A Portfolio of Academic, Therapeutic Practice, and Research Work

Including an Investigation of:

An Exploration of Therapists’ Experiences of Conducting Mentalization Based Therapy with Borderline Personality Disorder Clients: An Interpretive Phenomenological Analysis.

By

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Statement of Anonymity

To ensure the confidentiality and anonymity of all patients and research participants, pseudonyms have been used and all identifiable information has been changed, throughout this portfolio.
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Abstract

This part of the portfolio encompasses the research dossiers that cover various papers submitted as part of my Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. The research has been written throughout my training as a counselling psychologist, capturing features of both my personal and professional development during my training. The dossiers present the research facets of the course, all of which emphasise my main interests and competencies.

The research dossier includes three papers: a literature review and two qualitative research studies. The literature review explores and compares two models of borderline personality disorder, specifically the cognitive model and the mentalization based therapy model. The first empirical study utilises grounded theory in exploring Muslim cultural identity, how this might influence their ways of seeking psychological help, their perspectives on psychodynamic therapy, and its compatibility with Muslim cultural and religious values. The second empirical study relates to the literature review and explores therapists’ experiences of conducting mentalization based therapy with borderline personality disorder clients, using Interpretive Phenomenological Analysis.
Research Dossier

The research dossier contains three papers, all of which present a research narrative that covers the work conducted throughout my training on the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. Within this dossier a literature review is presented, as well as the second and third year research.

The first paper presented in the research dossier is the literature review, and in this piece of work I present a critical discussion of the significant characteristics of two models of borderline personality disorder (BPD), as well as a reflection of the theoretical foundations of how far they are compatible with what is consistently recognised in the common arena of psychology. The models discussed in the literature review are the Mentalisation Based Therapy (MBT) model and the Dialectical Behavioural Therapy (DBT) model: two prominent, evidence-based psychotherapy approaches offering explanatory models and specific treatment strategies for Borderline Personality Disorder (BPD). The mentalisation based model is psychodynamically-oriented and is primarily rooted in attachment theory, whereas the biosocial model (DBT) is rooted in more traditional cognitive behavioural principles. The models share a number of characteristics, and these cover various differences in the fundamental assumptions and definitions of BPD, which are related to distinct therapeutic methods.

This literature review is also written partly in response to years of grappling with my own understanding of both a family member and a close friend who have been diagnosed with Borderline Personality Disorder (BPD). These relationships have been ridden with crises, challenges, and opportunities for me to learn and to try to understand the frame of reference of someone with BPD. Thus, the literature review has been an attempt to let myself into the secrets and mysteries of the disorder, as well as making myself a trainee counselling psychologist to better understand the emotions and behaviours presented by my clients.

The second year research paper deviates to a certain degree from the topic paradigms of the literature review. The purpose of the study was to explore Muslim cultural identity, and how this might influence their ways of seeking psychological help, their perspectives on psychodynamic therapy, and its compatibility with Muslim cultural and religious values. The study took a qualitative approach and data was analysed using constructionist grounded
theory (GT). I think that with being a trainee counselling psychologist, having a strong interest in Middle Eastern culture and the religion of Islam, and having been brought up in this culture, religion has increased my interest in Muslim psychological help-seeking behaviours and how compatible psychodynamically-oriented therapies might be with this client group. Moreover, attending my second year psychodynamic placement, I was intrigued by the model and its underlying thinking; I have always had a keen interest in the theoretical aspects of psychoanalysis, and was often left wondering how its theoretical foundations would be applicable to working with certain ethnic minority clients, especially Muslim clients. This is due to the therapeutic models being rooted in western epistemological values regarding what constitutes human thinking and behaviour.

The process of writing up this research helped me get a provisional insight into the potential barriers Muslim clients might experience when utilising mental health services and talking therapies. Additionally, my own experience of being in psychodynamic therapy was another factor that made me explore other Muslim clients’ and psychologists’ perspectives on such therapies, with reference to their congruency with Muslim cultural and religious values. The barriers and challenges I faced with my own psychodynamic therapist due to culturally related differences were reasons for my being eager to explore the area, and to examine if other individuals from the same cultural background shared similar experiences to me.

Finally, my third year research is related to the literature review, with the study exploring the MBT models’ core principles, and aiming to explore and produce an in-depth understanding of therapists’ experiences of conducting mentalisation based therapy (MBT) with borderline personality disorder (BPD) patients. The study explores the therapists’ own understandings of the process of mentalising with the initial research questions: how do MBT therapists practise psychotherapy, and how do they make sense of the model? In doing so, the study enabled me to explore the benefits and challenges of such therapy, working with BPD presentation. The study took a qualitative approach using Interpretative Phenomenological Analysis (IPA). My interest in MBT – after conducting the literature review in my first year – further encouraged me to attend the basic skills training programme in mentalisation based therapy at the Anna Freud Centre, with Professor Anthony Bateman and Peter Fonagy. This intensified my understanding and interest in the model, but equally left me in a state of confusion and uncertainty about the multi-faceted concept of mentalisation, leading me to conduct research in the area in order to elaborate on the subject.
A Comparative Review of Two Models of Borderline Personality Disorder: The Mentalization Based Model and Biosocial Model

Jahangeer Sakhi

Literature Review

Year 1

Supervisor: Dr. Fiona Warren

University of Surrey
Abstract

Mentalization Based Therapy (MBT) and Dialectical Behavioural Therapy (DBT) are among the small number of psychotherapy approaches offering explanatory models and specific treatment strategies of Borderline Personality Disorder (BPD). The Mentalization based model stems from a more psychodynamic orientation and is primarily rooted in attachment theory, while the biosocial model is rooted in more traditional cognitive behavioural principles. Both of the models share a number of characteristics and cover various differences in fundamental assumptions and definitions of BPD. In this article, I present a critical discussion of the significant characteristics of both models, as well as a reflection of the theoretical foundations of how compatible they are with what is consistently recognised in the common arena of psychology.

Keywords: Borderline Personality Disorder, Attachment Theory, Mentalization Model, Biosocial Model.
Introduction

It is possible to make eloquent statements about the epidemiology and management of a personality disorder if an approved definition of the disorder exists. However, health professionals and other experts in the area have not agreed on the classification of how to best describe a personality disorder, nor if the term ‘personality disorder’ has any relevance at all (Allertz & Van Voorst, 2007; Tyrer et al, 1991). Conversely, over the last two decades, extensive research has been conducted and a diagnosis of personality disorder is now applicable through a number of structured interviews using questionnaires (Clark & Livesley, 1997; Feiganbaum & Fonagy, 2012). Although a diagnosis is now available and allowed to be used in practice, mental health professionals still remain largely at odds with regards to how to best conceptualise personality disorders (Cohen, 2008; Rogosch & Cicchetti, 2005). Etiological models of personality disorders have only recently been developed, drawing on research from longitudinal studies of child development and how traumatic events in childhood may impact on personality functioning in adulthood (Davidson, 2007; Linehan, 1993; Batema & Fonagy, 2004, 2012).

Whilst both clinical and research methods for the diagnosis of personality disorders significantly deviate, it is uncertain how well these diagnostic tools essentially capture individual experiences of having a personality disorder. There are recognised health organisations, such as the World Health Organization (WHO) and the American Psychiatric Association (APA), that have formed definitions. The Diagnostic and Statistical Manual of Mental Disorders (4th Edition) – better known as the DSM-IV-TR (American Psychiatric Association, 2000) – defines a personality disorder as: “an enduring pattern of inner experiences and behavior that deviates markedly from the expectations of the individual’s culture”. However, this definition has been revised and has undergone some significant changes in the new DSM-V, published in 2013 (American Psychiatric Association, 2013). The new proposed definition explains a personality disorder as an “adaptive failure involving: impaired sense of self-identity”, as well as changing the ten classical personality types to five: antisocial, avoidant, borderline, obsessive-compulsive, and schizotypal personalities.

The current revision and suggested changes for the DMS-IV-TR, published in the DSM-V in 2013, only supports the notion that a definition of personality disorders still remains a somewhat blurred, fluid, and contested area. Furthermore, the International Classification of
Mental and Behavioural Disorders (ICD-10) (World Health Organization, 1992) have a slightly different definition: “a severe disturbance in the character condition and behavioral tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption”. Moreover, the ICD-10 defines BPD differently and uses the terminology such as Emotional Unstable Personality Disorder, further verifying the ongoing debate about this personality disorder.

However, as the conceptualisation of a personality disorder is presently loaded with significant debate and misperceptions (Emmelkamp & Kamphius, 2007; Oldham & Riba, 2001) most mental health professionals stick to the existing ICD-10 and DSM-V criteria in defining what a personality disorder is (Poznyak & Reed, 2011). Commonly defined by both health organisations are the behavioural patterns in personality disorders, which are characteristically related with stark disturbances in the behavioural propensities and frequently involve various areas of the personality, and are almost continuously related with substantial personal, relational, and social disruption.

During the last two decades there has been an increasing interest in personality disorders, and consequently, a demand for effective treatments and models that can better conceptualise the various different personality disorders (Bateman & Fonagy, 2004, 2012; Tyrer & Simmonds, 2003; Linehan, 1993). There is now evidence that individuals with personality disorders are treatable and that therapeutic interventions show good results (Bateman & Ryle, 2007; Hutsebaut & Bales, 2012; Liotti & Gilbert, 2011; Feigenbaum & Fonagy, 2012), but interpretation of these empirical studies are complex, unclear, and questionable. It is debatable whether a conflict of interest has led to publication bias within the literature, with the non-publication of negative or non-significant clinical appraisals of certain modalities for BPD. Hence, both efficacy and generalisability are important factors to take into consideration when authenticating or even recommending a therapeutic approach to a specific personality disorder.

Borderline personality disorder (BPD) is a complex and severe mental disorder, and it is also the most common, occurring in 1-2 percent of the overall population (Torgerersen et al., 2001). Around ten percent of all psychiatric outpatients and twenty percent of inpatients are assessed as having BPD (Freenstra, Busschbach, Verheul, & Hutsebaut, 2011). Moreover, mortality by suicide among individuals with this diagnosis is ten to fifty percent higher compared to the
general population. Subsequently, there has been an increase in interest and research into the aetiology of BPD, and aims to develop effective treatment interventions have been substantial.

The notion of borderline personality disorder can be dated back to around 60 years ago, and was first defined by Stern (1938). The first descriptions of borderline personality traits were conceptualised as the intrapsychic characteristics of a midway level of internal personality orientation, more troubled than the neurotic but less troubled than the psychotic (Kernberg, 1967). This notion of the disorder being described as in between the neurotic and psychotic gave rise to the label “borderline”, and the disorder was further characterised as an individual having severe identity dispersal, as well as the use of primitive defence mechanisms, such as being in a state of denial, projection, and at times faulty reality thinking behaviours (Kernberg, 1967). Nevertheless, according to the DSM-V-TR, the diagnostic criteria for BPD do overlap with other personality disorders such as antisocial, narcissistic, and more schizoid types, adding to the confusion around the conceptualisation of BPD (Becker & Grilo, 2000). Comorbidity is significant, and an individual is rarely diagnosed with pure BPD; rather, the traits of the disorder are significantly associated with PTSD, leading to some researchers regarding it as a delayed form of PTSD (Yen & Shea, 2002).

However, it was the work of Gunderson & Singer (1975) – who applied BPD in the DSM-IV through the empirical literature – which gave it its individuality. Consequently, various research studies were conducted in order to identify patients with BPD and separate these individuals from others. Finally, eight conditions were approved for use in the earlier DSM-III (American Psychiatric Association, 1980) for diagnostic practice, and later another criterion was implemented in the revised DSM-IV-TR (American Psychiatric Association, 2000). However, this has been further modified in the new DSM-V. According to the DSM-IV-TR, the essential characteristics of BPD indicate persistent patterns of noticeable impulsivity and instability in interpersonal relationships and self-image, affecting both mood and emotions. The previous DSM-IV had adopted nine criteria, where the presence of any five of these can validate a diagnosis of BPD (see Table 1).
Nonetheless, the conceptualisation of BPD is rooted in the psychoanalytic perception of being between the neurotic and psychotic organisation of personality. Yet, during the last two decades, the interest in BPD has unfettered itself from the pure psychoanalytic conceptualisation and has become an area of research and attention in more conventional psychiatry and psychology. This transition has contributed to more reliable diagnoses as it is no longer just a psychoanalytic concept.

Various studies have replicated the stability of BPD diagnosis ranging from 78 percent to 90 percent (Silk et al., 1990; Barasch et al., 1985). The study conducted by Silk et al. (1990) had a 1-3 year follow-up period and consisted of 9-30 patients, while the study by Barasch et al. (1985) had a 3 year follow-up period with 10 patients. Nevertheless, both studies did have significant participant attrition and varied follow-up intervals, which questions the validity of

<table>
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<th>Table 1. (DSM-IV) Diagnostic Criteria for Borderline Personality Disorder.</th>
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<td>A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:</td>
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<tr>
<td>1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.</td>
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<tr>
<td>2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.</td>
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<td>3. Identity disturbances: markedly and persistently unstable self-image or sense of self.</td>
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<td>4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).</td>
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<td>5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.</td>
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<td>6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).</td>
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<td>7. Chronic feelings of emptiness.</td>
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<td>8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).</td>
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<tr>
<td>9. Transient, stress-related paranoid ideation or severe dissociative symptoms</td>
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these studies. However, another important longitudinal research study conducted by The Collaborative Longitudinal Personality Disorder Study (CLPS), who used standardised interviews in order to assess all DSM-IV personality disorders, indicated that the reliability of BPD symptoms and diagnosis was very good to excellent (Zanarini et al. 2000). Additionally, another study, using self-report measures that examined the relationship of early BPD symptoms in children from the age of 14 with a 20 year follow-up period, indicated significant persistence into later adulthood (Winograd & Cohen, 2008), which may clarify that BPD symptoms are not merely a temporary developmental complexity. This notion makes the validity and reliability of a BPD diagnosis potentially strong. However, standardised interviews and the required criteria for diagnosis are not equal, with outstanding clinical judgment and, unless clinicians are well trained in the exact diagnosis of BPD, both validity and reliability will be less legitimate.

BPD tends to be more frequently diagnosed in women compared to men (American Psychiatric Association, 2000); the female/male gender ratio of 3:1 is very significant for a personality disorder, indicating a biological or sociocultural bias that can lead to the onset of BPD. However, this notion is debatable, with one example being that women are more inclined to seek psychological help (Addis & Mahalik, 2003). Moreover, as sexual abuse in childhood is defined to be one of the strongest predictors for BPD (Bateman & Fonagy, 2004, 2012), and with it being 10 times more common in women than men (Finkelhor & Hotaling, 1990), this could consequently shape the current gender ratio, alongside studies showing gender biases playing a role in the diagnostic process of BPD (Bjorklund, 2007). There are various risk factors associated with BPD that are resultant from both biological and sociocultural orientations; as a result, there are many theories about the aetiology of BPD. Whilst some professionals in the arena conclude that characteristics of the disorder can be best explained in light of more genetic and neurobiological origins, some argue that it is best clarified in terms of a history of hostile experiences during childhood and infancy.

