be similar to the mode of psychic equivalence in MBT (Fonagy & Target, 1996; Swenson & Choi-Kain, 2015). This might highlight how common features of DBT and MBT could be disguised by different language and treatment cultures, but nonetheless seem helpful for patients in similar ways. Furthermore, it provides an example of how the common factors are put into context of the specific treatment's theories and techniques. In light of this overlap, some authors have suggested incorporating work with mentalization in DBT to increase self-coherence, metacognition and attachment security (Swenson & Choi-Kain, 2015). This could represent a natural dialectic opposite to the way DBT breaks behavioral patterns into small components through chain analysis (Swenson & Choi-Kain, 2015).

Communication system 1 and 2 could therefore be emphasized somewhat differently by MBT and DBT. However, both could represent ways of developing epistemic trust in the

therapeutic relation. System 3 could represent an ability to generalize this trust to the outside world. “This means that it is not just what is taught in therapy that helps the patient, but that the patient’s capacity for learning from social situations is rekindled” (Fonagy et al., 2017, p. 9). Even though epistemic trust is a concept primarily used in MBT, it could be useful when attempting to understand how patients accept a treatment’s rationale, and therefore be relevant to different schools of psychotherapy. Simultaneously, one could question the application of epistemic trust, an MBT concept, on the experiences provided by the DBT informants. This is because it may compromise with the established DBT theory.

In addition to communicating a rationale believed by the patient, the CF approach stress the importance of a culturally embedded explanation for the disorder that is being treated (Frank & Frank, 1993; Laska et al., 2014; Wampold & Imel, 2015). This could be understood as an explanation that is in line with the dominant view of human experience in a given culture at a given time (Frank & Frank, 1993). An important part of the MBT and DBT informants’ change narratives was being provided with an explanation for why they struggled, and how this facilitated a feeling of normalization and acceptance that was important for healing. In MBT, such an explanation can consist of how struggles with mentalization can lead to interpersonal difficulties and internal pain (Karterud et al., 2020). In DBT, an explanation could consist of how BPD patients often struggle with emotion regulation, which can lead to emotions being in control over a person’s decision making, thus leading to relational difficulties as well as internal pain (Linehan, 1993, 2014). These differing explanations were evident in the informants’ narratives of how they struggled prior to treatment. Although the explanations were different both could be understood as befitting for the dominant view of human existence in the present culture and time.

The CF approach also points to the importance of a therapeutic procedure or a healing ritual that promotes progressive behavior (Frank & Frank, 1993; Laska et al., 2014; Wampold & Imel, 2015). For the DBT informants, this was easy to put into words as it was communicated and worked with explicitly in therapy, exemplified by the rehearsal of alternative options to self-harm for dealing with painful emotions, such as counting objects in the environment. It seemed harder for the MBT informants to explicitly formulate the specificities of what the treatment provided them, but they all highlighted implicit learning of mentalizing that promoted more positive behavior. Instead of specific tools and techniques, they also pointed to how their interaction with others changed as they increased their ability to take the other’s separate mind into account, which could reflect the development of a mentalizing stance.

Thus far, we have discussed how the common features of psychotherapy, suggested by the CF approach (Frank & Frank, 1993; Laska et al., 2014; Wampold & Imel, 2015) interacted with the treatment our informants received to create a complete change narrative. The development of expectations and hope, the rationale for a given treatment, the culturally embedded explanations for symptoms and the healing rituals are all factors that in one way or the other are dependent on the therapist, whom the treatment will be provided through, as well as the therapeutic relation. The results from this study indicated a variance in how the working alliance was perceived by the informants. This variance ranged from the emotional bond being central for change to elements of the working alliance being strained in different ways. For instance, Daniel (MBT) and Anna (DBT) emphasized how the connection with their therapists was of paramount importance for their change in treatment. They spoke about their therapists' empathy, willingness to adapt, competency, and their ability to contain them even at times when the alliance was challenged. These results can be understood in the light of Finsrud and colleagues' (2022) findings that confidence in the therapist was one pathway to change related to the working alliance.

Lisa (DBT) and Amanda (MBT), in contrast, experienced the emotional bond and the connection with their therapists as more challenging. However, they still spoke about having benefited greatly from treatment. Amanda described how the mentalizing stance felt like a superpower, which may imply that she accepted the rationale provided by MBT, and therefore bought into the treatment. Lisa experienced that DBT offered her new perspectives on herself and the world, and that these perspectives felt like a paradigm shift. Amanda and Lisa's experiences of change therefore seem to correspond with Finsrud et al., (2022) second pathway of change, confidence in the treatment. This may imply that even though the bond was described as strained, the therapists seemed to convey a believable change narrative by tapping into the cultural healing myth of the treatments, and linking this to expectancy and hope (Frank & Frank, 1993; Wampold & Imel, 2015).

These differences in pathways of change that seemed to have been experienced by the informants in both groups, and may imply a greater variation between therapists within a treatment than between treatments (Nissen-Lie et al., 2010). Different therapists may therefore use different strategies to build the working alliance. For example, a therapist who is struggling with expressing empathy could be very skilled at considering a patient's hopelessness and building hope linked to the treatment ritual itself, and therefore being engaged in a process of change regardless. However, most therapists will, to some degree, be able to make use of both pathways for change (Finsrud et al., 2022; Zilcha-Mano et al., 2019).

To be able to convey confidence in the treatment, it seems central that the therapist believes in the healing myth they are providing. Studies on expectancy effects and hope have suggested that the effect of treatment increase with the provider's belief in and expectations for the treatment (Enck & Zipfel, 2019; E. J. Folmo, 2021; Frank & Frank, 1993; Howe et al., 2019; Rosenthal & Rubin, 1978; Wampold, 2021). Furthermore, this could be connected to research suggesting that being anchored in a theoretical framework is associated with positive outcomes in therapy (Lorentzen et al., 2011; Orlinsky & Rønnestad, 2005). When discussing what characterizes expert therapists, factors such as professional self-doubt, empathy and warmth, and the ability to monitor the therapeutic process are often emphasized (Anderson et al., 2009; Nissen-Lie et al., 2010, 2017; Wampold & Imel, 2015). However, considering the effects of placebo and expectancy, and the findings of the present study, one may argue that another central characteristic of expert therapists is the fact that they believe in, and master, the treatment they provide. This assumption is in line with our findings, where therapist characteristics such as the ability to convey empathy or inspire hope in the treatment ritual became central aspects of the informants change narratives.

To summarize, we have discussed how the common features of psychotherapy, suggested by Frank and Frank (1993), and Wampold (2001) and later revisited by Laska and colleagues (2014) and Wampold and Imel (2015), interacted with the treatment our informants received, and the therapists they met, to create a complete change narrative. Furthermore, the discussion has shed light on how different ways of communicating the healing myth may indicate some similarities and differences in MBT and DBT which in turn contributed to development of the informants' change narrative. The specificity of the treatment the informants received provided a unique opportunity to research the joint effects of the methods provided and the therapist's impact on the informants' experiences of change.

5.5 Implications

Our study has shed light on the significance of theories of change embedded in all psychotherapies, as well as how this is conveyed and communicated to the patient. Hence, these findings seem to converge with the significance and interest that therapist put into their clinical theories of change. This is because the change narrative may become a core component of therapeutic change. Furthermore, it may suggest some of the strengths that lie in treatments and therapists that are able to offer a complete healing myth consisting of techniques, interventions, explanations, and distinct ways to facilitate the therapeutic

relationship. Therapists who can accomplish this could also benefit from placebo and expectancy effects. Moreover, this could also be related to therapist affiliation, and allegiance effects, because if therapists believe in what they are offering, the healing myth may possibly become more believable for the patient and could therefore be accepted and integrated in their stories of change. One could therefore argue that the most effective therapists are those who are allowed to provide the treatment they believe in. Furthermore, according to the Evidence-based practice in psychology (EBPP), patients have the right to receive treatment befitting for their characteristics, culture and, preferences (Norsk Psykologforening, 2007). This may relate to the importance of having a pluralistic approach to the treatment of mental illnesses in public mental health care.

In addition to the suggested importance of pluralism for the individual patient and the individual therapist, a lack of thereof could potentially limit the field of psychotherapy's progress in research because favoring one evidence based treatment over another could hinder equal chance of funding (Goldfried, 2016). Having a pluralistic approach to the treatment of mental health also makes it easier for practitioners to learn from each other and from other schools of thought. Aspects of this thesis also suggest what MBT and DBT could possibly learn from each other while highlighting the importance of the two treatments holding on to their respective healing myths. This could not only benefit the treatments and the therapists, but potentially also the patients who will meet well-educated and well-informed professionals who have been exposed to a wide range of therapeutic methods, interventions, techniques and thinking (Leichsenring et al., 2018; Leichsenring & Steinert, 2017).

5.6 Limitations

There are several limitations to this thesis considering choice of method, participants, and design. Firstly, IPA research is interpretative in its nature and the findings of the present study will therefore both be a result of, and limited by, our own pre-conceptions, values, and interests (Smith et al., 2009). Our theoretical biases, as well as the supervisors', accounted for in the methods section, inevitably will have affected the direction of the thesis. With this in mind, it is clear that multiple ways of understanding and analyzing the material on which this thesis is based is possible. The quotes used to highlight the points made in the analysis have thus been a way of making it possible to trace our findings back to the informants and the material. This has been an attempt at transparency regarding the analytic path we have chosen. However, the quotes will inevitably mirror a small sample of the whole material and other researchers might have been interested in different subjects. In addition, as we also

conducted the interviews, the analysis might have been affected by the shape and form of the interviews. To counteract such influences, the reasonableness of our interpretations was discussed with our supervisors.