An interesting study showed that BPD may be hereditary: a twin study indicated 35 percent concordance in monozygotic twins compared with 7 percent of dizygotic twins (Torgersen et al., 2000). Moreover, studies have indicated a significant difference in brain maturation in females diagnosed with BPD, which were measurable with electroencephalography (Hesselbrock & Bauer, 2006), and this may suggest that BPD is associated with deficits in the frontolimbic circuitry, amygdala, hippocampus, and thalamus (Brendal et al., 2005). This
perspective generates a genetic-oriented model for the disorder, but studies have also indicated strong sociocultural components in the development of BPD. Loss or separation from a parent in childhood, and poor or careless experience with a primary caregiver, have also been indicated to potentially contribute to the onset of BPD. Various studies have indicated that the most recurrent finding for parenting in people with personality disorders has been the absence of bonding due to neglect and childhood sexual abuse among individuals with BPD (Bateman & Fonagy, 2012; Paris et al., 1994; Ogata et al., 1990). A study conducted by Zanarini et al. (2000) showed that 40-76 percent of BPD individuals had been subject to sexual abuse in childhood and 92 percent had described having an insecure attachment with a primary caregiver.

However, a simple explanation regarding the aetiology of BPD might be difficult, and a more sensible approach would include both nature and nurture-oriented factors to explain its onset. Many researchers have expressed sexual abuse and insecure attachment history during childhood as the most significant risk factor of BPD (McLean & Gallop, 2003; Lynch & Kelly, 2002), and some even adopt it as the fundamental aetiological factor of the disorder (Fonagy & Bateman, 2006). Although childhood abuse may be common among BPD individuals, it is not specific to the disorder, as studies show that child abuse affects about 80 percent of the general population but does not lead to any sort of psychopathology (Fossati & Madeddu, 1999; Beitchman & Zucker, 1992).

**Attachment Theory**

Several models have been produced in order to explain the aetiology of BPD, and this review will first concentrate on the mentalisation based model, which is primarily rooted in John Bowlby’s attachment theory (Bateman & Fonagy, 2004). John Bowlby’s work on developing attachment theory started in 1944, when he had his first clinical research experience with 44 juvenile offenders, contributing to the early formulation of attachment theory. In his first study, he found that what distinguished these juveniles from others was their apparent prolonged separation from their parents, and a particular trait of affectionless behaviour (Bowlby, 1944). This notion further extended his interest in the principles of what is today called attachment theory, and concentrated the basis for his theory around the mother-infant relationship.
In its most basic form, attachment theory suggests that an infant needs to develop a secure and stable attachment relationship with a primary caregiver in order for social and emotional growth to develop normally. Nonetheless, the caregiver’s responses to the child lead to the development of patterns of attachment that allow internal working models to be created, regulating the individual’s thoughts and emotions with respect to relationships formed in adulthood.

The central foundation to Bowlby’s (1958) theory focuses on the infant’s need for a secure early attachment to the mother. He theorised that the child who does not have such an attachment with the primary caregiver was prone to show signs of deprivation, extreme need for love or revenge, depression, unresponsiveness, delay of development, and later on the development of signs of superficiality, absence of concentration, and compulsive thieving (Bowlby, 1951). According to Bowlby (1969), there is a significant biological orientation to attachment behaviour and there is an overall agreement that this behavioural system involves inherent motivations and key psychological mechanisms (Spangler & Schieche, 1998). Various empirical research studies have been conducted around attachment theory, and it would be beyond the capacity of this brief review to propose a summary of decades of findings. Yet, this review will draw reference to some significant and supporting findings around attachment theory, as well as drawing references to its critique.

Evidence relating attachment in infancy with borderline personality characteristics later in adulthood is very apparent in various studies. Weinfield et al. (1999) indicated that using the Ainsworth Strange Situation (Ainsworth & Wittig) and Berkeley Adult Attachment Interview (George & Kaplan), pre-school children with secure attachment histories were steadily rated with higher self-esteem, were more emotionally stable, and more compliant to their teachers. However, the validity and use of the Ainsworth Strange Situation has been subject to some critique, as some argue that it does not measure general attachment styles or attachment behaviours, and that it has low ecological validity (Lamb & Thompson, 1984). Studies have also found that children with more secure attachment histories express a more positive definition of themselves compared to children with histories of insecure attachment (Cassidy, 1988). Another study conducted by Laible & Thompson et al. (1998) indicated that children who appeared to be closer with their caregiver also obtained significant higher scores on self-assessments of emotional understanding.
However, Bowlby’s attachment theory has also been subject to significant criticism; as any other theory in the field of social science, it is destined to be challenged, and one of the theory’s main critics has been J. R. Harris. According to Harris (1998), the primary caregiver does not form the child’s character, but the child’s peers have a more profound influence. Harris (1998) assumes that nurture should not be labelled as a substitute for environment, nor that genes or parental upbringing influences a child’s development, which she calls the nurture assumption. Harris argues that how children are brought up in the home may be inconsequential in the outside world by drawing reference to studies showing that identical twins brought up in separate environments still show predominantly similar habits, hobbies, and characters. She argues that this indicates the influence of nature, and dismisses the significance of nurture.

Additional criticism explains that attachment theory limits itself only to the primary caregiver, usually the mother; the theory cuts short of taking the father’s or sibling’s attachment to the child into consideration, nor does it consider attachments that occur during adolescence or adulthood (lovers or spouses) as influential. It has been suggested that the attachment model would need modification in order to provide numerous attachments to a variety of figures at several stages throughout a lifespan (Field, 1996).

**Attachment Theory and Psychopathology**

There is a common agreement in the field that healthy and secure attachments during infancy and childhood produce the basis for healthier and normal psychological development, and furthermore, that it provides a shielding factor against psychopathological personality variables (Bateman & Fonagy, 2012; Collins & Read, 1990). Insecure attachment history during the critical stages of infancy has commonly shown to provide a higher proneness to depression, anxiety, aggression, psychosomatic symptoms, and lower self-esteem (Grunebaum et al., 2010; Lee & Hankin, 2009), only adding support to attachment theory.

A study conducted by Lyons & Ruth et al. (1995) on 64 high risk infants with a history of insecure attachment showed that 71 percent of the infants practised traits of hostility and disorganised behaviour in preschool, compared to 12 percent in the control group, who had a more secure attachment history. A more recent study – examining the relationship between insecure attachment history and depression in a sample of 140 children – used semi-structured clinical interviews to assess symptoms, indicating that in line with attachment
principles, the children showed higher levels of depressive symptoms (Abela et al., 2005). Another study conducted with a sample of 500 adolescence students, completing questionnaires measuring the association between attachment and paranoid personality traits, indicated that insecure attachment history predicted strong paranoid traits (Pickering & Simpson et al., 2008). These studies do indicate the significance of attachment history as a contributing factor to psychological disturbance, as well as an association with potential psychopathology.

However, the question of whether insecure attachment is consequently a trait dependent on biological inheritance, and a further indication of the individuals’ psychopathological characteristics, is still open to debate. The main principles of attachment theory are very much equivalent with more psychoanalytic formulations. The notion that early childhood experiences and secure attachment history with the primary caregiver are significantly associated with psychological development and psychopathology in later life provides an integrated model between the two structures. There is significant research indicating a confirmation of these suggestions, as there is an apparent correlation between this and early childhood experiences of neglectful caregiving producing the same developmental character.

Another interesting study confirming this notion was conducted by Marvin & Britner et al. (1999), who observed attachment orientation in adopted Romanian children in the UK between the ages of four to six years. The study found that children who developed secure attachment quickly with their new parents were the children that spent the shortest time in the orphanage. This study, along with others presented in this article, may explain the significance of sensitive and responsive caregiving by providing tools in which positive prospects around intimacy and care from others are permanently arranged, consequently developing various internal perception and cognition.

Accordingly, insecure attachment experiences may play a crucial role in the development of maladaptation through the caregiver’s and child’s interactions by creating traits of mistrust, anger, anxiety, and fear (Depue & Morrone-Strupinsky, 2005; Main, 1995). Further evaluations have aimed to extend the theoretical framework to more neurobiological orientations, and an example of this would be that emotion regulation in infancy may alter fear conditioning processes in the amygdala or prefrontal cortex (Porges, 2003, 2007; Schore, 1997). Evidence exists indicating an association between high cortisol secretion and late
return to the baseline in individuals with insecure attachment orientation (Spangler & Schieche, 1998). These principles of attachment theory have drawn significant interest from the psychoanalytic lobby to incorporate and compromise explanations and models to various psychopathologies.

**Mentalization Model in understanding BPD**

It is assumed that in order to achieve stable internal mental organisation, the child requires secure attachment by its emotional expressions being correctly reflected by the primary caregiver. One way of understanding BPD is through the mentalisation model, which outlines that people who suffer from BPD have a deficit in their mentalising capacities.

Mentalisation at its most basic principle is the ability to understand and make sense of the self and others in relation to subjective states and mental processes. With reference to attachment theory, secure attachment relationships evolving in infancy must be enabled in order to achieve the ability to understand other people’s behaviour with regards to their emotions and thoughts. Our understanding of ourselves and others significantly rests on how our own mental states were sufficiently understood and responded to during infancy, and therefore this development is very complex and susceptible to disturbance. The model places primary emphasis on unbalanced mentalization capacities – one of the essential characteristics of BPD – and adopts a dynamic developmental view of the causes for such unbalance (Bateman & Fonagy, 2006).

The model has adopted a transactional perspective, in which it considers the development of the social affiliative system as the central influence in mentalization capacity. This conceptualisation explains that the social affiliative system enables various social cognitive functions that support interpersonal interaction (Fonagy, Gergely, & Target, 2003). Within this conceptualisation, various aspects are core in understanding BPD: affect representation and regulation, attentional control associated with regulation of affect, and finally, a system of interpersonal understanding (Bateman & Fonagy, 2006). The development of these principles is heavily reliant on the child’s relationship with its primary caregiver, consequently making it vulnerable to maltreatment.

Criteria of BPD in the DSM-V include intense episodic dysphoria, irritability, and anxiety. According to Denham (1998), the achievement of emotion regulation skills begins in infancy.
and endures throughout the lifespan and, in order to achieve normal self-experience, it is required that the infant’s emotional expressions are correctly mirrored by the primary caregiver. Consequently, the absence of this has significant consequences for affection regulation (Wang, 2001). However, the notion of mirroring the child’s emotional expressions does not merely include contingency, but also mild distortion in order to make the child comprehend the primary caregiver’s display as part of their personal emotional experience (Fonagy et al., 2002; Liotti & Gilbert, 2011). This therefore allows the infant to adopt the representation of the image of their experience and create a representational guide for internal states (Gergely & Watson, 1996). Studies have confirmed this notion, indicating that the exclusion of contingent mirroring is linked with disorganised attachment (Gergely & Watson, 2002), and hence, later in middle childhood, this leads to developing very controlling behavioural characteristics, as well as dissociative personality traits in adulthood (Lyons & Ruth, 2003).

Moreover, studies have indicated that BPD individuals typically have complications with attentional control (Kernberg, 2004), which therefore may indicate problems with impulsivity and the capacity to function effectively in interpersonal frameworks. According to the mentalization model of BPD, self-regulation is taught by the primary caregiver’s regulatory activities with the child (Mundy & Neal, 2001), and studies have confirmed that there might be a significant link between early attachment experiences as a provider of stable internal attentional systems in an individual. Studies with late adopted Romanian children – who had a history of insecure attachment – indicated significant attention deficits (Rutter, 2001). Consequently, it is assumed that attentional control and impulsivity tends to be embedded in mutual receptivity from the primary caregiver.

There has been a growing interest and research in the association between attachment history and people with BPD, with various studies confirming an existing association. Much of the research conducted has used some of the most reliable tools in measuring attachment in adults: rating scales, self-report measures, and attachment questionnaires, showing a significant association with BPD individuals and insecure attachment history (Levy, 2005). These studies may indicate features of children’s attachment history that may correlate significantly with their mentalization capacities, and their internal working model with regards to their attachment relationship indicated significant correlations with emotional understandings (Levy & Johnson, 2015; Rosnay & Harris, 2002). Adopting this notion,
family environments and discourses may contribute and influence the mentalization capacities that people develop (Crowe, 2002).

Although the mentalization model does emphasise genetic inheritance – as personality traits tend to have a strong genetic predisposition (Hudson, 2003) – the primary emphasis is linked with childhood environmental histories. Studies have indicated strong links between early childhood traumatic separation experiences from the primary caregiver as being a distinctive feature in BPD patients (37-64 percent) (Bradley & Western, 2005; Levy, 2005). Moreover, neglect, maltreatment and, particularly, child sexual abuse seems to be a contributing variable in predicting the development of BPD (Zanarini et al., 1997, 2000). According to the mentalisation model, people with BPD have more primitive mentalization abilities because they were forced to abandon this ability when experiencing high emotional arousal due to maltreatment. This abandonment of mentalization is a response to the trauma experienced with regards to attachment; the individual with BPD will avoid thinking about mental states because the mental states of the abuser – typically the attachment figure – are too painful to experience. Consequently, their mentalization capacities did not fully develop during the early stages of childhood. Much research has supported this perspective, as children with this kind of history typically show a decrease in empathic responses to other children, as well as more emotionally dysregulated behaviour (Main & George, 1985; Maughan & Cicchetti, 2002).

The mentalization model of BPD suggests that if the development of a more stable sense of self is absent or disturbed, it will consequently result in further complications for that individual. By affective communication of mirroring between the child and the primary caregiver, it enables the child to find a version of their own internal states; the mirroring of the child’s expressions by the caregiver allows for the development of understanding both internal and external representation (Fonagy et al., 2002). If this concept of mirroring is not available to aid the child’s development, it fails to develop stable self-experience. Moreover, if the primary caregiver fails to reflect the child’s expressions correctly, the child will be forced to use disassociated imitations to assist their internal states, which will eventually have a destructive effect on their mentalization capacities. This unrelated replication of the self in order to understand their own experience will result in disorganisation and fragmentation of the self’s internal states.
This notion is also rooted in object relations theory (Winnicott, 1967), a psychoanalytic input which suggests that the unrelated mirroring makes the child internalise representations of the caregiver rather than their own states, resulting in feelings and emotions that are distant from the real self, also called the alien self. Children who have a history of insecure attachment in terms of neglect, maltreatment, or sexual abuse do not have a coherent association between their senses of self-representation and self-structure, consequently creating an imbalanced mentalization ability. It is reported that the key deficits in people with BPD are their primitive abilities to perceive mental states of both themself and others (Fonagy et al., 2000). However, not all mentalisation capacities are primitive in BPD, rather deficits are instead concentrated around intense attachment relationships.

The primary aim of mentalization based treatment for people with BPD is to enable a process wherein the mind of the patient becomes the main focus in the therapeutic process. The aim of the therapy is to provide tools and assistance that empower the patient to find out what they think and feel about both themselves and others internally and externally. The main focus is to explore and elaborate on more diverse images based on the patient’s experiences with the therapist. As the experiences of BPD individuals are typically entrenched in the reality of psychic equivalence and as other perspectives are often rejected harshly, the therapist aims to create a therapeutic alliance, moving towards an exploration of these experiences that the patient might have, as well as teasing out other standpoints.

**Biosocial Model in Understanding BPD**

Another model put forward to explain the aetiology of BPD is the biosocial theory, first suggested by Marhsa M. Linehan (1993). This theory has drawn significant attention and is probably one of the most thoroughly defined models of BPD along with the attachment mentalization model (Fonagy, 2006). Linehan (1993) has taken a somewhat different stance compared to the mentalization model by theorising that BPD is a disorder of emotion dysregulation, arising primarily by biological susceptibilities, and secondly by particular environmental effects. The theory puts prime emphasis on the biological irregularities that influence the emotional capacities of an individual, consequently causing further deregulations. However, the theory also authenticates that an invalidating environment during childhood also contributes to the emotional dysregulations in BPD.
The emotional susceptibility in BPD individuals is defined by significant sensitivity to emotional stimuli, emotional concentration, and a slow return to emotional baseline (Linehan, 1993). This exceptional sensitivity means that the individual responds rapidly and that, compared to others, they have a low threshold for an emotional response to various things. The conceptualisation of slow return to emotional baseline means that reactions are long lasting, because the emotional arousal that BPD individuals experience tends to affect various cognitive processes, consequently influencing both activation and responses to the emotional states of the individual (Bower, 1981; Linehan, 1993). With the high emotional sensitivity and increased levels of arousal in BPD, actions and behaviour consistent with the mood state are attended to in the environment. In BPD there is a significant effect of mood state on cognitive processes, as the theory implies that emotions are complete system responses (Linehan, 1993).

The theory also emphasises how trait impulsivity might have a strong correlation with action components in emotions. As more extensive research has been conducted in the areas around Linehan’s (1993) biosocial theory in the past decade, she has elaborated slightly on its principles and implied that early impulsivity is a predisposing vulnerability for considerable BPD characteristics such as suicidal and self-injuring orientation (American Psychiatric Association, 2000), which has been supported by various research studies (Beauchaine & Neuhaus, 2008). Furthermore, the theory implies that the impulsivity is a predisposing vulnerability for emotion regulation and therefore includes high impulsivity as a variable into the aetiology of the disorder. Poor impulse control emerges early in the development of BPD, with the development of extreme emotional sensitivity being formed and preserved by environmental factors such as invalidating parenting, but which is rooted in the child’s personality traits. Moreover, the transactional system between the biological and environmental factors potentiates emotion dysregulation along with impaired behavioural dyscontrol, consequently leading to serious deficits in both cognitive and social skills. By adolescence, these characteristics and maladaptive coping strategies further potentiates the individual to develop BPD.

Research on the biological aspects of BPD has been concentrated around both neurochemical and genetic vulnerabilities. The biosocial theory formulates strong links between impulsivity and BPD, putting a lot of emphasis on biological risk factors. Evidence proposes that both impulsivity and affective instability are related to precise genetic polymorphisms and
functional impairments within the central serotonergic (5-HT) system, and research findings indicate that there appears to be a deficit in the 5-HT functioning of individuals with BPD and those with various other psychiatric disorders (Oquendo & Mann, 2002). Studies designed to specifically test the 5-HT activity in people with various personality disorders indicated significant decreased activity of the 5-HT serotonergic system (Soloff, 2000). Moreover, the dopamine system is believed to be associated with certain traits of BPD, as specific mechanisms of dopamine deficits tend to influence levels of impulsivity (Skodol et al., 2002). The theory implies that dopamine dysfunction may be a compensatory response to alterations in certain neural systems that control impulsivity and emotions, which in turn is also mediated by the brain’s neurotransmitter pathways. However, although these studies indicate a link between personality traits such as impulsivity and mood instability with various personality disorders, they do not specify the traits of BPD. Furthermore, this concept seems to attribute too many of the BPD traits to very few neurotransmitter deficits.

Nonetheless, to further elaborate and validate this association, it is worth bringing some attention to Cloninger’s (2002) personality dimensions, which also suggests that there are heritable components to BPD personality traits. Traits that are identified as being significantly associated with BPD are high harm avoidance (fearful & shy) and high novelty seeking (impulsivity), which have been found to be significantly high compared to control groups (Barnow et al., 2007). This notion does show consistency with the idea that certain BPD traits are heritable, but the cross-sectional orientation of these studies limits its ability to draw any definite conclusion. However, research studies have tried to identify whether there is a significant link between behavioural genetics and BPD.

One study, which drew a lot of attention, was conducted on 92 monozygotic and 129 dizygotic twins in Norway, which indicated that the concordance rate for BPD was 38 percent among monozygotic twins compared to 11 percent in the dizygotic twins (Torgersen et al., 2000), supporting a genetic orientation to BPD. Although the biosocial theory puts prime emphasis on the biological vulnerabilities making an individual more prone to BPD, the formulation also encompasses environmental factors in its aetiological explanation. According to Linehan (1993), an invalidating family environment that consists of neglect, physical abuse, emotional abuse, or even sexual abuse may contribute to the development of the disorder, but argues that genetics and environmental factors may influence attachment processes across the development. Accordingly, the consequences of an invalidating
environment are failing to validate the child’s emotional expressions or teach the child how to label private experiences, such as emotions and modulate emotional arousal. Therefore, the emotional, vulnerable child’s real concerns and problems are not addressed, and the main issues are excluded, leaving the child helpless. The non-acceptance and simplification of the actual problem of the child being emotionally vulnerable are dismissed, and this notion hinders the type of assistance the child really requires. Additionally, in the invalidating environment, major problems are often required to provoke a helpful environmental response, and social contingencies favour the development of extreme emotional reactions (Linehan, 1993). Consequently, by unpredictably punishing expressions of negative emotions and sporadically strengthening expressions of intensified emotions, this invalidating environment teaches the child to oscillate between emotional inhibition and extreme emotional states. This practice fails to assist the child to trust their own emotions, cognitive responses, and interpretations of internal and external circumstances. In contrast, this kind of invalidating environment not only encourages the child to dismiss their own experiences, but also to seek encouragement from the social environment on how to feel and behave.

The biosocial model proposes that children who are already biologically vulnerable to emotional stimuli and who were brought up in an invalidating environment can, over time, become significantly invalidating of each other, consequently leading to BPD. It is formulated in terms of a transactional and vicious circle, where the child and parents form and reinforce negative behaviours in each other, leaving both sides dysfunctional. One of the main errors of the caregiver’s practice is expecting more from the child than the child is able to perform, leading to punishment when this cannot be fulfilled. Hence the child will express more extreme emotional behaviours, leading the caregivers to stop trying to control the child and therefore reinforcing this kind of extreme expression. In turn this may lead to the development of BPD (Linehan, 1993).

According to the biosocial conceptualisation of BDP, Linehan (1993) developed a therapeutic approach called dialectical behavioural therapy (DBT). The therapeutic approach is a comprehensive cognitive behavioural treatment method, aimed at complex and problematic mental disorders, but originally directed at individuals with chronic suicidal behaviours. However, today DBT seems to be one of the most adopted therapeutic treatment approaches when working with BPD individuals, as the treatment targets emotion dysregulation, depression, self-harm, and parasuicidal behaviour (Dimeff & Linehan, 2001).
In its most basic form, DBT is a highly structured and time limited cognitive behavioural psychotherapeutic treatment combined with eastern mindfulness practices. The terminology dialect emerges as the treatment aims to improve dialectical thinking processes to substitute inflexible and destructive thinking patterns. The therapeutic approach uses the principles of mindfulness to express validation and acceptance towards the patient, while at the same time assisting and potentiating change. The changing strategies include behavioural analysis of maladaptive behaviours and problem solving techniques, which is typical to the more cognitive behavioural model. The therapeutic approach concentrates on improving skills around self-regulation, distress tolerance, and dysfunctional behaviours.

Comparing the Two Models

The attachment mentalization model of BPD introduces some concepts from the biosocial model, notably the transactional orientation between both biological and environmental factors in its aetiology of BPD. While both models adopt this developmental and transactional approach for its formulation, they each put significant emphasis on either biological or environmental factors contributing to the disorder’s emergence. Seemingly, the biosocial model emphasises biological variables – such as personality traits and genetic inheritability – as having prime significance to the development of BPD, whereas the attachment mentalization model puts prime emphasis on environmental variables such as insecure attachment history during infancy and early childhood. Although both signify a developmental and transactional model in their aetiology, they both differ somewhat.

The attachment mentalization model theorises that deficits in mentalization capacities and the disorganisation of self-structure may explain the characteristics of BPD. The central thesis of this model summarises that the development of the social affiliative system is the central influence in mentalization capacities. Therefore, this enables various social cognitive functions, which lead to the emergence of stable interpersonal interaction in light of the attachment perspective (Fonagy & Bateman, 2006). Within this conceptualisation, various aspects are core in understanding BPD: affect representation and regulation, attentional control associated with regulation of affect, and finally, a system of interpersonal understanding mentalization in the context of attachment principles (Bateman & Fonagy, 2006). The development of these principles is heavily reliant on the child’s relationship with its primary caregiver, consequently making it vulnerable to ecological errors. Accordingly,
the achievement of emotion regulation skills starts primarily in infancy and endures throughout their lifespan, and in order to achieve normal self-experience, it is required that the infant’s emotional expressions are correctly mirrored by the primary caregiver. Consequently, the absence of this has significant consequences in terms of affect regulation and other social cognitive skills developing normally.

When comparing Linehan’s (1993) biosocial model with the attachment mentalization model of BPD, some distinctions are seen. Although they both overlap in some aspects and adopt a developmental and transactional approach, the biosocial model does not adopt the perspective that a BPD individual’s main deficit lies in their mentalization capacities, nor do they form their theoretical basis in accord with attachment theory. The theory emphasises that BPD is principally a disorder of emotional dysregulation, due to emotional vulnerability and the incapacity to control emotions. The main deficit in BPD individuals is concentrated around their inability to modulate emotions, which is primarily caused by biological factors and not the social affiliative system between the infant and primary caregiver. Compared to the mentalization model – which theorises that deficits in mentalization capacities are the central thesis in BPD, taught through the concept of mirroring – the biosocial model adopts the notion that the child is inheritably emotional vulnerable, thus leading the child to be difficult from birth. Therefore, the biosocial theory suggests that children who are already biologically vulnerable to emotional stimuli, and who were brought up in an invalidating environment, can over time become significantly invalidating of each other, which may cause unstable development and consequently lead to BPD.

Although both models place significance on trait impulsivity and how this may affect emotional regulation in an individual, they diverge in terms of the aetiology, and what this may be a consequence of. Additionally, the MBT model (Bateman & Fonagy, 2012) theorises that early disorganisation of a primary attachment relationship leads to impaired social cognitive capacities, consequently failing to create a secure attachment relationship between child and the primary caregiver, leading to a disorganised self-structure. This notion consequently leads to impaired mentalization capacities. In contrast, Linehan’s (1993) biosocial model suggests that it is the inheritable characteristics of the child that makes it difficult to adapt to the environment, and therefore a slightly invalidating environment along with irregularities in biological functions may contribute to distorted development and maladaptive functioning. Linehan (1993) also adopts the conceptualisation that the child’s
“goodness to fit” or “poorness to fit” to its environment will lead to its later behavioural capabilities. Equating the two models clearly indicates that the MBT model emphasises environmental variables such as neglect, maltreatment, and sexual abuse in its aetiology of BPD, whereas the DBT model emphasises biological variables such as neurochemical deficits. However, both models overlap in terms of their implementation of various environmental and biological variables playing a role in the emergence of BPD, but the emphasis they each put on these variables diverges significantly.

Both Linehan (1993) and Fonagy (2006) present very influential aetiological models of BPD, although the precise nature of the link between insecure attachment and biological predisposition with the disorder remains subject to broader debate. Despite many research studies indicating a high percentage of individuals with BPD disclosing a history of insecure attachment such as neglect (92 percent), physical abuse (25-73 percent), and sexual abuse (40-76 percent), many researchers have criticised the retrospective orientation of these declarations of abuse, implying the significance of not looking at any single event as the peak risk factor for the emergence of BPD (Zanarmini et al., 1998). Moreover, the idea of mentalisation has been critiqued as being too extensive and multi-facetted in order to be put into practice as therapeutic treatment and understanding due to its formulation for BPD (Choi-Kan & Gunderson, 2008; Holmes, 2005). While the MBT model describes insecure attachment and abuse of some sort as the central aetiology that leads to the development of BPD, it still leaves some significant questions unanswered.

One example would be that the theory of mentalizing takes a complex attachment perspective and the idea of mirroring seems to offer a reductive explanation. The mentalization approach considers the concept of mirroring as the central and crucial contribution from the primary caregiver for the future development of stable mentalization capacities. However, as sexual abuse is considered one of the strongest precursors of BPD (Gunderson, 2005), and usually not occurring in infancy but in later childhood with the peak time of sexual abuse being between 7-13 years (Finkelhor, 1994), it does put the significance of mirroring during infancy for the stable development of mentalizing into question. While the principle of mirroring provides a worthy understanding in many respects, the MBT model adopts a very simple reference to its concepts, only involving isolated interaction between infant and primary caregiver in the early stages of infancy.
In various aspects, the MBT model adopts a complex and reductionist attachment perspective, undermining the child’s developing capacities isolated to mental state terms and early infant and caregiver proximity. However, the significance of insecure attachment history throughout childhood as an indicator for later psychiatric instability is well adopted in the general arena (Lynch & Kelly, 2002). As a result, further research into attachment theory and the concepts of mirroring is desirable, as there might be diverse vulnerabilities to the development of mentalization capacities, which can assist further elaboration on the MBT model, as well as treatment for BPD.

The biosocial model of BPD suggests that the main deficits to the emotion regulation system are primarily a consequence of biological abnormalities emphasised around the neurochemical systems of the brain, notably the serotonergic system, which is also linked with impulsivity. The model adopts the notion that BPD is associated with significant pathology as a consequence of high impulsivity, leading to self-destructive behaviour and emotional dysregulation. However, the link between biological vulnerabilities and a slight invalidating environment to the development of BPD still lacks robust empirical evidence (Crowell et al., 2009). First of all, no prospective longitudinal studies testing these biological assumptions of the theory have been conducted, nor is there any evidence to suggest a clear link between the serotonergic system and impulsive behaviour. Studies have indicated that medication that is not serotonergic mediated – such as carbamazepine and various other anticonvulsant mood stabilisers – is proven to be useful (Haller et al., 1994). Although evidence does suggest a link between impulsivity and the serotonergic system, the 5-HT assumption presented in the biosocial model of BPD is not certain. The comprehensive role of 5-HT activities and its difficult communication with various other neurotransmitters and receptors in impulsivity have not yet been entirely explained. So, whether biological variables or insecure attachment history plays a lead role in the development of BPD is still subject to major debate.

It is clear that there are still major inconsistencies between both the MBT and DBT model in describing and verifying the development of BPD. This review has not resolved, nor aimed to resolve, these incompatibilities evident in both models presented by Linehan (1993) and Bate & Fonagy (2006, 2012), but has simply aimed to critically review both models in light of the current literature. One must decide how far both models can draw support from available literature and research conducted around the subject arising – perhaps comparing the two therapeutic practices is more of a productive and convincing goal. As mentioned earlier, even
though both models overlap each other, the differences in therapeutic practice and goal are varied. Therefore, empirical studies concentrated around comparing the outcome of MBT and DBT therapy with BPD individuals could propose significant explanations to its aetiology in the future.