Another limitation may be the unequal number of DBT and MBT participants. However, the recruitment period did not last long enough to achieve identical group sizes. Furthermore, there was only one man included in the sample, and a valuable asset would have been to include more male participants. One could also argue that the sample size of the present study was small. However, Smith et al., (2009) have proposed that 6-10 participants is a suitable sample size for an IPA. The small sample size, lack of more male informants and other aspects of the design, may limit the generalizability of the findings in the present study. However, one may argue that qualitative research does not aim towards discovering generalizable conclusions, such as is the goal in quantitative research (Yardley, 2007). Instead, our aim has been to develop new understandings that could serve as a guide in other cases or other settings where this could be useful. When using this approach to generalization, some of the responsibility of assessing the usefulness of the findings is put on the reader to make an independent judgement (Maxwell & Chmiel, 2014). This in turn makes transparency and openness about the analytic process, as well as our position in the research field and affiliations, important so that a reader could make an informed decision. Furthermore, an explicit goal in IPA research is to provide detailed accounts of specific aspects of lived experience and through this get a better sense of the complexity of human existence. With this in mind, the particular becomes equally as important as the generalizable, and even studies with small sample sizes can thus provide the field of psychology with valuable contributions (Smith et al., 2009).

Lastly, we wish to address the fact that several of our informants described experiences of severe stigmatization connected to the BPD diagnosis in public mental and somatic health care. We recognize this as an important issue to address. However, this subject was beyond the scope of this thesis. Future research on this topic is therefore encouraged.

5.7 Conclusion

This thesis suggests that DBT and MBT, two evidence-based treatments for BPD and statistically speaking similarly effective, produce different therapeutic changes and/or change narratives in their patients. The DBT informants spoke about the provision of an explicit approach, where concrete tools, techniques, and knowledge were offered, as well as a

therapeutic relationship consisting of predictable and safe therapists. In contrast, the MBT informants spoke about a long-lasting process of procedural learning, focused on mentalizing abilities through exploration of past and present as well as describing a therapeutic relationship where the therapist followed the patient's lead. Hence, the change narratives received by the two groups of informants seemed strongly influenced by the culture, myths, rationales, explanations, and procedures represented in the treatment they received. When considering the experienced impact of psychotherapy, the culturally embedded change narrative, and how it is created and conveyed, seems to strongly influence the impact of the received treatment. This is in line with the five essential elements proposed by the CF approach. As this is one of the first studies, that we are aware of, that specifically target the change narrative, further studies seem in strong need.

References

Allen, J. G., & Fonagy, P. (Eds.). (2006). *Handbook of Mentalization-Based Treatment*. John Wiley & Sons, Ltd. https://doi.org/10.1002/9780470712986

American Psychiatric Association (Ed.). (2013). *Desk reference to the diagnostic criteria from DSM-5*. American Psychiatric Publishing.

Anderson, T., Ogles, B., Patterson, C., Michael, L., & Vermeersch, D. (2009). Therapist Effects: Facilitative Interpersonal Skills as a Predictor of Therapist Success. *Journal of Clinical Psychology*, *65*, 755–768. https://doi.org/10.1002/jclp.20583

Axelrod, S. R., Perepletchikova, F., Holtzman, K., & Sinha, R. (2011). Emotion regulation and substance use frequency in women with substance dependence and borderline personality disorder receiving dialectical behavior therapy. *The American Journal of Drug and Alcohol Abuse*, *37*(1), 37–42. https://doi.org/10.3109/00952990.2010.535582

Bales, D., van Beek, N., Smits, M., Willemsen, S., Busschbach, J. J. V., Verheul, R., & Andrea, H. (2012). Treatment outcome of 18-month, day hospital mentalization-based treatment (MBT) in patients with severe borderline personality disorder in the Netherlands. *Journal of Personality Disorders*, *26*(4), 568–582. https://doi.org/10.1521/pedi.2012.26.4.568

Balestrieri, M., Zuanon, S., Pellizzari, J., Zappoli-Thyrion, E., Ciano, R., & ResT-MBT. (2015). Mentalization in eating disorders: A preliminary trial comparing mentalization-based treatment (MBT) with a psychodynamic-oriented treatment. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *20*(4), 525–528. https://doi.org/10.1007/s40519-015-0204-1

Barnicot, K., Gonzalez, R., McCabe, R., & Priebe, S. (2016). Skills use and common treatment processes in dialectical behaviour therapy for borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, *52*, 147–156. https://doi.org/10.1016/j.jbtep.2016.04.006

Bateman, A., Campbell, C., Luyten, P., & Fonagy, P. (2018). A mentalization-based approach to common factors in the treatment of borderline personality disorder. *Current Opinion in Psychology*, *21*, 44–49. https://doi.org/10.1016/j.copsyc.2017.09.005

Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *The American Journal of Psychiatry*, *156*(10), 1563–1569. https://doi.org/10.1176/ajp.156.10.1563

Bateman, A., & Fonagy, P. (2003). Health service utilization costs for borderline personality disorder patients treated with psychoanalytically oriented partial hospitalization versus general psychiatric care. *The American Journal of Psychiatry*, *160*(1), 169–171. https://doi.org/10.1176/appi.ajp.160.1.169

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry*, *9*(1), 11–15. https://doi.org/10.1002/j.2051-5545.2010.tb00255.x

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

Bateman, A. W., & Fonagy, P. (2004). Mentalization-Based Treatment of BPD. *Journal of Personality Disorders*, *18*(1), 36–51. https://doi.org/10.1521/pedi.18.1.36.32772

Berge, T., & Repål, A. (2015). *Håndbok i kognitiv terapi*. Gyldendal Akademisk.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bloom, J. M., Woodward, E. N., Susmaras, T., & Pantalone, D. W. (2012). Use of Dialectical Behavior Therapy in Inpatient Treatment of Borderline Personality Disorder: A Systematic Review. *Psychiatric Services*, *63*(9), 881–888. https://doi.org/10.1176/appi.ps.201100311

Bo, S., Sharp, C., Beck, E., Pedersen, J., Gondan, M., & Simonsen, E. (2017). First empirical evaluation of outcomes for mentalization-based group therapy for adolescents with BPD. *Personality Disorders*, *8*(4), 396–401. https://doi.org/10.1037/per0000210

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252–260. https://doi.org/10.1037/h0085885

Bouchard, M.-A., Target, M., Lecours, S., Fonagy, P., Tremblay, L.-M., Schachter, A., & Stein, H. (2008). Mentalization in adult attachment narratives: Reflective functioning, mental states, and affect elaboration compared. *Psychoanalytic Psychology*, *25*(1), 47–66. https://doi.org/10.1037/0736-9735.25.1.47

Budd, R., & Hughes, I. (2009). The Dodo Bird Verdict—controversial, inevitable and important: A commentary on 30 years of meta-analyses. *Clinical Psychology & Psychotherapy*, *16*(6), 510–522. https://doi.org/10.1002/cpp.648

Byrne, G., & Egan, J. (2018). A Review of the Effectiveness and Mechanisms of Change for Three Psychological Interventions for Borderline Personality Disorder. *Clinical Social Work Journal*, *46*(3), 174–186. https://doi.org/10.1007/s10615-018-0652-y

Campbell, K., & Lakeman, R. (2021). Borderline Personality Disorder: A Case for the Right Treatment, at the Right Dose, at the Right Time. *Issues in Mental Health Nursing*, *42*(6), 608–613. https://doi.org/10.1080/01612840.2020.1833119

Carroll, L., & Bond, A. (1865/2015). *Alice's adventures in wonderland*. Puffin Books.