However, the biosocial model leans towards the cognitive approach’s epistemological framework and fails to emphasise the salience of the individual’s lived experience. The approach suggests that a person with BPD presentation is disordered because of cognitive and physiological impairments. Consequently, psychological treatments are tailored and targeted to modify these biological and cognitive impairments (Bennet, 2006). Thus the course of treatment can only be tailored and targeted according to the cognitive assessment and diagnosis given, leaving the person within the spectrum of BPD in a state of abnormality.

The model fails to encompass the person’s lived experience of their distress, thus it might make them feel negligible and helpless as the approach puts prime emphasis on their symptoms, not their phenomenology and personal history. Furthermore, as the biosocial approaches are influenced by the biomedical model, it might even reinforce this view in the individual affected with such human distress, promoting stigma. As the cognitive approach’s primary focus is on the symptomatology of BPD, I think it is at odds with counselling psychology’s philosophical foundations, which are grounded in a different epistemology that focuses more on the therapeutic relationship, phenomenology, and being with the client in order for change to occur (Woolfe et al., 2003). In contrast, the MBT model encourages the therapist to take a not-knowing stance (Bateman & Fonagy, 2012), which is closer to a philosophical foundation of counselling psychology.
References


Appendix
Appendix G: Europe’s Journal of Psychology, Notes for Contributors.

Insert Running Head Here (no more than 50 characters)

Insert Article Title Here

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Abstract

Insert an abstract of 150 to 250 words here.

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Insert keywords here. 5 to 7 keywords, lowercase (except nouns), separated by commas, no period after the keyword sequence.
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Figures

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Muslim Clients’ Cultural Identity, and how this might Influence their Ways of Seeking Psychological Help: Towards a Grounded Theory Analysis

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Abstract

The purpose of the present study was to explore Muslim cultural identity, how this might influence their ways of seeking psychological help and their perspectives on psychodynamic therapy, and its compatibility with Muslim cultural and religious values. Seven Muslim psychology graduates working in mental health settings were interviewed and the data was analysed using constructionist grounded theory (Charmaz, 2006).

According to the grounded theory analysis, the Muslim clients’ ways of seeking psychological help were consonant with their sense of identity, which developed in interaction with their cultural and religious values, community and family relationships, and experiences with western culture. Approaching psychotherapy services for support with emotional and psychological difficulties was incongruent with more traditional Muslim cultural values. The participants’ narratives indicated that Muslims – who strongly identified with their cultural values – might reject help from outside their family and community networks, such as the suggestion of having psychodynamic therapy, or would not respond well to it. However, most participants’ narratives suggested that Muslims who had a more conflictual relationship with conservative Muslim cultural values, and whose identity had accepted the host culture, were seen as more acceptable and open in seeking help outside their cultural values, such as with regards to psychotherapy.

Keywords: Muslim, Culture, Religion, Ways of Seeking Psychological Help.
Introduction

Using the guidelines of a constructionist grounded theory (GT) method (Charmaz, 2006), the current study is an exploration of influences on Muslim cultural identity when seeking psychological help. Additionally, the study explores Muslim perspectives on psychodynamic theory and practice, and how compatible this therapeutic approach might be with Muslim cultural and religious values.

Rationale

Islam signifies the second largest religion in the United Kingdom (Weatherhead & Daiches, 2010), and Muslims are the fastest growing religious minority in the United States (Haniff, 2003; Ali, Liu, & Humedian, 2004). However, despite this, there is still little published research concerning Muslim ways of seeking psychological help, and the compatibility of western psychotherapeutic approaches with Muslim cultural and religious values. Yet, while multicultural, clinical, and counselling research literature around ethnic minorities has grown significantly during the past two decades (Akhtar, 2008), there has been a paucity of research on the Muslim minority group, leaving a significant gap in the literature (Sayed, 2003). Literature is especially restricted on psychodynamic therapy with reference to its compatibility with Muslims’ cultural and religious values (Dwairy, 2006). Consequently, the present research study is timely, and located in a context that begins to attend more explicitly to the cultural identity of the Muslim clients. It aims to further explore how cultural identity might inform our understanding of Muslims’ ways of seeking psychological help, as well as the compatibility of psychotherapy with Muslim cultural values.

Research studies have suggested that the Muslim population living in the west have a higher risk of psychological morbidity than the overall population (Fazil & Cochrane, 2003; Department of Health, 2005). This may be due to several factors, such as stressors associated with migration, and the experience of political instability in home countries, forcing many Muslims to migrate. A considerable number of research studies suggest that migrants may experience cultural bereavement, lower socioeconomic status, social isolation, and prejudicial treatment, all of which intensify the risk of experiencing psychological distress (Dalgard & Thapa, 2007; Karlson & Nazroo, 2002; Tinghog, Hemmingson & Lundberg, 2007). Overall, empirical studies reveal that ethnic minorities – especially from Middle Eastern descent in Europe – are continuously experiencing mental health difficulties, that there are significant discrepancies in the usage of mental health services, and that there is often poorer access to
these services compared to the general population (Merlo, 2008; Hedayat-Diba, 2000; Hodge, 2005; Kelly, Aridi, & Bakhtiar, 1996; Mahmoud, 1996).

Moreover, approaching mental health caring for clients of Middle Eastern descent presents a range of challenges, and these are partly due to the inherent complexities with reference to their mental health-seeking related behaviours (Pooremamali & Persson, 2010). Some literature (Black & Wells, 2007; Cnaan, Wineburg, & Boodie, 1999) suggests that culture might be an essential factor, with cultural differences between mental health services and this minority group possibly being a significant barrier. The significant absence of the Muslim minority in mental health services might be due to cultural barriers (Sheridan & North, 2004). In addition, stigma, fear about treatment, self-concealment, and social norms seem to be related with help-seeking attitudes of ethnic minorities (Anderson, Brownlie & Given, 2009; Bassaly & Macallen, 2006).

**Muslim Culture and Beliefs**

Despite the size of the Muslim community, most mental health practitioners seem to have been exposed to fairly little content on Muslim cultural and religious values throughout their educational careers (Furnman, Benson, Grimwood, & Canda, 2004). This lack of content signifies a critical oversight, as the Muslim cultural and religious values represent a distinct cultural narrative (Nadir & Dziegielewski, 2001). Therefore, concerns exist that this lack of acquaintance with Muslim cultural and religious values might result in the use of therapeutic approaches incongruent with Muslim clients. Especially with reference to counselling psychologists – who place significant emphasis on the therapeutic relationship and their clients’ phenomenology (Elvis & Green, 2008) – further understanding of their clients’ cultural and religious values might assist in building stronger therapeutic relationships, enabling better therapy outcomes, thus making this study important within the philosophical foundations of counselling psychology.

Western cultures are influenced by a specific set of epistemologically rooted values, such as individualism, self-determination, independence, and self-expression (Hodge, 2005), and just as Western culture emphasises specific values, so too does Muslim culture. For Muslims, some of these values are rooted in more ancient Middle Eastern traditions (Esposito, 1988; Smith, 1999). The Muslim culture adopts a variety of values such as the importance of community, consensus, interdependence, self-control, implicit communication, and identity more influenced by family, community, and religion (Nyang, Bukhari, & Zogby, 2001;
Williams, 2005). Consequently, the contrast in values between Western and Middle Eastern culture might explain the potential Muslim pathways for seeking psychological help, as well as the absence of Muslims in mental health services in the UK. Culture might suggest a number of factors that influence attitudes, subjective values, and perceived behavioural control, and these are consequently associated with ways of seeking psychological help (Pilkington, Msetfi & Watson, 2012).

This variation is often associated with the dissimilarities in individualism and collectivism between cultural values (Oyserman, Coon & Kemmelmeier, 2002). Previous research indicates that cultural orientation will affect how mental health services are perceived, as well as the probability of accessing such services (Hill & Bale, 1980). Muslim psychological help-seeking behaviours might also be influenced by their highly collectivistic cultural values. Ways of seeking psychological help and comfort is often congruent with cultural identity, and research suggests that Muslims who identify with more traditional Middle Eastern values are less likely to access psychological services and will instead seek assistance in more traditional ways, such as through family, community networks, and spiritual healers (Gilbert & Sanghera, 2004; Anand & Cochrane, 2005).

Acculturation

Another factor influencing ethnic minorities’ psychological help-seeking behaviour is their level of acculturation (Kim & Omizo, 2003); the concept of acculturation refers to the degree in which a person belonging to an ethnic minority adapts to the host culture, and if their values and beliefs are influenced by contact with the dominant culture (Berry, Trimble, & Olmedo, 1986). With reference to the Muslim population living in Western countries, it has been well documented that attitudes towards mental health services and ways of seeking psychological help are associated with their levels of acculturation. Thus, literature suggests that Muslims with low levels of acculturation are less likely to seek psychological services outside their family and community networks (Zhang & Dixon, 2003; Erickson & Al-Timimi, 2002).

Psychodynamic Therapy and Cultural Competency

Psychodynamic therapy emphasises the use of therapy to increase emotional, as well as intellectual, awareness. The model recognises that early life experiences with parents and other authority figures form present perspectives, behaviours, attachment styles, and
relationships (Maroda, 2010), with the model being established primarily within Western culture, where support for its effectiveness has generally been established within these cultures (Gorkin, 1996). There are debates on whether psychodynamic theory and practice may not be congruent with more traditional Muslim cultural values (Al-Abdul-Jabbar & Al-Issa, 2000), and this area lacks empirical research.

To the best of my knowledge, no empirical studies have been conducted indicating evidence based psychodynamic therapy with Muslims and how effective it might be. However, the rapidly changing demographics in the West, and the wars in the Middle East over the last two decades, have caused an influx of immigrants from Muslim countries to the West, increasing the number of Muslims seeking psychodynamic therapy (Akhtar, 2008). Nevertheless, there are only approximately forty Muslims who have gained psychoanalytic training from the institutes recognised by the International Psychoanalytic Association, and all of these are practising in Western countries such as North America and Europe (Akhtar, 2008). Muslim entry into the psychoanalytic domain has largely been through immigration to the West, and the question remains unanswered as to why psychoanalysis has failed to take root in the Middle East and in other Muslim nations.

Some have argued that psychodynamic-oriented therapy might not work well within the Muslim culture, because the therapeutic model tends to look inwards and has a more individualistic approach, whereas in contrast, the Muslim culture generally tends to be more outward looking, forming identity influenced by family and community factors. Consequently, this could make them less interested in more introspective therapy such as the psychodynamic model (Al-Abdul-Jabbar & Al-Issa, 2000; Hodge & Nadir, 2008). Nevertheless, I think the time has arrived for a dialogue between psychodynamic theory and Muslims, both in terms of culture and religion.

**Aim of Research**

The present research study aims to use grounded theory analysis to explore and provide an understanding of: i) Influences on Muslim psychological help-seeking behaviours ii) The compatibility of psychodynamic therapy with Muslim cultural and religious values.
Design

*Reasons for Using a Qualitative Approach*

A qualitative approach was utilised in this study primarily due to the research question, as well as what the research study aimed to explore and discover, which was how cultural identity might inform our understanding of the ways in which Muslims seek psychological help, and their experience of western psychotherapies congruent with Muslim cultural values. There is scarce empirical literature on Muslims’ psychological help-seeking behaviours, or on their respective perspectives on psychotherapies. Most studies are quantitative and concentrate on topics such as comparing modified psychotherapies versus standard psychotherapies with ethnic minorities, and therefore only focus on measurable outcomes, like treatment effectiveness (Lim et al., 2014). Existing research doesn’t elaborate on how cultural identity influences the ways in which Muslims seek psychological help, or on their experiences of and perspectives on psychotherapy. Thus, the study aims to explore this area, enhance our understanding, and fill the gap in the existing literature. Hence, a qualitative approach seemed most suitable for what the research aimed to gain.

On its most basic level, qualitative research is considered as comprising the collection and analysis of non-numerical data, and through a psychological lens, it provides the tools for in-depth description and explanation of certain experiences and conditions (Willig, 2008). Analysis of this data was carried out using a qualitative approach, given that the current research study aims to provide rich descriptions and possible explanations of people’s meaning-making and how they experience particular events (Lyons & Coyle, 2007). This allows the study to achieve a more contextualised understanding and to permit the data analysis to capture the processes of these contextual reflections communicated through the subjectivities of the participants in this study (Lyons & Coyle, 2007; Willig, 2008). Utilising a qualitative approach allowed the study to investigate the Muslim client’s journey through their cultural identity, exploring experiences and perspectives on how this might influence their ways of seeking psychological help.

Moreover, as the researcher himself is a trainee counselling psychologist, the epistemological stance of qualitative research methodologies sits well with the core philosophical values of counselling psychology (CP). Although CP overlaps the provinces of psychotherapy, clinical psychology, and psychiatry, its philosophical grounds focuses extensively on the therapeutic relationship and phenomenology (Woolfe et al., 2003). Moreover, the profession is embedded
in the exploration of the meaning of events and experiences, especially in terms of emotion (BPS, 2014). Therefore, there is an overlap between CP and qualitative epistemology, which equally focuses on phenomenology and meaning-making, rather than quantitative research, which adopts a more positivist approach (Cox, 2012). Accordingly, qualitative research can be an exploratory and engaging dialogue between researcher and participant regarding a certain research topic, whilst also processing characteristics of the interaction itself, which can equally mirror the therapeutic process that occurs in psychologist and client relationships, highly emphasised in CP (Nolan & West, 2014). Therefore, a qualitative inquiry is suitable for what the study aims to gain, which is to allow a dialogue to emerge between researcher and participant, thus giving a better understanding on factors that might influence the ways in which Muslims seek psychological help, as well as their experiences of psychotherapy.

Nonetheless, as there is a significant gap in literature and qualitative research regarding the ways in which Muslims seek psychological help, as well as western psychotherapies’ congruency with Muslim cultural values (Dwairy, 2006; Sayed, 2003), exploration into this area seems ideally appropriate to an open, qualitative method. Although (as formerly mentioned) there are limited qualitative studies around this topic, a comparable quantitative research study examined factors that affected intention to access psychological services in a sample of British Muslims (Pilkington et al., 2012). This quantitative study used various questionnaires in order to measure intention and other factors associated with seeking psychological help amongst British Muslims. Consequently, there appears to be limited qualitative empirical research on the ways in which Muslims seek psychological help, as well as western psychotherapies’ congruency with Muslim cultural values, and so the topic remains incomplete.

Furthermore, qualitative literature is especially restricted on psychodynamic therapy with reference to its compatibility with Muslims’ cultural and religious values (Akhtar, 2008; Dwairy, 2006). Therefore, the study took a qualitative approach outside of the positivist paradigm of quantitative research designs, by focusing on in-depth exploration of the meaning of events and experiences, and how they might inter-correlate.

Using Grounded Theory Methodology

In order to explore and answer the research question, a grounded theory (GT) approach was used to inform the data collection and analysis. On a basic level, GT is a systematic methodology in social science comprising the creation of theory through constant
comparative measures and analysis of the data gathered (Charmaz, 2006). In answering the research question and exploring the topic area, which was, *How and what cultural and religious factors might be influencing the Muslim clients’ ways of seeking psychological help, and how the participants perceived psychotherapy?* GT seemed most suitable with its bottom-up approach. Since GT is also suitable for more exploratory research, as well as developing inductive theory and perspective in an area that lacks empirical research, (Charmaz, 2006; Payne, 2007), it was considered most suitable for the current study, which also lacks empirical research.

Furthermore, in answering the research question, the study adopted Charmaz’s (2006) GT constructionist approach to data analysis. This approach is closer to the epistemological grounds of qualitative research compared to the more positivist paradigms of the original version of GT (Strauss & Corbin, 1990) and quantitative research (Elliott, Fischer, & Rennie, 1999; Tweed & Charmaz, 2012). In contrast to the original version of GT, Charmaz’s (2006) constructionist approach to the data itself is a social construction of reality as perceived by the participants whose experiences are studied, whereas the researcher – as an alternative of being passive – is viewed as being actively involved in creating knowledge from the data. This notion is also closer to the philosophical grounds of qualitative inquiry, where the researcher’s own beliefs will inform the findings of the research study.

However, another reason for utilising Charmaz’s (2006) constructionist approach before Glaser and Strauss’s (1967), was due to the notion of avoiding reviewing the literature, as this could result in theoretical sensitivity and could risk the rigour of the research study. This notion was viewed as a limitation for this study, consequently adopting Charmaz’s (2006) approach, which reviews the literature as essential to situate the study within the body of related literature.

*Other Qualitative Approaches*

Several other methods of analysis were considered, including Interpretative Phenomenological Analysis (IPA: Smith, Flowers & Larkins, 2009) and Thematic Analysis (TA: Braun & Clarke, 2006). However, GT seemed most suitable from the myriad of qualitative methodologies available for the current study, as the specific method allows the building up of inductive theories through data analysis where existing theory is either incomplete or absent in current literature (Charmaz, 2005). With reference to the current research topic, which lacks empirical research, a GT approach would permit the development
of abstract theoretical explanations to the ways in which Muslims seek psychological help, allowing emerging perspectives on psychotherapy’s congruency with Muslim cultural values. Generating theory and research around this topic would be essential given the focus on equality in mental health services in the West, as well as the suggestion that the Muslim population may have high levels of mental health problems due to factors such as immigration, experience of civil war, political prosecution in home countries, and stressors associated with acculturation (Fazil & Cochrane, 2003; Department of Health, 2005). Consequently, more literature and theory would facilitate mental health practitioners’ understanding of this minority group, avoiding misinterpretations and enabling more culture-appropriate treatments.

In contrast to IPA’s idiographic approach, which focusses on phenomenological inquiry on the subjective experience of a certain phenomenon (Smith, Flowers & Larkins, 2009), GT concentrates on the development of abstract theoretical explanations, which was the preferred method. Thematic Analysis (TA) was also considered as a tool for analysing the data, as like GT, it too aims to identify, analyse, and report patterns (McLeod, 2001). However, in TA primacy is given to identifying themes and there is no clear and structured way of conducting data analysis (Attride-Stirling, 2001), while GT aims to generate theory rather than themes, thereby providing a more dynamic overview of a given behaviour.

Consequently, as clarity around the process and the practice of a method was an important factor in the current research in understanding why and how Muslims seek psychological help, Charmaz’s (2006) version of GT was utilised as it presents a structured way of collecting data, identifying categories, connecting emergent categories, and generating theoretical explanations of a given phenomenon.

**Sample**

The grounded theory research method operates in a more reverse manner, in that it does not begin with a hypothesis, but rather begins with collecting data via a structured process. Participants are usually recruited through the concept of theoretical sampling; a cyclic and emergent process by which the researcher collects, transcribes, analyses, and codes the data, constructing tentative categories. Grounded Theory presupposes that the researcher constructs preliminary categories from early data gathering and samples, followed by changing protocols (See Appendix E, Interview Schedule), before going back to the field for further empirical inquiry in order to develop emerging categories (Charmaz, 2006). This process
provides the ground for re-examining abstract categories and ideas by constant comparative methods and analysis, as early constructed categories are merely suggestive and not conclusive. The initial process of theoretical sampling provides a point of departure, but not a conclusive theoretical elaboration, therefore further data gathering is instructed. This process is practised in order to advance new ideas, elaborating and refining existing abstract categories to develop an emerging theory. Furthermore, an important criterion in Grounded Theory is the process of theoretical sampling, which allows categories to be saturated, and when data no longer triggers new insight and ideas, theoretical saturation has been obtained (Charmaz, 2006).

There were 7 participants, all of whom defined themselves as Muslims, were interviewed. All participants had at least an undergraduate degree in psychology, as well as experience with mental health services, and psychodynamic theory and practice at some level – participants had either knowledge of psychodynamic theory and practice by experience of being in psychodynamic therapy themselves, or through academia. Four participants were women while three were men, and they ranged in age from 28 to 38 years. Some participants were born in Europe, and some came from Pakistan, Iraq, Iran, and Afghanistan as children, though all attended and obtained their academic qualifications in the United Kingdom and Denmark. All of the participants defined themselves as Muslims and stated that they belonged to the two main schools of thought in Islam: Shia and Sunni Islam. The researcher was looking for participants identifying themselves as Muslims and being psychology graduates, though they differed in their level of education – from undergraduate to doctoral level.

Table 1

Participants’ Demographics

<table>
<thead>
<tr>
<th>Participant No.</th>
<th>Age</th>
<th>Gender</th>
<th>Religious Affiliation</th>
<th>Practising Muslim</th>
<th>School of Thought</th>
<th>Level of Education</th>
<th>Had Psychodynamic Therapy Before</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatima</td>
<td>33</td>
<td>Female</td>
<td>Muslim</td>
<td>No</td>
<td>Shia</td>
<td>Undergraduate</td>
<td>Yes</td>
</tr>
<tr>
<td>Babar</td>
<td>30</td>
<td>Male</td>
<td>Muslim</td>
<td>Yes</td>
<td>Shia</td>
<td>Masters</td>
<td>Yes</td>
</tr>
<tr>
<td>Ali</td>
<td>34</td>
<td>Male</td>
<td>Muslim</td>
<td>Yes</td>
<td>Sunni</td>
<td>Undergraduate</td>
<td>No</td>
</tr>
<tr>
<td>Mariam</td>
<td>38</td>
<td>Female</td>
<td>Muslim</td>
<td>Yes</td>
<td>Sunni</td>
<td>Doctoral</td>
<td>Yes</td>
</tr>
<tr>
<td>Farzanah</td>
<td>29</td>
<td>Female</td>
<td>Muslim</td>
<td>Yes</td>
<td>Shia</td>
<td>Doctoral</td>
<td>Yes</td>
</tr>
<tr>
<td>Aisha</td>
<td>28</td>
<td>Female</td>
<td>Muslim</td>
<td>No</td>
<td>Sunni</td>
<td>Masters</td>
<td>No</td>
</tr>
<tr>
<td>Faisal</td>
<td>30</td>
<td>Male</td>
<td>Muslim</td>
<td>No</td>
<td>Sunni</td>
<td>Masters</td>
<td>No</td>
</tr>
</tbody>
</table>
Ethical Considerations

Ethical approval was obtained through the University’s Faculty of Arts and Human Sciences Ethics Committee with no further comments or guidelines (see Appendix A). In order to ensure that ethical guidelines were followed appropriately, the research study also followed the BPS Code of Human Research Ethics (BPS, 2009), which presents ethical guidelines required to explain the conditions under which psychological research can be practised appropriately. The revised Code of Ethics and Conduct (BPS, 2009) outlines some abstract guideline principles for psychologists conducting research with human and non-human samples. The code requires psychological research with human participants to be guided by certain core principles such as: Respect for Autonomy and Dignity of a Person, Scientific Value, Social Responsibility, and Maximising Benefit and Minimising Harm (Code of Human Research Ethics, 2009).

Adherence to these core principles is considered essential when conducting psychological research with human participants, and there is a clear duty for the psychologist towards the participants. An indispensable component of the guided principles in the Code (BPS, 2009) is the psychologists’ respect for the participants’ dignity and autonomy, whereby making rational judgement about any actions in the course of conducted research that will have an impact on the autonomy and dignity of the participants. Also in accordance to the Code’s ethics principle (BPS, 2009), ‘psychologists should consider all research from the standpoint of the research participants, with the aim of avoiding potential risks to psychological well-being, mental health, personal values, or dignity’.

The researcher at all times aimed to keep his research model congruent within these principles. This was partly done by researcher debriefing participants regarding the study, obtaining consent, and constantly being aware of participants’ psychological well-being by checking with them during the course of the interview and after. Consequently, the researcher aimed to keep his study within the principles of ‘maximising benefit and minimising harm’ (BPS, 2009).

Other protocols required by the Code (BPS, 2009) are risk assessment, obtaining valid consent, debriefing participants and confidentiality following the Data Protection Act. In accordance with the Code of Human Research Ethics (BPS, 2009) and the Data Protection Act (BPS. 2002; UK Legislation, 1998), the participants in the study were debriefed with regards to the nature and value of the research, and had the right to withdraw from the study.
at all times if they wished to do so. Furthermore, all data recorded was saved on an encrypted USB drive, stored safely during the research project, and destroyed after transcription. Transcripts were kept under pseudonyms in order to protect the identity of the participants.

Furthermore, as the researcher is a trainee counselling psychologist, he always aimed to guide his research model according to the values articulated in counselling psychology. This was conducted by following the Division of Counselling Psychology (DoCP) Professional Practice Guidelines (BPS, 2013). The DoCP was used in addition to the BPS Code of Conduct, Ethical Principles and Guidelines, and Code of Human Research Ethics. This sets the minimum standard threshold for which behaviour should not cross, both in generic professional practice and in research ethics with human participants. As one of the core principles of counselling psychology (CP) promotes a phenomenological model of therapeutic practice, and is significantly influenced by a strong psychotherapeutic tradition (DoCP, 2013), the researcher tried to keep his research within the principles of CP at all times. This was achieved by the researcher always attempting to engage with the subjectivity of the participants, respecting their religious and cultural beliefs, and keeping an anti-discriminatory attitude to the emerging narratives.

Although ethical approval was ratified without any further recommendation, ethical considerations are still complex and have multifaceted implications for practice and research in counselling psychology and psychotherapy (Rowson, 2001; Tribe & Morrissey, 2015). There are two commonly appealed principles followed in therapeutic practise research: beneficence and non-maleficence (Emanuel et al., 2000). Beneficence relates to the production of useful findings and contributing to the given research area, and non-maleficence encompasses not to causing emotional or physical discomfort to the participants (Olsen & Jordan, 2015). The two principles are not straightforward in counselling psychology research and therefore the ethical decision making process contains choices that are subject to scrutiny and sometimes consequences (Tribe & Morrissey, 2015).

It is the author’s opinion that the current study strongly grounds itself within the principles of beneficence due to the lack of empirical literature focussing on help-seeking behaviours and psychotherapy of Muslim individuals (Sheikh & Furnham, 2000). However, the current research study was not excluded from this complex process of ethical possibilities due to the sensitive nature of the research topic, sample and the methodological approach chosen. Ethical guidelines emphasise the social, cultural, religious and political context of ethnic
minority persons (Knight, Roosa, & Taylor, 2009). Thus, overlooking the participants’ religious and cultural issues within the study could result in a breach of ethical considerations and therefore affect the quality of the research.

The significance of recognising diverse cultural groups and the ability to work effectively with them in therapeutic practice and research have been argued from an ethical perspective (Nagayama, 2001). Cultural and religious knowledge provides a context in which to understand the participants’ narrative, whereby providing more correct analysis of the data gathered. Thus a culturally competent psychologist or researcher should be able to realise the limitations in their understanding of the client or participant (S. Sue, 2009). Beyond the ethical possibilities of religious and cultural issues, the participants were also a ‘hard to access group’ and a rather marginalised group, as they are not considered a psychological care seeker group and are considered to be an ethnic minority often feeling relegated by the media and current political climate in the West (Pilkington, 2012). As a result the researcher made sure that they were constantly aware of the topics being discussed, ensuring that an anti-discriminatory attitude was maintained and that his awareness of the participants’ psychological wellbeing was maintained throughout the course of the interviews. Possibly the most significant concern in this study was the risk of causing participant discomfort and distress, signifying the non-adherence to the non-maleficence principle or section 2.4 of the Code of Human Research Ethics (BPS, 2009) which is Maximising benefit and minimizing harm. In the case of the current study, there were some challenges associated with conducting research around sensitive topics with ethnic minority groups (Knight, Roosa, & Taylor, 2009).

One of the most significant ethical challenges of conducting research with ethnic minorities is the lack of knowledge and understanding of their values, culture and lifestyles. In accordance with Knight, Roosa & Taylor (2009), researchers need to gain knowledge of the targeted study group, in order anticipate potential ethical challenges and to avoid them before the study begins. The researcher himself can identify as a member of the target group, and as such had prior knowledge and understanding of such complexities and was aware of his ethical obligations towards the participants at all times.

Using a qualitative approach, the study aimed to explore how cultural identity might inform an understanding of Muslims’ ways of seeking psychological help, and their experience of Western psychotherapies and their agreement with Muslim cultural and religious values. The
research aimed to create a dialogue around participants’ personal experience of being in therapy, which covered sensitive and complex topics such as sexuality, religious and cultural values. This can carry the risk of stimulating participant distress or discomfort. Historically, mental illness and certain topics such as sexuality and family concerns often evoke negative responses and significant stigma amongst the Muslim ethnic minority (Gilbert, Gilbert, & Sanghera, 2004). In an attempt to minimise participant discomfort, the researcher used gentle introductory questions at the beginning of the semi-structured interviews (Sen Gupta, 2009; Abrahams, 2007). This ensured a non-intrusive approach through the use of basic counselling skills, such as empathy and genuineness, and introduced a safe environment for them. Additionally, the researcher remained within the philosophical values of CP and the guidelines of the DoCP Professional Practise Guidelines (2013). When the researcher encountered sensitive topics in the dialogue with participants, he made sure to recognise the participants’ individual social and cultural views, and engaged in their subjectivity, values and beliefs with a non-intrusive, but empathic approach.

Other ethical possibilities when dealing with ethnic minorities can be the rules of social interaction, and with the values and belief systems of the targeted research group (Dumka, Lopez & Carter, 2002; Flaskerud & Nyamathi, 2000). Without adequate familiarity with such ethnic minorities and their social norms and cultural values, researcher might unintentionally violate certain social norms or ask questions that might not be appropriate according to the participants’ belief systems (Sanchez-Burks, Nisbett, & Ybarra, 2000). However, the researcher’s personal experience, such as being a member of the research’s target group (Muslim), helped to alleviate some of these potential insecurities. The researcher’s pre-existing understanding of the target group provided him with an ethical sensitivity which was considered beneficial. However, there was always the potential that this could potentially also create a reverse effect, as the participants would risk conversing topics which are deemed stigmatising with another member of their ethnic group. Hence, awareness of potential psychological discomfort and stigmatisation around certain topics when conversing with the participants was taken into consideration.