Choi-Kain, L. W., Albert, E. B., & Gunderson, J. G. (2016). Evidence-Based Treatments for Borderline Personality Disorder: Implementation, Integration, and Stepped Care. *Harvard Review of Psychiatry*, *24*(5), 342–356. https://doi.org/10.1097/HRP.0000000000000113

Cristea, I. A., Gentili, C., Cotet, C. D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). Efficacy of Psychotherapies for Borderline Personality Disorder: A Systematic Review and Meta-analysis. *JAMA Psychiatry*, *74*(4), 319–328. https://doi.org/10.1001/jamapsychiatry.2016.4287

De Meulemeester, C., Vansteelandt, K., Luyten, P., & Lowyck, B. (2017). Mentalizing as a Mechanism of Change in the Treatment of Patients With Borderline Personality Disorder: A Parallel Process Growth Modeling Approach. *Personality Disorders: Theory, Research, and Treatment*, *9*. https://doi.org/10.1037/per0000256

DeCou, C. R., Comtois, K. A., & Landes, S. J. (2019). Dialectical Behavior Therapy Is Effective for the Treatment of Suicidal Behavior: A Meta-Analysis. *Behavior Therapy*, *50*(1), 60–72. https://doi.org/10.1016/j.beth.2018.03.009

Dragioti, E., Dimoliatis, I., Fountoulakis, K. N., & Evangelou, E. (2015). A systematic appraisal of allegiance effect in randomized controlled trials of psychotherapy. *Annals of General Psychiatry*, *14*(1), 1–9. https://doi.org/10.1186/s12991-015-0063-1

Dyson, H., & Brown, D. (2016). The Experience of Mentalization-Based Treatment: An Interpretative Phenomenological Study. *Issues in Mental Health Nursing*, *37*(8), 586–595. https://doi.org/10.3109/01612840.2016.1155246

Ellison, W. (2020). Psychotherapy for Borderline Personality Disorder: Does the Type of Treatment Make a Difference? *Current Treatment Options in Psychiatry*, *7*(3), 416–428. https://doi.org/10.1007/s40501-020-00224-w

Enck, P., & Zipfel, S. (2019). Placebo Effects in Psychotherapy: A Framework. *Frontiers in Psychiatry*, *10*, 456. https://doi.org/10.3389/fpsyt.2019.00456

Engward, H., & Goldspink, S. (2020). Lodgers in the house: Living with the data in interpretive phenomenological analysis research. *Reflective Practice*, *21*(1), 41–53. https://doi.org/10.1080/14623943.2019.1708305

Falkenström, F., Granström, F., & Holmqvist, R. (2013). Therapeutic alliance predicts symptomatic improvement session by session. *Journal of Counseling Psychology*, *60*(3), 317. https://doi.org/10.1037/a0032258

Falkenström, F., & Larsson, M. H. (2017). The Working Alliance: From Global Outcome Prediction to Micro-Analyses of Within-Session Fluctuations. *Psychoanalytic Inquiry*, *37*(3), 167–178. https://doi.org/10.1080/07351690.2017.1285186

Feigenbaum, J. (2007). Dialectical behaviour therapy: An increasing evidence base. *Journal of Mental Health*, *16*(1), 51–68. https://doi.org/10.1080/09638230601182094

Finsrud, I., Nissen-Lie, H. A., Vrabel, K., Høstmælingen, A., Wampold, B. E., & Ulvenes, P. G. (2022). It's the therapist and the treatment: The structure of common therapeutic relationship factors. *Psychotherapy Research*, *32*(2), 139–150. https://doi.org/10.1080/10503307.2021.1916640

Flückiger, C. (2022). Alliance. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/j.cbpra.2022.02.013

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316. https://doi.org/10.1037/pst0000172

Folmo, E. (2022). *Pedagogical stance in mentalization-based treatment—Folmo—- Journal of Clinical Psychology—Wiley Online Library*. https://onlinelibrary.wiley.com/doi/full/10.1002/jclp.23335

Folmo, E. J. (2021). *Measuring MBT - A marriage of the common and specific psychotherapy factors* [Doctoral dissertation]. University of Oslo.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, *51*(3), 372–380. https://doi.org/10.1037/a0036505

Fonagy, P., & Bateman, A. (2008). The Development of Borderline Personality Disorder—A Mentalizing Model. *Journal of Personality Disorders*, *22*(1), 4–21. https://doi.org/10.1521/pedi.2008.22.1.4

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self* (pp. xiii, 577). Other Press.

Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic Petrification and the Restoration of Epistemic Trust: A New Conceptualization of Borderline Personality Disorder and Its Psychosocial Treatment. *Journal of Personality Disorders*, *29*(5), 575–609. https://doi.org/10.1521/pedi.2015.29.5.575

Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2017). What we have changed our minds about: Part 2. Borderline personality disorder, epistemic trust and the developmental significance of social communication. *Borderline Personality Disorder and Emotion Dysregulation*, *4*(1), 1–13. https://doi.org/10.1186/s40479-017-0062-8

Fonagy, P., Luyten, P., & Bateman, A. (2015). Translation: Mentalizing as treatment target in borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment*, *6*(4), 380–392. https://doi.org/10.1037/per0000113

Fonagy, P., & Target, M. (1996). Playing with reality: I. Theory of mind and the normal development of psychic reality. *International Journal of Psycho-Analysis*, *77*, 217–233.

Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective-functioning manual, version 5.0, for application to adult attachment interviews*. University College London.

Frank, J. D., & Frank, J. B. A. (1993). *Persuasion and healing: A comparative study of psychotherapy* (Third Edition). The Johns Hopkins University Press.

Freud, S. (1953). Psychical treatment. In J. Strachey (Ed.), *Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume VII (1901-1905): A Case of Hysteria, Three Essays on Sexuality and Other Works*. Hogarth Press.

Garred, S., & Gough, E. M. (2021). *Den terapeutiske relasjonen i DBT og MBT* [Master's thesis, University of Oslo]. http://urn.nb.no/URN:NBN:no-90056

Gillespie, C., Murphy, M., Kells, M., & Flynn, D. (2022). Individuals who report having benefitted from dialectical behaviour therapy (DBT): A qualitative exploration of processes and experiences at long-term follow-up. *Borderline Personality Disorder and Emotion Dysregulation*, *9*(1), 1–14. https://doi.org/10.1186/s40479-022-00179-9

Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist*, *35*(11), 991. https://doi.org/10.1037/0003-066X.35.11.991

Goldfried, M. R. (2016). On possible consequences of National Institute of Mental Health funding for psychotherapy research and training. *Professional Psychology: Research and Practice*, *47*(1), 77–83. https://doi.org/10.1037/pro0000034

Gunderson, J. G., Zanarini, M. C., Choi-Kain, L. W., Mitchell, K. S., Jang, K. L., & Hudson, J. I. (2011). Family study of borderline personality disorder and its sectors of psychopathology. *Archives of General Psychiatry*, *68*(7), 753–762. https://doi.org/10.1001/archgenpsychiatry.2011.65

Haavind, H. (2019). Livsformsintervjuet: En veiviser til subjektive erfaringer. In *Hverdagsliv, barndom og oppvekst. Teoretiske posisjoner og metodiske grep* (pp. 26–56). Universitetsforlaget.

Horvath, A. O., Bedi, R. P., & Norcross, J. C. (2002). The alliance. In J. C. Norcross, *Psychotherapy relationships that work: Therapists contributions and responsiveness to patients* (pp. 37–69). Oxford University Press.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*(2), 139. https://doi.org/10.1037/0022-0167.38.2.139

Howe, L. C., Goyer, J. P., & Crum, A. J. (2017). Harnessing the placebo effect: Exploring the influence of physician characteristics on placebo response. *Health Psychology*, *36*(11), 1074. https://doi.org/10.1037/hea0000499

Howe, L. C., Leibowitz, K. A., & Crum, A. J. (2019). When Your Doctor "Gets It" and "Gets You": The Critical Role of Competence and Warmth in the Patient–Provider Interaction. *Frontiers in Psychiatry*, 475. https://doi.org/10.3389/fpsyt.2019.00475

Humphreys, K. L., & Zeanah, C. H. (2015). Deviations from the Expectable Environment in Early Childhood and Emerging Psychopathology. *Neuropsychopharmacology*, *40*(1), 154–170. https://doi.org/10.1038/npp.2014.165

Johnson, E. L., Mutti, M.-F., Springham, N., & Xenophontes, I. (2016). Mentalizing after mentalization based treatment. *Mental Health and Social Inclusion*, *20*(1), 44–51. https://doi.org/10.1108/MHSI-11-2015-0042

Karterud, S. (2012). *Manual for mentaliseringsbasert gruppeterapi (MBT-G)*. Gyldendal akademisk.

Karterud, S. (2013). Emosjoner i mentaliseringsbasert terapi (MBT). *Tidsskrift for Norsk Psykologforening*, *50*(8), 759–764.

Karterud, S., & Bateman, A. (2021). *Manual for mentaliseringsbasert terapi (MBT) og MBT vurderingsskala*. Gyldendal Akademisk.

Karterud, S., Folmo, E., & Kongerslev, M. T. (2020). *Mentaliseringsbasert terapi (MBT)*. Gyldendal Norsk Forlag AS.

Krantz, L. H., McMain, S., & Kuo, J. R. (2018). The unique contribution of acceptance without judgment in predicting nonsuicidal self-injury after 20-weeks of dialectical behaviour therapy group skills training. *Behaviour Research and Therapy*, *104*, 44–50. https://doi.org/10.1016/j.brat.2018.02.006

Kulacaoglu, F., & Kose, S. (2018). Borderline Personality Disorder (BPD): In the Midst of Vulnerability, Chaos, and Awe. *Brain Sciences*, *8*(11), 201. https://doi.org/10.3390/brainsci8110201

Kvarstein, E. H., Pedersen, G., Urnes, Ø., Hummelen, B., Wilberg, T., & Karterud, S. (2015). Changing from a traditional psychodynamic treatment programme to mentalization-based treatment for patients with borderline personality disorder—Does it make a difference? *Psychology and Psychotherapy*, *88*(1), 71–86. https://doi.org/10.1111/papt.12036

Lambert, M. J. (Ed.). (2013). *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed). John Wiley & Sons.

Lambert, M. J., & Archer, A. (2006). Research Findings on the Effects of Psychotherapy and their Implications for Practice. In *Evidence-based psychotherapy: Where practice and research meet* (pp. 111–130). American Psychological Association. https://doi.org/10.1037/11423-005

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 357–361. https://doi.org/10.1037/0033-3204.38.4.357

Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy*, *51*(4), 467. https://doi.org/10.1037/a0034332

Leichsenring, F., Abbass, A., Hilsenroth, M. J., Luyten, P., Munder, T., Rabung, S., & Steinert, C. (2018). "Gold Standards," Plurality and Monocultures: The Need for Diversity in Psychotherapy. *Frontiers in Psychiatry*, *9*, 159. https://doi.org/10.3389/fpsyt.2018.00159

Leichsenring, F., & Steinert, C. (2017). Is Cognitive Behavioral Therapy the Gold Standard for Psychotherapy?: The Need for Plurality in Treatment and Research. *JAMA*, *318*(14), 1323–1334. https://doi.org/10.1001/jama.2017.13737

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. The Guilford Press.

Linehan, M. M. (2014). *DBT® Skills Training Manual* (2nd ed.). The Guilford Press.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., Korslund, K. E., Tutek, D. A., Reynolds, S. K., & Lindenboim, N. (2006). Two-Year Randomized Controlled Trial and Follow-up of Dialectical Behavior Therapy vs Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder. *Archives of General Psychiatry*, *63*(7), 757–766.

Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D., McDavid, J., Comtois, K. A., & Murray-Gregory, A. M. (2015). Dialectical Behavior Therapy for High Suicide Risk in Individuals With Borderline Personality Disorder: A Randomized Clinical Trial and Component Analysis. *JAMA Psychiatry*, *72*(5), 475–482. https://doi.org/10.1001/jamapsychiatry.2014.3039

Little, H., Tickle, A., & das Nair, R. (2018). Process and impact of dialectical behaviour therapy: A systematic review of perceptions of clients with a diagnosis of borderline personality disorder. *Psychology and Psychotherapy*, *91*(3), 278–301. https://doi.org/10.1111/papt.12156

Lonargáin, D. Ó., Hodge, S., & Line, R. (2017). Service user experiences of mentalisation-based treatment for borderline personality disorder. *Mental Health Review Journal*, *22*(1), 16–27. https://doi.org/10.1108/MHRJ-04-2016-0008

Lorentzen, S., Rønnestad, M. H., & Orlinsky, D. (2011). Sources of influence on the professional development of psychologists and psychiatrists in Norway and Germany. *European Journal of Psychotherapy & Counselling*, *13*(2), 141–152. https://doi.org/10.1080/13642537.2011.570016

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T. P., Berman, J. S., Levitt, J. T., Seligman, D. A., & Krause, E. D. (2002). The dodo bird verdict is alive and well—Mostly. *Clinical Psychology: Science and Practice*, *9*(1), 2–12. https://doi.org/10.1093/clipsy.9.1.2

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative Studies of Psychotherapies: Is It True That "Everyone Has Won and All Must Have Prizes"? *Archives of General Psychiatry*, *32*(8), 995–1008. https://doi.org/10.1001/archpsyc.1975.01760260059004

MacMillan, C. (2020). Mentalization-Based Treatment Plays Well with Others. In L. Williams & O. Muir, *Adolescent Suicide and Self-Injury* (pp. 99–108). Springer. https://doi-org.ezproxy.uio.no/10.1007/978-3-030-42875-4_7

Marcus, D. K., O'Connell, D., Norris, A. L., & Sawaqdeh, A. (2014). Is the Dodo bird endangered in the 21st century? A meta-analysis of treatment comparison studies.

Clinical Psychology Review, *34*(7), 519–530. https://doi.org/10.1016/j.cpr.2014.08.001

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*(3), 438–450. https://doi.org/10.1037/0022-006X.68.3.438

Maxwell, J. A., & Chmiel, M. (2014). Generalization in and from Qualitative Analysis. In U. Flick, *The SAGE Handbook of Qualitative Data Analysis* (pp. 540–553). SAGE Publications Ltd. https://doi.org/10.4135/9781446282243.n37

McKay, M., Wood, J. C., & Brantley, J. (2019). *The Dialectical Behavior Therapy Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance* (2nd ed.). New Harbinger Publications.

McMain, S., Korman, L. M., & Dimeff, L. (2001). Dialectical behavior therapy and the treatment of emotion dysregulation. *Journal of Clinical Psychology*, *57*(2), 183–196. https://doi.org/10.1002/1097-4679(200102)57:2<183::AID-JCLP5>3.0.CO;2-Y

McSherry, P., O'Connor, C., Hevey, D., & Gibbons, P. (2012). Service user experience of adapted dialectical behaviour therapy in a community adult mental health setting. *Journal of Mental Health*, *21*(6), 539–547. https://doi.org/10.3109/09638237.2011.651660

McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. Guilford Press.

Mehlum, L. (2021). Mechanisms of change in dialectical behaviour therapy for people with borderline personality disorder. *Current Opinion in Psychology*, *37*, 89–93. https://doi.org/10.1016/j.copsyc.2020.08.017

Mehlum, L., Ramberg, M., Tørmoen, A. J., Haga, E., Diep, L. M., Stanley, B. H., Miller, A. L., Sund, A. M., & Grøholt, B. (2016). Dialectical Behavior Therapy Compared With Enhanced Usual Care for Adolescents With Repeated Suicidal and Self-Harming Behavior: Outcomes Over a One-Year Follow-Up. *Journal of the American Academy of Child and Adolescent Psychiatry*, *55*(4), 295–300. https://doi.org/10.1016/j.jaac.2016.01.005

Mehlum, L., Ramleth, R.-K., Tørmoen, A. J., Haga, E., Diep, L. M., Stanley, B. H., Miller, A. L., Larsson, B., Sund, A. M., & Grøholt, B. (2019). Long term effectiveness of dialectical behavior therapy versus enhanced usual care for adolescents with self-

harming and suicidal behavior. *Journal of Child Psychology and Psychiatry*, *60*(10), 1112–1122. https://doi.org/10.1111/jcpp.13077

Mehlum, L., Tørmoen, A. J., Ramberg, M., Haga, E., Diep, L. M., Laberg, S., Larsson, B. S., Stanley, B. H., Miller, A. L., Sund, A. M., & Grøholt, B. (2014). Dialectical Behavior Therapy for Adolescents With Repeated Suicidal and Self-harming Behavior: A Randomized Trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *53*(10), 1082–1091. https://doi.org/10.1016/j.jaac.2014.07.003

Morken, K. T. E., Binder, P. E., Arefjord, N., & Karterud, S. (2019a). Juggling thoughts and feelings: How do female patients with borderline symptomology and substance use disorder experience change in mentalization-based treatment? *Psychotherapy Research*, *29*(2), 251–266. https://doi.org/10.1080/10503307.2017.1325021

Morken, K. T. E., Binder, P.-E., Arefjord, N. M., & Karterud, S. W. (2019b). Mentalization-Based Treatment From the Patients' Perspective – What Ingredients Do They Emphasize? *Frontiers in Psychology*, *10*, 1327. https://doi.org/10.3389/fpsyg.2019.01327

Muir, O. (2020). Mentalizing Crisis Management of Suicide and Self-Injurious Behavior. In L. L. Williams & O. Muir (Eds.), *Adolescent Suicide and Self-Injury* (pp. 109–124). Springer International Publishing. https://doi.org/10.1007/978-3-030-42875-4_8

Nissen-Lie, H. A. (2013). Teknikk eller relasjon i psykoterapi—En uhensiktsmessig dikotomi? In *God Psykoterapi* (pp. 316–337). Pax forlag.

Nissen-Lie, H. A., Monsen, J. T., & Rønnestad, M. H. (2010). Therapist predictors of early patient-rated working alliance: A multilevel approach. *Psychotherapy Research*, *20*(6), 627–646. https://doi.org/10.1080/10503307.2010.497633

Nissen-Lie, H. A., Rønnestad, M. H., Høglend, P. A., Havik, O. E., Solbakken, O. A., Stiles, T. C., & Monsen, J. T. (2017). Love Yourself as a Person, Doubt Yourself as a Therapist? *Clinical Psychology & Psychotherapy*, *24*(1), 48–60. https://doi.org/10.1002/cpp.1977

Nissen-Lie, H., Oddli, H., & Wampold, B. (2013). Fellesfaktordebatt på ville veier. *Tidsskrift for Norsk Psykologforening*, *50*(5), 489–491.

Norsk Psykologforening. (2007). *Prinsipperklæringen om evidensbasert praksis*. https://www.psykologforeningen.no/medlem/evidensbasert-praksis/prinsipperklaering-1-om-evidensbasert-psykologisk-praksis-2

Oldham, J. M., Skodol, A. E., Bender, D. S., & American Psychiatric Publishing (Eds.). (2014). *The American Psychiatric Publishing textbook of personality disorders*

(Second edition). American Psychiatric Publishing, a Division of American Psychiatric Association.

Orlinsky, D., & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth.* American Psychological Association. https://doi.org/10.1037/11157-000

Orlinsky, D., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of process-outcome research: Continuity and change. *Handbook of Psychotherapy and Behavior Change*, 307–390.