Nevertheless, the researcher considered most of the participants well educated, psychologically minded and acculturated European Muslims, and open to dialog. However, in the case of cultural and religious similarities between the researcher and the participant, this could also become a barrier due to potential pre-assumptions by the researcher regarding perspectives on certain topics. Consequently, this could limit thinking in the researcher and
cause misinterpretations of the participants’ narratives. Hence, the researcher at all times aimed to keep an open mind and stay close to the participants’ phenomenology, and often sought guidance with his research supervisor to avoid these limitations.

Although researcher ensured that participants’ distress and discomfort were minimal during the whole interview, a core principle learned from being an ethically sound scientist-practitioner was the consideration of potential distressing effects to participants following completion of the interviews, which would have been further beneficial. As sensitive and complex topics were covered during the interviews, consideration of introducing support systems, such as Muslim help-lines or support groups for Muslims, in case any of the participants should require such assistance would have been further beneficial and ethically sound.

Additionally, conducting qualitative research can expose researcher to certain ethical dilemmas due to the approach’s fluidity and inductive uncertainty (Birch, Miller, Mauthner & Jessop, 2012). The complexities of utilizing a qualitative approach, researching and exploring private lives, world views and sensitive topics such as cultural and religious values of an ethnic minority group, can raise multiple ethical issues for researcher. This cannot exclusively be solved by the application of abstract rules and guidelines being put forward by ethics committees in academic institutions and the Code of Human Research Ethics (BPS, 2009). Furthermore, the research model used semi-structured interviews, which is characterised by the researcher following topical trajectories in the dialog between researcher and participant (Barriball, 1994). There is significant ethical obligation when conducting such semi-structured interviews, because the conversation may stray away from the question protocol when appropriate. Consequently, both the researcher and participant can enter sensitive and complex topic territories, thus risking psychological discomfort or unanticipated risk.

Nevertheless, qualitative approaches do not pledge to the norms of the positivist research paradigm, but rather views the researcher as unavoidably occupied in the research process, transferring abstract ethical principles can become a challenge. However, the researcher took care to remain aware of his ethical obligations at all times, and if any distress was observed, the participants would be offered a break, the opportunity to continue on another day, or could completely withdraws from the research at any time. Furthermore, the beneficence principle (to achieve the greatest good) in this research was considered of much significance.
to the researcher. Thus it was hoped the study might produce useful findings, such as expanding the Muslim population in psychotherapy and counselling research might improve their access to psychological services, and help develop more culture sensitive therapies.

**Procedure**

After obtaining ethical approval from the University of Surrey (see Appendix A), the researcher contacted Muslims in academic institutions, and cultural and religious centres in the UK and Denmark. Flyers were also distributed (see Appendix B) through email and Facebook requesting participants.

In order to make sure all of the potential participants met the inclusion requirements, everyone interested in participating completed a brief demographic screening questionnaire (see Appendix C), submitted to the researcher via email prior to the interview. This screening questionnaire required information regarding the participant’s age, gender, religious affiliation, level of education, and knowledge of psychodynamic theory and therapy.

Face-to-face semi-structured interviews were conducted with all participants, integrating key topic areas in the interview process that were identified as theoretically relevant. The questions for the interview were continuously reviewed by an experienced academic supervisor (see Appendix D). Open-ended questions were developed to focus on aspects of the participants’ understanding of Muslim cultural and religious values, factors influencing ways of seeking psychological help, and their understanding of psychodynamic theory and practice.

The researcher used pseudonyms to respect the confidentiality of participants, and all interviews – that were approximately 40-50 minutes in length – were audio recorded and transcribed. Both the semi-structured interviews and transcriptions were conducted by the researcher. To guarantee accuracy and consistency of the transcripts, and to strengthen the validity of the study, the transcripts were emailed to the participants, who were then encouraged to give relevant changes or delete responses they did not want to be included in the final analysis. Furthermore, at the beginning of each semi-structured interview, the researcher distributed and reviewed the informed consent forms and information sheets (see Appendix F).
Interview Schedule

1. What is your understanding of Muslim cultural and religious values?

2. In what way do you think the Muslim culture is, or is not compatible with western culture, can you explain that?

3. What about the religion of Islam, does the religion differ from the culture, what do you mean about that, can you elaborate?

4. What is your perspective on Muslims’ psychological help seeking behaviours?

5. What factors do you think influences Muslim psychological behaviours?

6. What is your understanding of Psychodynamic Theory?

7. How do you think the therapeutic model sits with Muslim cultural values?

Data Analysis

As mentioned earlier, data analysis was conducted according to the guidelines of Charmaz’s (2006) constructivist version. Initially, the steps described by Charmaz (2006) were followed by transcribing the first three interviews, which were coded line-by-line with memo-writing and analytic auditing, ensuring the quality and reliability of the preliminary analysis and emergent categories. The initial categories informed the process of further empirical enquiry, consequently assisting the researcher in seeking further exploration and elaboration on ideas and categories in following interviews. Accordingly, early reflections on preliminary ideas and categories influenced the forthcoming data collection as well as going towards generating a preliminary theory.

Each interview was line-by-line coded, with the raw data being transformed into phrases and words that captured significant events, actions, or themes. These were re-read and transformed into focused codes, which captured themes across line-by-line codes. Evolving codes were then compared with existing codes, using continuous comparative analysis to examine similarities or dissimilarities, and parallel codes were grouped together to form
categories and sub-categories. Explanations were given to codes to safeguard consistency in the coding strategy. As the data analysis proceeded, associations between the main categories and subcategories were established via theoretical coding (Charmaz, 2006). In this phase, a potential core category emerged that had sufficient explanatory power to integrate the remaining categories into an explanatory whole (Charmaz, 2006). Theoretical codes formed the basis for the preliminary grounded theory of “influences on Muslim identities on ways of seeking psychological help, and perspectives on psychodynamic therapy”.

Reflexivity

With reference to Charmaz’s (2006) interpretative definition of theory, which suggests that numerous realities exist, the emerging preliminary theory did not occur solely from the data, but instead the theoretical categories were created through continued dynamic interaction between the participant and the researcher, and an interpretative context with the data. Hence, it has been important for the researcher to embrace a reflexive stance, and to work alongside his supervisor in order to limit personal contributions to the data, due to his own Muslim cultural and religious background.

Credibility

The significance of this research study can be measured by considering Yardly’s (2000) evaluative requirements. In order to establish and indicate close commitment to the topic, the guiding principles of constructivist grounded theory approach were adopted. Every stage of the research process has been described in detail, and possible researcher preconceptions were reflected on, in order to improve research transparency. Furthermore, a literature review was completed prior to the analysis, and the researcher remained flexible and open to developing ideas and thoughts (Charmaz, 2006; Payne, 2007).

Findings

Analysis of the seven semi-structured interviews produced one core category, and five main categories each with sub-categories. The identified categories formed the basis of a preliminary theory of Muslim clients’ journeys on their cultural identity, and perspectives on how this might influence their ways of seeking psychological help.
Overview of categories

Within the core category ‘conflict’, the participants’ narrative reflected on their experience of the Muslim clients’ tense and conflicting journey in deciding whether to seek psychological help from within their respective cultural values – such as family and community networks – or seeking help outside these norms, such as mental health services. Conflict seemed to set the landscape for the participants when reflecting on their experience of Muslim culture and Western culture, as well as the religion of Islam, and how they might assemble within their own distinct communities and form their own cultural and religious subdivisions due to diversity.

Although participants expressed shared characteristics existing within Muslim culture, it seemed essential to often emphasise the cultural and religious diversity that prevails among Muslims. The core category of conflict captures how participants experienced Muslim and western culture, and also Islam as a religion. Culture and religion influenced how the participants assembled within their communities, but they were also experienced as a source of contradiction. The differences or contradictions between cultures and religion were then experienced as a sense of conflict, as participants were pulled in different directions. Consequently, conflict became an important theme, which influenced all other main and sub categories.

The second main category that emerged was ‘ways of seeking help’, and most participants described the conflicting dilemma of possible cultural resistance in seeking therapeutic help outside of the traditional way (i.e. Mental Health Services) vs. within the traditional way (i.e. family and community network). The participants’ narratives reflected that seeking psychological help outside the Muslim cultural values may not be widely accepted, and might even compromise the importance of loyalty towards family and community. This will be further elaborated on in detail with reference to the participants’ experience of Muslim cultural values, which is the third main category emerging from the participants’ narratives. Within this main category, participants described their experience and perspectives of Muslim cultural values, and how most perceived it as being rather conservative and perhaps not always compatible with more western culture, which might reflect tension and conflict again. Muslim cultural values promote the adoption of various commonly held characteristics, such as the importance of family and community, loyalty, and avoiding
disclosure outside this paradigm. There is also a stigma attached to acting outside of these cultural standards.

The fourth main category grounded in the data was identified as ‘psychodynamic therapy’. Again, tension and conflict seemed to set the landscape within this category, and most participants described the model with reference to their own experience of being Muslim and in psychodynamic therapy. Participants highlighted the conflict of individualism, sexuality, and elucidating intrapsychic insight, which might clash with Muslim cultural values that emphasise conservatism, collectivism, and self-control. The final main category was the decision-making process, which was influenced by all previous core and main categories. Participants described how cultural awareness and acculturation is important for the Muslim when positioning themselves within their own cultural and religious community, as well as when making choices of whether to seek psychological help within or without their cultural values, and the perspectives on how a Muslim client might respond to psychodynamic therapy.
Diagram 1.

A Grounded Theory Diagram illustrating Muslim clients’ conflicting and dynamic journeys in deciding to seek psychological help within or without their cultural values, and the potential barriers they might face.
Core Category: Conflict

The core category ‘conflict’ seemed to set the landscape for the Muslim clients’ journeys in defining their cultural identity, how this might influence their ways of seeking psychological help within or without their cultural values, and how congruent psychodynamic therapy might be with their cultural and religious values. This core category influenced each of the main categories and their subcategories.

Main Category: Muslim Client

The category ‘Muslim client’ consists of three subcategories: Muslim culture, Religion of Islam, and Western culture, all of which were described as being important for the Muslim individual, but were also a source of contradiction and tension. Participants presented their difficulty in attempting to process and negotiate the complex interplay of Muslim culture, religion, and western culture, endeavouring to find coherence in the discrepancy and consistency of the three subcategories (i.e. Muslim culture, Religion of Islam, and Western culture). Finding a way through this conflict then influenced how the Muslim clients sought help, moving towards either psychotherapy or a more culturally bound support within family and community.

Muslim Culture

Participants discussed Muslim culture with reference to their experience of its diversity, and the comparative association to the religion of Islam and also to Western culture. Mariam reflects on her experience of Muslim culture in the context of its diversity and western culture:

“Well I think the cultures differ based upon where you are from originally, but I suppose the values are quite traditional in general and quite conservative and not necessarily positive, I would say... and not necessarily compatible with modern western life style in some ways...” (Mariam).

This extract highlights the tension between the complex interplay of Muslim culture and western culture, but before discussing what the implications might entail, Mariam seems to find it essential to highlight the diversity that exists among self-identified Muslims. Later in the interview, she explains that rooted in the more eastern enlightenment, Muslim culture generally affirms certain conservative values, and this emphasis on conservatism was typical of many participants’ narratives. With reference to its compatibility with a more Western
lifestyle, she perceives these values as being less positive, which might indicate an external conflict between two worlds (i.e. Conservatism vs. Western Lifestyle).

**The Religion of Islam**

Most participants reflected on a perceived differentiation between the Muslim culture and the religion of Islam, by separating the two categories:

“I think it is very important to distinguish between the Muslim culture and the religion itself, and Muslim culture is so diversely practised in the Middle East, each according to the country, but... I think Muslim culture in many ways is more strict and conservative...” (Fatima).

Fatima seems to reflect on the complex interaction between Muslim culture and the Western lifestyle, but she also separates cultural values from religious values, presenting a tension and conflict within the interplay of Eastern and Western culture, and the religion of Islam. Conservatism seems to create tension and set the landscape of conflict. Additionally, she attempts to distinguish the two entities of culture and religion, which might not only represent an external conflict and tension between east vs. west, but which also possibly presents an internal imbalance and tension between Muslim culture and the religion of Islam. Below, Babar’s narrative also reflects on a possible internal tension that might exist when separating culture from religion:

“I think that Islam as a religion is very different from the Muslim culture or cultures as so. However, in my understanding the religion of Islam represents tolerance, individual growth, self-acceptance, and most important of all peace and respect to all religions and people...but I think the Muslim culture does not necessarily advocate this notion”. (Babar)

Furthermore, most participants reflected on and recognised the implication of conservatism, which is generally prevalent in Muslim culture and that might clash with a more Western lifestyle. Participants also underlined the differentiation between what Muslim culture and religion represents. However, emphasising the ability to differentiate might not be the dominant practice in the Muslim community, as cultural values seem to inform religious perspectives and interpretations. Participants reflected that being a Muslim was not viewed as a unitary construct. Rather, most participants were keen to detach themselves from general Muslim cultural values, which were perceived as conservative. Ali explains:

“In my perspective, being a Muslim is not necessarily the same as our religion, sometimes the cultural factors overrides the important principles of our religion...
and it’s not always possible for Muslims to be able to differentiate between these two concepts, and maybe here... or this is just my perspective, levels of education and environment plays a significant role”. (Ali)

Ali’s narrative suggests a detachment from Muslim culture, but also a possible attachment to the religion of Islam, which again reflects an internal conflict. However, he also goes on to explain the significance of educational background, and how that might form Muslim perspectives on both culture and religion, as well as their ability to differentiate between these two categories. The influence of educational background forming perspectives on culture and religion was often expressed in the participants’ narratives.

**Western Culture**

Participants often reflected on their perspectives of Western culture in relation to Muslim cultural values and practices. Ali refers to Western culture in a comparative manner and with reference to possible experiences Muslim immigrants might have living in the West:

“I would imagine it could be difficult for Muslims who’s not been brought up and raised here to proper integrate in western lifestyle and values, because here there is significant emphasis on the individual, where self-actualisation comes before community actualisation.” (Ali)

Ali’s perspectives on Western culture place a particular emphasis on the tense dilemma between home and host culture and their complex interplay. Perhaps Ali reflects an element of external and internal conflict and tension between Muslims who conform to conservative values and the Muslims who conform and adopt more Western values, enjoying the individual freedoms that self-actualisation might bring.

The complex and conflicting interplay between the subcategories of Muslim culture, religion of Islam, and Western culture seemed to influence the Muslim clients’ ways of seeking help, which will be outlined in the following section.