Orme, W., Bowersox, L., Vanwoerden, S., Fonagy, P., & Sharp, C. (2019). The relation between epistemic trust and borderline pathology in an adolescent inpatient sample. *Borderline Personality Disorder and Emotion Dysregulation*, *6*(1), 1–9. https://doi.org/10.1186/s40479-019-0110-7

Oud, M., Arntz, A., Hermens, M. L., Verhoef, R., & Kendall, T. (2018). Specialized psychotherapies for adults with borderline personality disorder: A systematic review and meta-analysis. *Australian & New Zealand Journal of Psychiatry*, *52*(10), 949–961. https://doi.org/10.1177/0004867418791257

Paris, J. (2016). Kronisk suicidalitet ved ustabil personlighetsforstyrrelse: Hvorfor det er behov for særskilte tilnærminger i behandlingen. *Suicidologi*, *21*(3), Article 3. https://doi.org/10.5617/suicidologi.4101

Paris, J., & Zweig-Frank, H. (2001). A 27-year follow-up of patients with borderline personality disorder. *Comprehensive Psychiatry*, *42*(6), 482–487. https://doi.org/10.1053/comp.2001.26271

Pompili, M., Girardi, P., Ruberto, A., & Tatarelli, R. (2005). Suicide in borderline personality disorder: A meta-analysis. *Nordic Journal of Psychiatry*, *59*(5), 319–324. https://doi.org/10.1080/08039480500320025

Ritschel, L. A., Lim, N. E., & Stewart, L. M. (2015). Transdiagnostic Applications of DBT for Adolescents and Adults. *American Journal of Psychotherapy*, *69*(2), 111–128. https://doi.org/10.1176/appi.psychotherapy.2015.69.2.111

Rosenthal, R., & Rubin, D. B. (1978). Interpersonal expectancy effects: The first 345 studies. *Behavioral and Brain Sciences*, *1*(3), 377–386. https://doi.org/10.1017/S0140525X00075506

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, *6*(3), 412–415. https://doi.org/10.1111/j.1939-0025.1936.tb05248.x

Rossouw, T. I., & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, *51*(12), 1304-1313.e3. https://doi.org/10.1016/j.jaac.2012.09.018

Rudge, S., Feigenbaum, J. D., & Fonagy, P. (2020). Mechanisms of change in dialectical behaviour therapy and cognitive behaviour therapy for borderline personality disorder: A critical review of the literature. *Journal of Mental Health (Abingdon, England)*, *29*(1), 92–102. https://doi.org/10.1080/09638237.2017.1322185

Ruocco, A. C., & Carcone, D. (2016). A Neurobiological Model of Borderline Personality Disorder: Systematic and Integrative Review. *Harvard Review of Psychiatry*, *24*(5), 311–329. https://doi.org/10.1097/HRP.0000000000000123

Schafer, R. (1983). *The Analytic Attitude*. Routledge.

Sharp, C., Shohet, C., Givon, D., Penner, F., Marais, L., & Fonagy, P. (2020). Learning to mentalize: A mediational approach for caregivers and therapists. *Clinical Psychology: Science and Practice*, *27*(3), 50. https://doi.org/10.1111/cpsp.12334

Skårderud, F. (2015). Terapiens essens: Om mentalisering og mentaliseringsbasert terapi. In R. Ulberg, A. G. Hersoung, & Knutsen (Eds.), *Psykoterapi i utvikling* (2nd ed., pp. 173–189). Fagbokforlaget Vigmostad & Bjørke AS.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. SAGE Publications Ltd.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain*, *9*(1), 41–42. https://doi.org/10.1177/2049463714541642

Soloff, P. H., & Chiappetta, L. (2017). Suicidal behavior and psychosocial outcome in Borderline Personality Disorder at 8-year follow-up. *Journal of Personality Disorders*, *31*(6), 774–789. https://doi.org/10.1521/pedi_2017_31_280

Sperber, D., Clément, F., Heintz, C., Mascaro, O., Mercier, H., Origgi, G., & Wilson, D. (2010). Epistemic vigilance. *Mind & Language*, *25*(4), 359–393. https://doi.org/10.1111/j.1468-0017.2010.01394.x

Spinhoven, P., Giesen-Bloo, J., van Dyck, R., Kooiman, K., & Arntz, A. (2007). The therapeutic alliance in schema-focused therapy and transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, *75*(1), 104. https://doi.org/10.1037/0022-006X.75.1.104

Stoffers-Winterling, J. M., Völlm, B. A., Rücker, G., Timmer, A., Huband, N., & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. *The Cochrane Database of Systematic Reviews*, *8*. https://doi.org/10.1002/14651858.CD005652.pub2

Stone, M. (1990). *The Fate of Borderline Patients: Successful Outcome and Psychiatric Practice*. Guilford Press. https://ps.psychiatryonline.org/doi/abs/10.1176/ps.42.2.202-a

Swenson, C. R., & Choi-Kain, L. W. (2015). Mentalization and Dialectical Behavior Therapy. *American Journal of Psychotherapy*, *69*(2), 199–217. https://doi.org/10.1176/appi.psychotherapy.2015.69.2.199

Torgersen, S. (2009). The nature (and nurture) of personality disorders. *Scandinavian Journal of Psychology*, *50*(6), 624–632. https://doi.org/10.1111/j.1467-9450.2009.00788.x

Ulvenes, P. G., Berggraf, L., Hoffart, A., Stiles, T. C., Svartberg, M., McCullough, L., & Wampold, B. E. (2012). Different processes for different therapies: Therapist actions, therapeutic bond, and outcome. *Psychotherapy*, *49*(3), 291. https://doi.org/10.1037/a0027895

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings* (pp. xiii, 263). Lawrence Erlbaum Associates Publishers.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277. https://doi.org/10.1002/wps.20238

Wampold, B. E. (2021). Healing in a Social Context: The Importance of Clinician and Patient Relationship. *Frontiers in Pain Research*, *2*, 684768. https://doi.org/doi: 10.3389/fpain.2021.684768

Wampold, B. E., & Brown, G. S. (Jeb). (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology*, *73*(5), 914–923. https://doi.org/10.1037/0022-006X.73.5.914

Wampold, B. E., & Budge, S. L. (2012). The 2011 Leona Tyler Award Address: The Relationship—and Its Relationship to the Common and Specific Factors of Psychotherapy. *The Counseling Psychologist*, *40*(4), 601–623. https://doi.org/10.1177/0011000011432709

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work, 2nd ed* (pp. x, 323). Routledge.

Wampold, B. E., Imel, Z. E., & Minami, T. (2007). The placebo effect: "Relatively large" and "robust" enough to survive another assault. *Journal of Clinical Psychology*, *63*(4), 401–403. https://doi.org/10.1002/jclp.20350

Wilberg, T. (2002). Modeller for forståelse av personlighetspatologi. *Tidsskrift for Den norske legeforening*, *122*, 54–58.

Williams, L. (2020). Core Mentalizing Techniques. In L. Williams & O. Muir (Eds.), *Adolescent Suicide and Self-Injury* (pp. 17–29). Springer International Publishing. https://doi.org/10.1007/978-3-030-42875-4_2

Winograd, G., Cohen, P., & Chen, H. (2008). Adolescent borderline symptoms in the community: Prognosis for functioning over 20 years. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, *49*(9), 933–941. https://doi.org/10.1111/j.1469-7610.2008.01930.x

Yalch, M. M., Hopwood, C. J., Fehon, D. C., & Grilo, C. M. (2014). The influence of borderline personality features on inpatient adolescent suicide risk. *Personality Disorders: Theory, Research, and Treatment*, *5*(1), 26. https://doi.org/10.1037/per0000027

Yardley, L. (2007). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 235–251). SAGE Ltd.

Zanarini, M. C. (2009). Psychotherapy of borderline personality disorder. *Acta Psychiatrica Scandinavica*, *120*(5), 373–377. https://doi.org/10.1111/j.1600-0447.2009.01448.x

Zeifman, R. J., Boritz, T., Barnhart, R., Labrish, C., & McMain, S. F. (2020). The independent roles of mindfulness and distress tolerance in treatment outcomes in dialectical behavior therapy skills training. *Personality Disorders*, *11*(3), 181–190. https://doi.org/10.1037/per0000368

Zilcha-Mano, S., Roose, S. P., Brown, P. J., & Rutherford, B. R. (2019). Not Just Nonspecific Factors: The Roles of Alliance and Expectancy in Treatment, and Their Neurobiological Underpinnings. *Frontiers in Behavioral Neuroscience*, *12*, 293. https://doi.org/10.3389/fnbeh.2018.00293

Appendices

Appendix A: Invitation letter

Invitasjon om å delta i forskningsprosjekt

Har du gått i dialektisk atferdsterapi eller mentaliseringsbasert terapi for emosjonelt ustabil personlighetsforstyrrelse, eller en annen personlighetsforstyrrelse med lignende vansker? Da ønsker vi å ha deg med i vårt forskningsprosjekt til vår hovedoppgave på profesjonsstudiet i psykologi ved Universitetet i Oslo. Vi søker deg som har avsluttet behandlingen for ca tre til fem år siden, og er trygg på å snakke om hvordan det var for deg.

Deltakelse vil innebære et intervju med en av oss på omtrent en time, hvor vi gjerne vil vite hva du opplevde som viktig i terapi, eventuelt om det var noe som ikke fungerte. Deltakelse er basert på skriftlig informert samtykke.

Resultatene fra studien vil bli brukt i en hovedoppgave på profesjonsstudiet i psykologi, som senere kan bli til en artikkel som kan publiseres i internasjonale tidsskrifter. Ingen vil kunne spore informasjonen tilbake til deg, og ingen andre enn de i prosjektgruppen vil ha tilgang til informasjon om deg. Deltakelsen er frivillig og du har mulighet til å trekke deg fra prosjektet frem til datamaterialet har inngått i analyser.

Vi tror at du som har vært gjennom et behandlingsforløp i DBT eller MBT sitter på verdifull kunnskap som kan bidra til bedre forståelse blant helsepersonell om hvordan terapi faktisk oppleves. Dette kan bidra til å styrke tjenestene som tilbys mennesker med lignende utfordringer som du selv har kjent på.

Hvis du synes dette høres interessant ut, eller ønsker mer informasjon, kan du ta kontakt med oss på telefon, sms eller e-post:

Kontakt Astrid Hermann Tobiassen og Thea Sundal
E-post: [redacted]
Mobil: [redacted]

Vi håper du har lyst til å delta i prosjektet vårt!

Vennlig hilsen
Thea Sundal og Astrid Hermann Tobiassen

Appendix B: Letter of consent

Samtykke- DBT/MBT

Obligatoriske felter er merket med stjerne *

Forespørsel om deltakelse i forskningsprosjektet

Likheter og forskjeller i tidligere pasienters opplevelser av meningsfull endring i etterkant av terapiforløp med henholdsvis MBT og DBT for Borderline personlighetsforstyrrelse.

Bakgrunn

Dette er et spørsmål til deg om å delta i en forskningsstudie. Vi søker deg som har gått i Dialektisk atferdsterapi (DBT) eller Mentaliseringsbasert terapi (MBT), og som har et avklart forhold til den behandlingen du fikk. Altså at du er komfortabel med å snakke om og reflektere rundt den behandlingen du har fått, og at du har et bilde av hva behandlingen har gitt deg, eller hva den ikke har gitt deg. Vi ønsker gjerne å snakke med deg for å finne ut hvordan terapien hjalp deg, og hvordan den ikke hjalp, og på hvilken måte dette skjedde. Du får invitasjon fordi du på et tidligere tidspunkt har møtt kriteriene for F60.3 Emosjonelt ustabil personlighetsforstyrrelse (EUPF) eller en annen personlighetsforstyrrelse, og har gått i MBT eller DBT.

Psykoterapiforskning viser at både MBT og DBT har effekt i behandling av pasienter med personlighetsforstyrrelser. Formålet med studien er å belyse hva tidligere pasienter diagnostisert med EUPF har opplevd som endringsbevirkende i de to ulike behandlingsmetodene. Vi vil dybdeintervjue om lag 5-10 individer som har gått i MBT og 5-10 individer som har gått i DBT. Resultatene av studien vil kunne bidra inn i forståelsen av hva pasientene selv opplever som nyttig i behandling.

Prosjektgruppen

Prosjektet er først og fremst et studentprosjekt ved profesjonsstudiet i psykologi ved Universitetet i Oslo. Universitetet i Oslo er behandlingsansvarlig institusjon. Dataene er grunnlaget for studentene, Thea Sundal og Astrid Hermann Tobiassen, sitt hovedoppgaveprosjekt. Hovedveileder for prosjektet er psykologspesialist og førsteamanuensis ved Psykologisk Institutt, Erik Stänicke. Biveileder er Espen Folmo, psykolog og ansvarlig for MBT Kvalitetslaboratorium ved Nasjonal kompetansetjeneste for personlighetspsykiatri (NAPP). Medlemmene av prosjektgruppen vil ha tilgang til informasjonen som innhentes fra deg.

Hva innebærer studien?

For deg som deltar i studien vil deltakelse innebære et intervju på omtrent 60–90 minutter. Intervjuene vil tas opp med en diktafonapp, som automatisk krypteres og sendes til prosjektmedarbeidernes område i Tjenester for sensitive data (TSD). Vi ønsker gjerne å snakke med deg for å finne ut hvordan terapien hjalp deg, hvis den hjalp, og på hvilken måte dette skjedde. Vi søker å forstå hvordan disse terapiformene virker, for dem de virker for. Resultatene fra studien vil først og fremst brukes i en hovedoppgave, som senere kan føre til en artikkel publisert i internasjonale tidsskrifter. Da vi vil anonymisere og avidentifisere all informasjonen om deg, så vil det heller ikke kunne spores tilbake til deg. Ingen, verken tidligere terapeuter eller medpasienter vil vite hvem du er.

Mulige fordeler og ulemper

Du vil ikke ha noen spesielle fordeler av studien, men erfaringer fra studien vil senere kunne hjelpe andre terapeuter i sitt arbeid med pasienter i psykisk helsevern, og kunne komme andre pasienter til gode.

Hva skjer med informasjonen om deg

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Informasjonen om deg, inkludert intervjumaterialet, vil lagres på en sikker måte i henhold til Universitetet i Oslo sine retningslinjer for personvern og oppbevaring av data, samt i henhold til norsk lov om behandling av personopplysninger. Alle opplysningene vil bli behandlet uten navn og fødselsnummer, og direkte gjenkjennende opplysninger vil avidentifiseres. En kode knytter deg til dine opplysninger gjennom en navneliste. Det er kun autorisert personell knyttet til prosjektet som har adgang til materiale og navnelisten, og som kan finne tilbake til deg. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres. Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner. Opplysningene som registreres om deg skal kun brukes slik som beskrevet under formålet med prosjektet, og planlegges brukt til 01.01.2023.

Av dokumentasjons- og oppfølgingshensyn skal opplysningene likevel bevares inntil 01.07.2028. Opplysningene skal lagres avidentifisert, dvs. atskilt i en nøkkel- og en opplysningsfil. Opplysningene skal deretter slettes eller anonymiseres, senest innen et halvt år fra nevnte dato.

Vi behandler opplysninger om deg basert på ditt samtykke.

Frivillig deltakelse

Det er frivillig å delta i studien. Dersom du ikke ønsker å delta, trenger du ikke å oppgi noen grunn, og det får ingen konsekvenser for deg. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på neste side. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten noen konsekvenser for deg.

Dersom du senere ønsker å trekke deg, kan du kontakte Thea Sundal [redacted] Astrid Hermann Tobiassen [redacted] Espen Folmo [redacted] eller Erik Stänicke [redacted]

Forsikring

Særskilt forsikring (Universitetet i Oslo er selvassurandør).

Godkjenning

Prosjektet er godkjent av Regional etisk komite (REK) Søknadsnummer: 280677. Tillatelsen gjelder frem til 01.01.23. På oppdrag fra Universitetet i Oslo har Norsk senter for forskningsdata (NSD) vurdert at behandlingen av personopplysningene i dette prosjektet er i samsvar med personvernregelverket.

Etter ny personopplysningslov har dataansvarlig og prosjektleder Erik Stänicke et selvstendig ansvar for å sikre at behandlingen av dine opplysninger har et lovlig grunnlag. Dette prosjektet har rettslig grunnlag i EUs personvernforordning artikkel 6 nr. 1a og artikkel 9 nr. 2a, og ditt samtykke.

Du har rett til å klage på behandlingen av dine opplysninger til Datatilsynet.

Kontaktopplysninger

Dersom du har spørsmål til prosjektet, eller ønsker å benytte deg av dine rettigheter, kan du ta kontakt med Thea Sundal [redacted] eller Astrid Hermann Tobiassen [redacted]

Personvernombud ved institusjonen er personvernombud@uio.no.

Hvis du har spørsmål knyttet til NSD sin vurdering av prosjektet, kan du ta kontakt med NSD – Norsk senter for forskningsdata AS på epost (personverntjenester@nsd.no) eller på telefon: 55 58 21 17.

Med vennlig hilsen

Thea Sundal og Astrid Hermann Tobiassen

Studenter, Universitetet i Oslo

Erik Stăncike
Hovedveileder, prosjektleder og dataansvarlig
Førsteamanuensis, Universitetet i Oslo

Espen Folmo
Biveileder
Psykolog og ansvarlig for MBT kvalitetslaboratorium NAPP

Sideskift

Obligatoriske felter er merket med stjerne *

Ditt fødselsnummer *

E-postadresse

Telefonnummer

Samtykker du til deltagelse i prosjektet?

- ○ Ja
- ○ Nei / jeg vil trekke tilbake mitt samtykke

Dersom du ikke ønsker å bli med i prosjektet og ikke har samtykket tidligere, kan du lukke din nettleser.

Om du har samtykket tildligere og ønsker å trekke tilbake ditt samtykke, må du signere dette skjema på nytt med BANKID hos Postens signeringstjeneste.

For å gi et signert samtykke, blir du videresendt til Postens signeringstjeneste. Her får du lese gjennom samtykket på nytt og kan signere dette digitalt med BANKID.

Etter signering blir du videresendt til spørreskjema.

Etter signering blir det sendt en kopi av samtykket til digitale postkasse. Dette kan ta opptil 1 døgn.