**Main Category: Ways of Seeking Help**

Within this main category, participants reflected on Muslim responses to problems and psychological difficulties, and their decisions about whether to seek psychological help within mental health services or within their respective cultural values. This was again creating a source of conflict and tension in the process of decision-making, both in terms of external and internal dynamics. Participants described this decision as perhaps being congruent with a sense of identity related to their abstract cultural values. Muslim cultural
values emphasise family and community, loyalty, and avoiding disclosure and levels of cultural attachment. All of these factors may be influencing Muslims’ ‘way of seeking help’. How levels of cultural attachment might be a mediator, moving towards or away from psychological therapy, will be further elaborated on later in the grounded theory analysis. However, Mariam reflects on the complex interplay between psychological work and Muslim culture:

“I think potentially any kind of psychological work would be difficult... I don’t think that the Muslim culture is particularly very receptive to outside work or interference...” (Mariam)

Family and Community

Most participants described Muslim cultures as being less individualistic, and more collective than Western cultures. As previously discussed, the participants’ narratives suggested a significant emphasis on social relations within family and community networks compared to the “self”, and that disclosure of complex problems outside this environment would normally be avoided. As a result, participants suggested that more conservative Muslims preferred to confine their help-seeking activities to their inner circles of family and community. Faisal further explains:

“...like talking about family and especially parents can be quite taboo amongst Muslims, and I think that have something to do with loyalty and the honour of the family, like there are many subjects that you should not talk about amongst more conservative Muslims, like how you raise the children, or just negative experiences within the family, are usually topics not discussed with anyone outside from the family or community, especially not a psychologist... or even psychological disorders, like if someone had a personality disorder... or even a depression”. (Faisal)

Faisal reflects on and describes the barriers and resistance the Muslim might encounter when deciding whether to seek help within or from without Muslim cultural values. Faisal also suggests that the decision on ways of seeking help is influenced by Muslim attitudes towards their cultural values regarding that behaviour, and later in the interview he also explains the significance of what family and community members might think is appropriate.

Mental Health Services/Psychologist

Most participants had accessed mental health services by being in private therapy themselves, and they reflected this experience as being positive. However, they also indicated that
seeking help outside of the cultural values might not be common within the Muslim community.

Mariam talks about the possible dilemmas faced by Muslims considering help from mental health services:

"...but what I think can be problematic is seeking psychological help, because it goes against the way maybe some Muslims traditionally seek help, which is usually through the family or within the community, and doesn’t know or even trust the external services available, like mental health services". (Mariam)

Mariam explains how most Muslims might prefer to confine their help-seeking activities to their inner circles, such as family and community, and have little knowledge or trust in any external services available. Most participants’ narratives indicated that factors affecting intention to access psychological services of any kind might be associated with the Muslims’ levels of attachment to their cultural values. The degree and importance of attachment to cultural values made it develop into a separate subcategory, which will be explored in more detail later.

**Within or Without**

Most participants explained that the role of culture on Muslim identity seemed to be influencing ‘ways of seeking help’ either within their cultural values or without, such as with a psychologist:

"I think amongst some more traditional Muslims if they had psychological difficulties, rather than turning to a psychologist, they would first prefer to talk to a community member or even someone who is the oldest in the family, and that they would feel more secure in disclosing to them, compared to a mental health professional... so overall, I think it really depends on the individual Muslim, one have to look at their cultural background and how attached they are to it". (Faisal)

Faisals’s narrative suggests that Muslim cultural attachment can be a significant influence on attitudes and perspectives of help-seeking behaviours. He also explains that amongst more traditional and conservative Muslims, when faced with psychological difficulties, one might prefer to seek help within family and community members, rather than outside this paradigm.

**Main Category: Cultural Values**

This category explores the perceptions and practice of Muslim cultural values, and how these might create tension and a landscape of conflict for Muslims living in the West who are adopting a more Western lifestyle, as well as influencing their help-seeking behaviours.
within or without their cultural values. Additionally, participants describe their own experience of the internal tension between home and host culture, and acknowledge the conflict in this process of help-seeking behaviours.

**Conservatism and Control**

Generally, the participants described Muslim cultural norms in terms of its conservative orientation and nature, often referring to it as “primitive”, “basic”, and *not compatible*. Aisha describes her understanding and experience of these values:

“Well... *I think in the Muslim culture there is a special code of conduct which you have to follow, there is a certain way you have to behave and there are certain boundaries you are not supposed to cross*. (Aisha)

Aisha appears to define certain aspects of Muslim cultural norms as being something quite powerful, and that is able to influence and control many Muslims in the community. She reflected on her own experiences of its conservative and controlling nature, by which she said that it brought about conflict between her and her family, as well as her community. This notion seemed to be common in the participants’ narratives, often conceptualising Muslim cultural values as something that “controls” and that can sometimes be “judgmental”. Also, Babar describes his experience of Muslim cultural norms as being something quite powerful and more influential than religion amongst Muslims:

“But *I think culture have a stronger influence compared to the religion... and I can really see this when I go to Muslim countries and observe people...*. (Babar)

It could be argued that becoming aware of the disadvantages to Muslim cultural norms by living in the West would orientate Muslims to construct their identity in a way that decreased their connection to such culture, but rather made them lean towards religious values. Even when these cultural norms were rejected, identity was still defined in relation to the religion of Islam, and this was still observed even if contradictory or opposing stances were adopted. Therefore, a sense of being Muslim appeared to pervade most aspects of the participants’ lives.

**Family and Community**

Participants reflected on how family and community play a significant role in everyday life amongst Muslims. Rather than looking inward to establish identity, most participants described how Muslim identity was predominantly defined by looking outward, through
relationships with both family and community. Faisal reflects on his experience with family and community:

“They (Muslims) have a very strong in-group identity, and they live very collectively, and they have some core cultural values that they follow, like for instance the oldest usually have the last say in everything and usually they make most of the big decisions in the family and extended family, and also the wider community have a say in many matters”. (Faisal)

Faisal explains how family and community play a central role for many Muslims. Moreover, many participants described how Muslims within the family, the extended family, and the community seemed to take an involved approach to each individual, and perhaps viewed their roles as to communicate cultural norms and to ensure that most acted accordingly. Farzanah also narrates her experience of the importance of family and community:

“Well I think the family and community for the more general Muslims are very important to them, including family relations... I mean the whole concept of uniting the Muslim brotherhood and sisterhood seems to be very important within Muslim values and culture”. (Farzanah)

Farzanah’s narrative explains how Muslim identity might be influenced by family and community, which might reflect a dynamic process of interdependence.

**Loyalty and Avoiding Disclosure**

Mostly, participants stated that family and community might be considered so significant that difficulties would normally be tolerated and overlooked. Therefore, problems appeared to be contained within the Muslim family and community, and disclosing problems outside this paradigm might result in rejection of one’s family and community. Ali reports on this notion:

“Or I think many of my Muslim friends avoid talking about certain problems they might be experiencing within their families... it’s almost as they are feel their loyalty is tested... and if you try to ask or dig into it, they seem to get really uncomfortable”. (Ali)

Ali’s narrative suggests that among Muslims there might be a need to contain problems in closed family networks, or to not acknowledge them at all, which may be related to a number of factors.
Main Category: Psychodynamic Therapy

Within this core category, most participants reflected on their own personal experience of being in psychodynamic therapy, as well as what tensions and difficulties might occur for the Muslim client who chooses such therapies. Subcategories emerging within the core category of psychodynamic therapy were Individualism/Self-expression, Disclosure, and Sexuality. Again, conflict seemed to set the landscape in the dynamic process of deciding whether or not to seek psychotherapy, and also finally being in therapy. Participants also reflected on the potential cultural clash between Muslim cultural values and Western psychotherapy, which is influenced by a particular set of epistemological values; arguably not always compatible with Muslim cultural values. Babar explains how psychodynamic therapy might not resonate well with Muslims from more conservative cultures:

“I think within the psychodynamic model it is a lot about putting down your defences and being open-minded, and psychologically reflective... I think more conservative Muslims who come from more conservative cultures use a different language, and it would not be appropriate or helpful to use psychodynamic language with them”. (Babar)

Individualism/Self-expression

Most participants highlighted their perspectives on psychodynamic therapy, and how the therapeutic model emphasises individualism, self-expression, and more explicit language. Farzanah explains how such values derived from more Western therapy projects might create tension and conflict with the more conservative Muslim clients:

“The psychodynamic approach is very individualistic and it is a lot about self-expression and living your inner fantasies, your sexuality and your sexual experiences... but in the Muslim culture topics like these is very private and it is not something that you neither express nor talk about”. (Farzanah)

Farzanah reflects on the dynamic contrast between Western-influenced psychodynamic therapy and Muslim cultural values, which might not go together but rather mirror two opposing worlds. Furthermore, one particular participant explained how she did not disclose being in psychodynamic therapy to her Muslim friends because she was worried that they might judge her:

“Hmmm... I don’t think I am ashamed or embarrassed about being in psychodynamic therapy... but I worry they (Muslims) might think badly of me or that they might judge me”. (Mariam)
Mariam’s narrative might suggest the difficult external conflict between Muslim cultural values and Western values, along with highlighting the conflicting journeys of Muslim clients who do choose to seek psychotherapy but might also face an internal conflict between self, family, and community.

**Disclosure**

Participants also explained how the concept of disclosure might create further tension and conflict for the Muslim client, as this might go against their cultural values:

“...the psychodynamic approach sort of is a lot about your instincts and your sexuality and about expressing these and becoming more aware of these, whereas in the Muslim culture this is not something which looked positively upon, there is a specific protocol you have to follow and there are certain things you just don’t talk about... and I think that talking about certain things and certain topics can be potentially boundary breaking, and almost maybe seem shameful and disloyal to family and community...”. (Ali)

Ali reflects on the psychodynamic emphasis on individualism, self-actualisation, and disclosure. Muslim cultural values foster the adoption of family and community values: self-control and disclosing outside the cultural paradigm might not represent something positive. This indicates the potential dilemma a Muslim client might be faced with when seeking help outside family and community circles, such as with psychotherapy, thus again defining a landscape of tension and conflict.

**Sexuality**

The majority of participants highlighted that the exploration of intrapsychic conflicts, and the elucidation of instincts and sexual desires, might not sit well with more conservative and traditional Muslim clients. Below are some of the participants’ reflections around the topic of sexuality:

“Well I suppose... sex and sexuality are considered something very private amongst Muslims, or that’s how I perceive it, many times there some taboo about these subjects. So I guess it is not really discussed openly... and in psychodynamic therapy, a lot of it is about one’s unconscious desires which include sexual desires and letting oneself free... which might not respond well with Muslims... or Muslims from more conservative backgrounds”. (Mariam)

Mariam reflects on how Muslim cultural values might clash with psychodynamic therapy, and how topics around sexuality might evoke negative responses amongst Muslims. This may
also potentially have some stigma attached. I wonder if this social stigma might act as a contributing factor in deciding whether or not to access psychotherapy, and if disclosure of topics considered taboo might compromise the Muslim clients’ identity, loyalty to their family, and their position within their community. Babar’s narrative also reflects the potential conflicts in exploring sexuality with the Muslim client:

“Overall I think it can be perhaps a bit problematic when maybe doing psychodynamic or psychoanalytical work with a Muslim patient, who is more culturally influenced rather than religiously influenced to work within the unconscious and the transference perhaps, because it involves early childhood experiences which includes parents and maybe sexual desires, and this can potentially create conflicts, in that one doesn't want to be or feel disloyal to the parents and maybe one is too ashamed of their sexual desires... so I think these topics or discussing these topics can potentially create some difficulties”. (Babar)

Within Babar’s narrative, loyalty and shame seems to be related to cultural values, and the intention of seeking psychotherapy might be affected by an individual’s belief about what family and community think is appropriate. This again might represent a cultural clash between Muslim cultural values and Western psychotherapy.

Main Category: The Decision Process

Reflecting on the influences on Muslim identities on deciding whether to seek psychotherapeutic help or not, the final main category looks at the decision-making process itself, which finally brings all of the main and subcategories together in coherence. The decision-making process is influenced by the complex interplay of Muslim and Western culture and the religion of Islam, and how all of these influence Muslim identity. These factors in turn are salient in deciding to move towards or away from psychological therapy. With reference to the participants’ narratives, the decision-making process is influenced by whether the Muslim client will accept their home or host culture, which is further elaborated under this specific subcategory.

Participants reflected on acceptance and rejection in both their home and host cultures, with reference to the decision-making process and the decision to either move towards Western psychotherapy or stay within their respective Muslim cultural values. Most participants’ narratives indicated that moving towards or away from psychotherapy might be dependent on how Muslims’ cultural identity might be influenced by their host or home culture. It was
indicated that amongst those who have immigrated, the length of time in the West, education, and levels of acculturation to Western values added to the decision-making process:

“...but most importantly I think the most significant thing would be to look at it from an individual perspective and see how culturally or religiously influenced is the patient or client and are they psychologically minded and then perhaps assess if psychodynamic therapy would be a good idea, or that one may perhaps take a more integrative approach and not practise hard-core psychoanalysis on a very culturally conservative individual, that might create some problems”. (Ali)

Ali explains how the Muslim clients’ levels of cultural attachment between home and host culture might affect the successful outcome of psychodynamic therapy.

Accepting Home or Host Culture

Some participants reflected on the importance of acculturation in Muslims’ journeys towards or away from psychotherapy. In their narratives, they referred to acculturation in terms of how the Muslim individual may adapt to a more Western culture and how the associated changes in their values and behaviours might play a part in the process of deciding ‘ways of seeking help’:

“I think I would rather see and make an evaluation on a more individual basis and see how self-expressive the Muslim client is and how connected they are to their family and community, I think an important factor would be their levels of acculturation, if they are, then I think they would be more open to psychotherapy and it might work well”. (Farzanah)

Farzanah explains that some Muslims who adopt more Western values might move towards help-seeking behaviours outside their cultural values and respond well to psychotherapy. Her narrative might imply that the fundamental differences between the culture of origin and the culture of the host society may influence the likelihood of seeking psychotherapy, as well as the possible outcome of such therapies. Faisal’s narrative also indicates this notion of how acculturation might play a significant role in ways of seeking help, and how a Muslim client might respond to such therapies:

“Yes, I think specifically, if you are going to work psychodynamically with a Muslim client, then you need to really look at what cultural background they come from. I think Muslims from especially the West, who are more acculturated, and who have higher education and the ability to be reflective, I think it should be ok to work with them with psychodynamic techniques, but less privileged Muslims who come from
very conservative families and backgrounds, I think for these individuals it would be very difficult to have an open dialogue and be psychologically reflective”. (Faisal)

Discussion

Using a grounded theory analysis, the aim of this research study was to explore: i) Muslim cultural identity and how this might influence the ways in which Muslims seek psychological help, and ii) Muslim clients’ perspectives on psychodynamic therapy, and its compatibility with Muslim cultural and religious values.

Limitations

Due to several practical limitations and the homogeneity of the sample, the complete version of grounded theory was not possible to conduct, as it requires that theoretical sampling is continued in order to elaborate and enhance the categories until no new ones develop within them, something that is also defined as ‘theoretical saturation’ (Charmaz, 2006; Walker & Myrick, 2006). An important criterion for grounded theory is that of saturation (Charmaz, 2006; Dey, 1999), and although all participants referred to the theme of conflict leading to the development of conflict as a core category, saturation on all main categories and subcategories was not fully obtained. However, as the participant sample was small, and due to the time restrictions experienced, an abbreviated style of grounded theory was used (Charmaz, 2006). Consequently, the study does not claim to have developed a comprehensive theory on Muslims’ psychological help-seeking behaviours.