For å endre dette samtykket, kan du logge inn i samtykkeportalen:
https://consent-portal.tsd.usit.no

Appendix C: Interview guide

For en stund siden ble du spurt om å delta i dette intervjuet. Det du forteller er konfidensielt, og det vil ikke være mulig for noen som leser dette til å knytte det tilbake til deg. Innsiktene fra det du sier vil bli brukt i en hovedoppgave i psykologi, og i tillegg til en forskningsartikkel. Som du har fått informasjon om, kan du trekke deg fra dette prosjektet når som helst uten å oppgi noen grunn.

Hensikten med at du og jeg snakker sammen nå er at jeg ønsker å få vite litt om hvordan det var for deg å gå i MBT/DBT. Jeg ønsker å forstå hvordan terapien hjalp deg, hvis den hjalp, og på hvilken måte dette skjedde. Jeg ønsker først å høre litt om livet ditt var før du begynte i terapi. Videre vil jeg høre om hvordan det var for deg å gå i terapi, hva du opplevde at fungerte og hva som fungerte mindre, og til slutt litt om hvordan livet har vært i etterkant av terapien. Intervjuet vil vare mellom 1 og 1,5 time, så vi har god tid. Hvis det er greit for deg, vil jeg gjerne at du forteller meg mest mulig fritt om din erfaring, så hopper jeg inn med eventuelle spørsmål etter hvert. Høres det greit ut?

1. Kan du fortelle litt om deg selv? Relasjoner, familie, venner.
    a. Hvordan er livet ditt nå?
2. Kan du fortelle om hvordan livet ditt var i perioden før du begynte i terapi?
    a. Hva var forventningene dine før du begynte i terapi?
    b. Hva så du på som dine største utfordringer forut for terapien?
3. Hva var bakgrunnen for at du ble henvist til MBT/DBT?
    a. Hadde du hørt om metoden før du begynte i terapi, evt. hva?
4. Hadde du noen tydelige tanker om hva du ønsket å jobbe med i terapi?
    a. Opplevde du at terapeutene forsto hva som var ditt prosjekt?
    b. Var det det dere jobbet med, altså ditt prosjekt?
    c. Hvis nei, hva opplevde du at dere jobbet med i stedet?
5. Fikk du noen nye mål underveis?
6. Hva var dine største utfordringer i terapien?
    a. Hvordan arbeidet dere med disse?
7. Hvilke typer endringer, om noen, opplevde du i behandlingen?
8. Opplevde du å få noen verktøy eller innsikter gjennom terapien som du klarte å bruke i hverdagen?
    a. Skapte disse positiv endring på de områdene i livet som var utfordrende for deg?
    b. Hvis ja, hvordan, hvis nei, hvorfor ikke?
9. Tror du det er en sammenheng mellom den behandlingsmetoden som ble brukt og at dine vansker enten ble bedre eller verre?

10. Er det noe du husker fra terapien som du opplevde/opplever, som spesielt betydningsfullt?
11. Hvis du i dag kunne snakket med den personen du var da du begynte i terapi, hva ville du sagt til den personen da?
12. Var det noe ved terapien du opplevde at ikke var nyttig?
13. Hvordan endret forståelsen din av deg selv i løpet av terapien?
    a. Har noe endret seg i etterkant av terapien?
14. Kan du fortelle litt om hvordan du opplevde kjemien med terapeutene?
    a. Var det noe som endret seg underveis?
    b. Hva var det viktigste terapeuten gjorde?
15. Var det noe i gruppeterapien du opplevde som endringsfremmende?
    a. Hva var det viktigste for deg med de andre pasientene?
16. Svarte terapien til de forventningene du hadde?
17. Hvis du hadde snakket med terapeuten din nå, er det noe du hadde hatt lyst til å si til han eller henne?
18. Er det noe du vil legge til som du tenker er viktig å få med?
19. Har du noen tanker før vi avslutter?
20. Hvordan har det vært å sitte her med meg i dag?

Appendix D: Tables

DBT		
First topic: Before DBT		
Meta-theme	**Themes**	**Sub-themes**
I lacked an understanding of myself, and coped with my struggles destructively	I could not control my inner states	My feelings were overwhelmingly chaotic
		No healthy tools to handle my feelings
	Strategies to deal with overwhelming feelings	Self-harm to get rid of feelings
		Self-harm to avoid being abandoned
		Eating disorders to get rid of feelings
		Withdrawal
First topic: Before DBT		
Meta-theme	**Themes**	**Sub-themes**
My struggles with seeing the situation from an outside perspective	Sensitivity to others' opinion of me	Fear of judgement
		Shame related to other people's perception of me
	I misinterpreted other people	I was sensitive to rejection
		I attributed meanings to others that they did not have
Second topic: During and after DBT		
Meta-theme	**Themes**	**Sub-themes**
Explicit learning of a provided approach specific to my struggles	Learning new ways of understanding myself and others	Looking at the situation objectively
		Learning about feelings
		Working explicitly with self-acceptance and self-care
	Learning new skills to handle my struggles	Learning new tools and repeat to automatize them
		Agency
		DBT more helpful than previous therapies
		Differing experiences with mindfulness
		Positive and negative sides of telephone coaching
Second topic: During and after DBT		
Meta-theme	**Themes**	**Sub-themes**
A predictable program felt safe but less flexible	Lack of flexibility	The therapists could be more willing to adapt to the individual
		Lack of participation from other group members
	Importance of knowing where I had my therapist	Importance of having a plan for the therapeutic work
		Importance of being genuine
		The therapists could reveal something about themselves
		Predictable and safe therapists

MBT		
First topic: Before MBT		
Meta-theme	**Themes**	**Sub-themes**
My life lacked coherence	An incomprehensible self	Empty existence (N=2)
		A life in chaos (N=2)
		I concealed my pain (N=1)
	Harmful ways I dealt with my pain	Suicidal ideation/suicide attempts to handle feelings (N=2)
		Eating disorders as control over feelings (N=1)
		Vague descriptions of self-harm (N=2)
First topic: Before MBT		
Meta-theme	**Themes**	**Sub-themes**
How my problems with mentalization affected myself and others	Challenges with setting boundaries	Let others know (N=2)
		Disproportional aggression (N=1)
	Lack of mentalization	Misinterpretation of others (N=3)
		Lack of capacity for the other (N=1)
		The imagined other (N=1)
Second topic: During and after MBT		
Meta-theme	**Themes**	**Sub-themes**
A long-lasting process of exploring to create procedural learning	Integration of relational experiences	Self-acceptance through exploring how my past has shaped me
		Changing how I perceive myself and the world through exploring takes time
	I understand more of my feelings through an increased capability to mentalize	Feelings are more predictable and easier to handle
		Increased ability to deal with my pain through a wider perspective of myself and others
		MBT superior to other methods
Second topic: During and after MBT		
Meta-theme	**Themes**	**Sub-themes**
The therapist followed my lead, which made therapy relevant but challenging	Positive outcomes related to the therapist's not knowing stance	A safe attachment to the therapists (N=2)
		The therapists spoke my language (N=1)
	Challenges related to the therapist's not knowing stance	The therapist was too passive and dismissive (N=1)
		Emotional intensity made the group therapy exhausting (N=1)

Appendix E: REK approval

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst C	Anders Strand		16.09.2021	280677

Erik Stänicke

Prosjektsøknad: Likheter og forskjeller i tidligere pasienters opplevelser av meningsfull endring i etterkant av terapiforløp med henholdsvis MBT og DBT for Borderline personlighetsforstyrrelse.

Søknadsnummer: 280677
Forskningsansvarlig institusjon: Universitetet i Oslo

Prosjektsøknad godkjennes

Søkers beskrivelse

Borderline personlighetsforstyrrelse (BPD) er en alvorlig tilstand, som tradisjonelt sett er ansett å være vanskelig å behandle. Lidelsen karakteriseres av patologi som påvirker både en selv og relasjonene en har (Folmo, 2021). En har sett pasienter med BPD har god nytte av både mentaliseringsbasert terapi (MBT) og dialektisk atferdsterapi (DBT), som er to svært forskjellige behandlingsmetoder (Linehan, Heard & Armstrong, 1993; Bateman & Fonagy, 2008). I vår oppgave ønsker vi å dybdeintervjue ti informanter som har gått i MBT, og ti pasienter som har gått i DBT. Informantene skal ha vært ferdig i behandling i 3-5 år. Vi ønsker å undersøke hva informantene selv har opplevd som endringsbevirkende, og ikke, i terapien. Videre ønsker vi å belyse om disse endringsbevirkende elementene er felles for begge terapiformene eller om de skiller seg fra hverandre i henholdsvis MBT og DBT. Problemstilling: Hvilke likheter og forskjeller ser man i tidligere BPD-pasienters opplevelse av meningsfull endring i henholdsvis MBT og DBT?

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst C) i møtet 19.08.2021. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10.

REKs vurdering

Det omsøkte prosjektet skal undersøke pasienterfaringer med henholdsvis mentaliseringsbasert terapi (MBT) og dialektisk adferdsterapi (DBT), inkludert hva informantene opplevde som endringsbevirkende. Studien er intervjubasert, det planlegges om lag 20 deltagere, og deltagelse er samtykkebasert.

REK sør-øst C
Besøksadresse: Gullhaugveien 1-3, 0484 Oslo
Telefon:22 84 55 11 | **E-post**:rek-sorost@medisin.uio.no
Web:https://rekportalen.no

Komiteen mener at det fremstår noe uklart om deltagerantallet er tilstrekkelig for å oppnå datametning, og legger til grunn at antallet vil justeres ved behov for dette, slik at studiens potensielle nytte realiseres. Dersom dette medfører behov for en vesentlig økning av deltagerantallet (dvs. til mer enn 30 deltagere totalt i dette tilfellet), ber komiteen om at dette søkes REK ved endringsmelding.

På denne bakgrunn finner komiteen prosjektet forskningsetisk forsvarlig og potensielt nyttig, og godkjenner dette som omsøkt.

Vedtak

Komiteen har gjort en helhetlig forskningsetisk vurdering av alle prosjektets sider. Prosjektet godkjennes med hjemmel i helseforskningsloven § 10.

Komiteen gjør samtidig oppmerksom på at etter ny personopplysningslov må det også foreligge et behandlingsgrunnlag etter personvernforordningen. Det må forankres i egen institusjon.

Tillatelsen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden og protokollen, og de bestemmelser som følger av helseforskningsloven med forskrifter.

Tillatelsen gjelder til 01.01.2023. Av dokumentasjons- og oppfølgingshensyn skal opplysningene likevel bevares inntil 01.07.2028. Opplysningene skal lagres avidentifisert, dvs. atskilt i en nøkkel- og en opplysningsfil. Opplysningene skal deretter slettes eller anonymiseres, senest innen et halvt år fra denne dato.

Komiteens avgjørelse var enstemmig.

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jfr. helseforskningsloven § 10, tredje ledd og forvaltningsloven § 28. En eventuell klage sendes til REK sør-øst C. Klagefristen er tre uker fra mottak av dette brevet, jfr. forvaltningsloven § 29.

Sluttmelding
Prosjektleder skal sende sluttmelding til REK på eget skjema via REK-portalen senest senest 6 måneder etter sluttdato 01.01.2023, jf. helseforskningsloven § 12. Dersom prosjektet ikke starter opp eller gjennomføres meldes dette også via skjemaet for sluttmelding.

Søknad om endring
Dersom man ønsker å foreta vesentlige endringer i formål, metode, tidsløp eller organisering må prosjektleder sende søknad om endring via portalen på eget skjema til REK, jf. helseforskningsloven § 11.

Klageadgang
Du kan klage på REKs vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes på eget

skjema via REK portalen. Klagefristen er tre uker fra du mottar dette brevet. Dersom REK opprettholder vedtaket, sender REK klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag (NEM) for endelig vurdering, jf. forskningsetikkloven § 10 og helseforskningsloven § 10.

Med vennlig hilsen

Erik Fosse
Prof., PhD.
Leder REK sør-øst C

Anders Strand
Seniorrådgiver, REK sør-øst C

Kopi til:

Universitetet i Oslo

Appendix F: NSD approval

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD sin vurdering

Prosjekttittel

Likheter og forskjeller i tidligere pasienters opplevelser av meningsfull endring i etterkant av terapiforløp med henholdsvis MBT og DBT for Borderline personlighetsforstyrrelse.

Referansenummer

424892

Registrert

17.09.2021 av Thea Sundal - [redacted]

Behandlingsansvarlig institusjon

Universitetet i Oslo / Det samfunnsvitenskapelige fakultet / Psykologisk institutt

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

Erik Stänicke ,[redacted]

Type prosjekt

Studentprosjekt, masterstudium

Kontaktinformasjon, student

Thea Sundal, [redacted]

Prosjektperiode

03.05.2021 - 01.01.2023

Status

21.10.2021 - Vurdert

Vurdering (2)

21.10.2021 - Vurdert

NSD har vurdert endringen registrert 21.10.2021.

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet med vedlegg den 21.10.2021. Behandlingen kan fortsette.

Endringen gjelder at det vil registreres fødselsnummer i sammenheng med løsning ofr elektronisk samtykke.

LOVLIG GRUNNLAG

Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

For alminnelige personopplysninger vil lovlig grunnlag for behandlingen være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 a.

For særlige kategorier av personopplysninger vil lovlig grunnlag for behandlingen være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 a, jf. personvernforordningen art. 9 nr. 2 a, jf. personopplysningsloven § 10, jf. § 9 (2).

OPPFØLGING AV PROSJEKTET
NSD vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/pågår i tråd med den behandlingen som er dokumentert.

Kontaktperson hos NSD: Jørgen Wincensen
Lykke til videre med prosjektet!

18.10.2021 - Vurdert

BAKGRUNN
Prosjektet er vurdert og godkjent etter helseforskningsloven § 10 av Regionale komiteer for medisinsk og helsefaglig forskningsetikk (REK) i vedtak av 16.09.2021, deres referanse 280677 (se under Tillatelser).

VURDERING
Det er vår vurdering at behandlingen vil være i samsvar med personvernlovgivningen, så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet den 18.10.2021 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte.

VURDERING AV BEHOV FOR DPIA
Prosjektet behandler særlige kategorier av personopplysninger (helseopplysninger) om en sårbar gruppe (personer med personlighetsforstyrrelse som har gått i terapi), noe som kan utløse en plikt til å foreta personvernkonsenkvensvurdering (DPIA).

NSD har vurdert at det ikke var behov for å gjøre en DPIA jf. personvernforordningen art. 35 nr. 1 for dette prosjektet. Dette var basert på en helhetsvurdering der følgende momenter ble vektlagt:

• De registrerte samtykker til bruk av sine personopplysninger
• De registrerte får god informasjon om behandlingen av personopplysningene og sine rettigheter
• Opplysningene lagres trygt på Tjeneste for Sikker Datahåndtering (TSD)
• Få personer har tilgang til personopplysningene
• Regionale komiteer for medisinsk og helsefaglig forskningsetikk (REK) har gjort en forskningsetisk vurdering av prosjektet og godkjent det
• Behandlingen har kort varighet
• Det behandles få personopplysninger

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle alminnelige personopplysninger, særlige kategorier av personopplysninger om helseforhold frem til 01.01.2023. Etter prosjektslutt skal opplysningene oppbevares i fem år av dokumentasjonshensyn. Enhver tilgang til prosjektdataene skal da være knyttet til behovet for etterkontroll. Prosjektdata skal da ikke være tilgjengelig for prosjektet.

Prosjektleder og forskningsansvarlig institusjon er ansvarlig for at opplysningene oppbevares av-identifisert i denne perioden, dvs. atskilt i en nøkkel- og en datafil. Etter disse fem årene skal data slettes eller anonymiseres.

LOVLIG GRUNNLAG

Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

For alminnelige personopplysninger vil lovlig grunnlag for behandlingen være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 a.

For særlige kategorier av personopplysninger vil lovlig grunnlag for behandlingen være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 a, jf. personvernforordningen art. 9 nr. 2 a, jf. personopplysningsloven § 10, jf. § 9 (2).

PERSONVERNPRINSIPPER
NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen:

- om lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet.

DE REGISTRERTES RETTIGHETER
NSD vurderer at informasjonen om behandlingen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18) og dataportabilitet (art. 20).

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

UNNTAK FRA RETTEN TIL SLETTING
I utgangspunktet har alle som registreres i forskningsprosjektet rett til å få slettet opplysninger som er registrert om dem. Etter helseforskningsloven § 16 tredje ledd vil imidlertid adgangen til å kreve sletting av sine helseopplysninger ikke gjelde dersom materialet eller opplysningene er anonymisert, dersom materialet etter bearbeidelse inngår i et annet biologisk produkt, eller dersom opplysningene allerede er inngått i utførte analyser. Regelen henviser til at sletting i slike situasjoner vil være svært vanskelig og/eller ødeleggende for forskningen, og dermed forhindre at formålet med forskningen oppnås.

Etter personvernforordningen art 17 nr. 3 d kan man unnta fra retten til sletting dersom behandlingen er nødvendig for formål knyttet til vitenskapelig eller historisk forskning eller for statistiske formål i samsvar med artikkel 89 nr. 1 i den grad sletting sannsynligvis vil gjøre det umulig eller i alvorlig grad vil hindre at målene med nevnte behandling nås.

NSD vurderer dermed at det kan gjøres unntak fra retten til sletting av helseopplysninger etter helseforskningslovens § 16 tredje ledd og personvernforordningen art 17 nr. 3 d, når materialet er bearbeidet slik at det inngår i et annet biologisk produkt, eller dersom opplysningene allerede er inngått i utførte analyser.

Vi presiserer at helseopplysninger inngår i utførte analyser dersom de er sammenstilt eller koblet med andre opplysninger eller prøvesvar. Vi gjør oppmerksom på at øvrige opplysninger må slettes og det kan ikke innhentes ytterligere opplysninger fra deltakeren.

FØLG DIN INSTITUSJONS RETNINGSLINJER

NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

For å forsikre dere om at kravene oppfylles, må prosjektansvarlig følge interne retningslinjer/rådføre dere med behandlingsansvarlig institusjon.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilken type endringer det er nødvendig å melde:
https://www.nsd.no/personverntjenester/fylle-ut-meldeskjema-for-personopplysninger/melde-endringer-i-meldeskjema
Du må vente på svar fra NSD før endringen gjennomføres.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/pågår i tråd med den behandlingen som er dokumentert.

Kontaktperson hos NSD: Jørgen Wincentsen

Lykke til med prosjektet!