However, the study did appear to reach significant saturation with regards to the core category conflict, which influenced all of the main and subcategories and consequently set the landscape for the Muslims’ journeys in seeking psychological help. In grounded theory, theoretical saturation is when the researcher reaches the point in their analysis of the emerging categories when no more properties emerge from the data (Charmaz, 2006). The study reached this point where no new information was emerging from the core category ‘conflict’, whereby the researcher concluded partial data satisfaction. The study also used some of Glaser’s (2002) and Glaser & Holton’s (2007) core principles on saturation, by treating the categories theoretically. If treating the emerging category ‘conflict’ theoretically and approaching it more generally, but preserving its connection to all other main and subcategories while no new properties were emerging, saturation might have been substantially achieved. Furthermore, according to Charmaz (2006), when a category does not lead to more comparisons, directions, or conceptualizations, then saturation has been
achieved. By comparing the core category ‘conflict’ across sampling, and with no new directions or conceptualizations emerging, the researcher concluded substantial saturation. This was obtained by following Charmaz’s (2006) approach to grounded theory and using the process of line-by-line coding, where raw data was transformed into phrases and words, capturing significant events, actions, and themes. These were re-read and transformed into focused codes, which captured themes across line-by-line codes, and evolving codes were then compared with existing codes, using continued comparative analysis, in order to examine the similarities and dissimilarities. As the data analysis continued, associations between the main categories and subcategories were established via theoretical coding, and the potential core category ‘conflict’ emerged. However, as the sample size was small, saturation on the core category might have been proclaimed too early in the study. Thus, this study does not claim to have achieved full theoretical saturation on all categories, nor did it develop a comprehensive theory. Rather, the study provided a modest claim and the basis for a preliminary theoretical development, giving valuable insight into the conflictual processes a Muslim client might experience in their journey towards seeking psychological help, with or without their cultural values and their perspectives on psychotherapy.

**Evaluation of Findings**

The evolving categories correspond to some of the existing literature regarding the subject of psychological issues pertaining to Muslims living in the West (Dwairy, 2006). Within these predisposing subjects are religious and cultural factors, individualism versus collectivism, stigma and acculturation concerns in the process of the Muslims’ clients’ journey towards seeking psychological help, and how they might correspond with western psychotherapies (Oyserman, Coon, & Kemmelmeier, 2002; Kim & Omizo, 2003; Naeem et al., 2015). I will present the main findings from this grounded theory analysis, and the findings from the current research suggest that the ways in which Muslims seek psychological help were consistent with their sense of identity, which developed in collaboration with their cultural values, family, and community relationships. Accessing various mental health services in order to get emotional and psychological support was incongruent with the more traditional Muslim cultural values. Furthermore, participants’ narratives indicated that Muslims who strongly associated themselves with such cultural values rejected the option of utilizing mental health services; Muslims with a strong cultural identity would prefer to disclose and manage their emotional and psychological difficulties within their own family and community networks, rather than seeking help from outside their cultural boundaries. This is
congruent with existing literature, which suggests that western psychotherapeutic approaches, working from an individualistic framework, might be less suitable and effective when working with more traditional Muslims (Dwairy, 2006). Hence, Middle Eastern culture and religion is a lifestyle that significantly influences an individual’s thinking, external and internal relationships, and daily life activities. Consequently, this approach might be incompatible with individualistic and more secular approaches of western psychotherapies in treating more traditional Muslim clients who have adopted a more collectivistic lifestyle (Bradley, 2014; Carter & Rashidi, 2004). Furthermore, as Muslim culture and society often reflects an attitude of stigma against mental illness, this could also explain why Muslims who strongly associate themselves with such collectivistic cultural and religious values rejected the mental health services as a help-seeking option (Al-Issa, 2000; Dein et al., 2008). The current research corresponds well within the current literature paradigms, as most participants’ narratives implied a rather conservative, collectivistic, and somewhat stigmatizing Muslim culture. Categories emerging from this research generally implied a complex interplay between Muslim culture and religion, and western culture. They also showed how this became a source of conflict in the Muslim clients’ journey towards seeking psychological help, and illustrated how well they would correspond with western psychotherapies, such as psychodynamic therapy. The research also highlighted that topics surrounding sexuality were considered taboo for Muslim clients who were influenced by the Muslim culture, and that such topics were not appropriate to discuss. However, participants in the current study also highlighted the importance of diversity amongst Muslims, and how cultural practices differed significantly amongst the Muslim community. Participants’ narratives reflected the importance of recognizing this diversity, showcasing that not all Muslim cultures were influenced by strong collectivistic and conservative paradigms, taboo, and stigmatization, which came from the emerging categories. Furthermore, in contrast to other studies conducted around the same research topic, all seven participants reflected on a perceived differentiation between Muslim culture and the religion of Islam, by separating the two entities. Narratives not only reflected an imbalance between eastern and western culture, but also a tension between Muslim culture and the religion of Islam, which was more congruent with western culture, compared to eastern culture. Participants implied that the religion of Islam allowed more individuality and openness about sexuality, and less stigmatization compared to the Muslim culture. This perspective deviates from previous studies, where the Muslim culture and religion is presented as one entity, rather than two distinctions (Pilkington, 2012; Dwairy, 2006).
By contrast, in this current study, Muslim participants who had a more conflictual relationship with traditional Muslim cultural values, and who identified more with western culture and the religion of Islam, were keener to seek psychological help outside of family and community networks, such as using mental health services. Participants typically indicated that their levels of education and acculturation were closely associated with ways of seeking psychological help, as well as the psychodynamic therapy’s compatibility with the Muslim client. Participants also suggested that high levels of acculturation predicted greater openness to psychological services, and better correspondence with psychodynamic therapy. These findings accord with previous cultural research studies on Muslim minority groups and psychotherapies, which focussed on factors such as culture, community networks, family dynamics, religious identity, and acculturation, and looked at how these influenced treatment (Naeem et al., 2015; Mir et al., 2015). Cultural and religious identity seems to be a prime focus in the Muslim identity, especially when compared to other ethnic minorities (Fernando, 2010; Nazroo, 1997; Gater et al., 2010). Hence, this might explain why secular and individualistic therapeutic approaches have proven less effective with more traditional Muslims, where their identities are significantly influenced by traditional Middle Eastern cultural values (Hook et al., 2010).

The preliminary theoretical construction in this research also overlaps other previous research studies, which have suggested that Muslims living in the West are less likely to seek psychological services if they have low levels of acculturation (Kim & Omizo, 2003; Zhang & Dixon, 2003). The concept of acculturation denotes the level to which an ethnic minority adapts to the main culture and the related changes in their beliefs, values, and behaviours that result from interaction with the new culture (Berry, Trimble & Olmedo, 1986). The findings of this study, as they indicate links between acculturation and accessing psychological services, seem to accommodate previous theoretical agreements that one obstacle to seeking psychological services for Muslims are the differences in approach to managing psychological difficulties amongst the Muslim culture and western countries (Erickson & Al-Timimi, 2002; Haque, 2004). To further elaborate on this, it might be useful to study the differences between collectivist and individualistic cultures. In contrast to the individualism valued in western culture, Muslim culture highlights the importance of collectivism, interdependence, and identity, rooted in both family and community (Williams, 2005). Consequently, they might find it more appropriate to seek psychological help and advice through alternative cultural networks, rather than through mental health services. Various
participants in the research reflected on the importance of acculturation in the Muslims’ journeys towards or away from seeking help through mental health services. They referred to acculturation in terms of how the Muslim individual adapted more to western culture, and how the associated changes in their cultural values may play a part in the decision-making process, making them more prone to seek psychological help from mental health services rather than within their family and community networks. The shift from a collectivistic and conservative cultural lifestyle to a more individualistic and liberal one influences their ways of seeking psychological help, corresponding more with the western method. However, drawing conclusions merely from the studies mentioned would be insufficient, given that there are too few studies involving religious minority groups such as Muslims in current psychotherapeutic research (Awad, 2010; Boghosian 2011, Sayed, 2003). Additionally, studies elaborating a more detailed notion of Muslim psychological help-seeking behaviours, and looking at the content of psychotherapeutic approaches for Muslim clients, are generally limited and not substantial enough to draw theoretical conclusions from (Walpole et al., 2013).

The current research study also highlighted that there was a certain amount of stigma attached to seeking psychological services amongst more traditional Muslims living in the West, which could also be an additional barrier in accessing mental health services. The importance of loyalty and avoiding disclosure outside family and community networks played a significant role in this process, which participants explained could be viewed as being disloyal and rejecting your own culture, family, and community. Consequently, this could lead to stigmatization by both family and community. This corresponds with one similar quantitative study conducted by Pilkington et al. (2012), which explains that the role of stigma in predicting the ways in which Muslims seek psychological help may be rooted in the collectivist nature of Muslim culture. The study also suggested that psychological disorders are associated with stigma and shame, and that traditional Muslims tend to see the self as an integral part of the family, not as a separate entity. Therefore, the role of family and community honour in the decision-making process to seek psychological help is often influenced by such factors (Pilkington et al., 2012). Consequently, more traditional Muslims avoid seeking psychological services due to the shame and stigma attached to mental illness, as family and community needs are placed before personal needs, which is also consistent with the current findings of this study. Furthermore, an individual’s perspective of mental illness can also vary across cultures, and cultural and religious factors may contribute to the
identification of mental illness and its symptomatology (Koenig, King, & Carson, 2012; Smith, McCullough, & Poll, 2003). Certain cognitions and behaviours may be considered clinical and pathological – and requiring medical and therapeutic attention in western culture – but they may be perceived differently in Muslim culture (Tabassum, Macaskill & Ahmad, 2000). Studies have indicated that Muslim minority groups are more likely than other ethnic minority groups to believe that there is primarily a biological or medical reasoning for psychological difficulties. Hence, they often report somatic presentations rather than resorting to psychological explanatory models and treatments (Pilkington et al., 2012). Additionally, in Muslim cultural belief, the prevalent existence of jinns (evil spirits) and possessions may also be a stronger explanatory model than recognizing a psychiatric problem or diagnosis (El-Islam, 2008), which could further complicate their access to psychological services. Although explanatory models to mental illness were not reflected in the participants’ narratives, they could still influence the ways in which Muslims seek psychological help, whether they seek help from mental health services or from within cultural and religious barriers.

The findings also provided an understanding into Muslim perspectives on psychodynamic theory and practice. This therapeutic model has primarily been established within western cultural principles and uses an individualistic framework, emphasizing sexuality and early life experiences with parental figures, in order to promote emotional and greater self-awareness. There are debates, however, on whether such therapy and theory might not correspond well with more traditional Muslim cultural values (Dwairy, 2007). Just as Muslim culture tends to look outwards and form identity through family and community networks, psychodynamic therapy encourages self-reflection and looking inwards, with a more individualistic approach to identity formation. Consequently, the research included this topic within its paradigm in order to create a dialogue between psychodynamics and the Muslims.

Participants suggested that the compatibility of psychodynamic theory and practice with the Muslim client might be dependent on their levels of cultural identity; all seven participants suggested that the compatibility of psychodynamic therapy with Muslims varied depending on their cultural orientation, acculturation, and levels of educational background. These preliminary findings overlap with other theoretical suggestions (Al-Abdul-Jabbar & Al-Issa, 2000; Azhar & Varma, 2000), stating that psychodynamic therapy may not sit well with more traditional Muslims. Participants explained that psychodynamic theory and therapy might not resonate well with Muslim culture, due to its more conservative and collectivist nature. Frequently, discourses implied that Muslim culture was more orthodox and conservative,
where aspects of self-expression, autonomy, and sexuality were partly sacrificed for the more collective goals of family and community. This is consistent with current literature on Middle Eastern cultural values, which argues that Muslims tend to form identities grounded on more external factors such as family, preferring a sense of collective actualization over the more psychodynamic sense of self-actualization (Ahmed & Amer, 2012). Participants also implied that this notion of collectivism in Muslim culture – which allowed less autonomy – could create a dilemma when conducting psychodynamic therapy with this client group. Participants suggested that classical introspective psychodynamic therapy (i.e. exploring childhood, relationships with family members, and sexuality) might not be suitable for the traditional Muslim client.

However, participants also suggested that more western acculturated Muslims – who had managed to distance themselves from the more conservative Middle Eastern culture and who adopted a more moderate version of Islam – reacted better to psychodynamic theory and practice, at least in some aspects. This might also explain why psychoanalytic thinking has failed to take roots in the Middle East (Akhtar, 2008). However, it might also indicate why Muslims in the West increasingly seek more psychodynamic therapy (Ahktar, 2008), and why most practicing Muslim psychoanalysts live in either North America or Europe.

Nevertheless, this study has been valuable in constructing a preliminary theory, and in allowing some understanding of the nature of a Muslim client’s possible journey through their cultural identity, plus perspectives on how this might influence their ways of seeking psychological help, as well as psychodynamic therapy. Analysis of the data using grounded theory (Charmaz, 2006) produced 1 core category and 5 main categories, each with subcategories, which formed the basis of the preliminary theory. The core category ‘conflict’, which reached substantial saturation, set the landscape for the Muslim client’s journey in deciding whether to seek psychological help from within their respective cultural values, such as their family and community networks. In contrast, ‘conflict’ also influenced the Muslim client’s decision if psychological help was sought outside of Muslim cultural norms, by seeking support through mental health services. Conflict became a significant theme that influenced all main and subcategories, such as the differentiations between Muslim culture, western culture, and the religion of Islam. The differences – as well as the contradictions between cultures and religion – were experienced as a sense of conflict, as the participants’ narratives reflected a sense of being pulled in many different directions. Categories emerging from the data were considered rather coherent, and the interaction between them was
significant. The main categories – such as psychodynamic therapy – also interacted with subcategories such as individualism and collectivism, sexuality, and stigma. Again, conflict seemed to influence the narratives in the sense that individualism, sexuality, and elucidating intrapsychic insight, could clash with Muslim cultural values, which are more influenced by collectivism and identity formation through the family and community.

The exploration of Muslim perspectives on the psychodynamic model was conducted deliberately in this study, as previous studies and authors have expressed concern over its compatibility with the Muslim clients’ cultural and religious values (Akhtar, 2008; Dwairy, 2006; Rassool, 2015). However, in doing so, it allowed some insight into the perspectives of Muslims on psychodynamic therapy’s congruency with Muslim religious and cultural values. Including this domain into the study equally became a source of limitation, as the study seemed too broad, and perhaps missed the opportunity to substantiate and reach satisfactory saturation on the emerging categories. Perhaps narrowing down the study into either ‘Muslim ways of seeking psychological help’ or ‘Muslim perspectives on psychodynamic therapy’ may have allowed more saturation and substantiation of the study and its categories, such as the complex interplay between cultures and religion, as well sexuality and stigma.

**Recommendation for Further Research**

With reference to the limitations of theoretical sampling, and with not achieving full saturation with regards to emerging categories in this study, the degree to which the findings can be applied to all Shia and Sunni Muslims are limited. Research and theoretical development in the topic area requires taking into consideration the ethnic diversity within the Muslim minority groups, as well as the disparity in understandings and personal significance of Islamic cultural and religious presentations, which are significantly culturally influenced (Abdullah, 2007; Maynard, 2008). Recognizing this diversity may assist to minimize inaccurate theoretical assumptions and generalizations about Muslim perspectives on mental health issues and their psychological help-seeking behaviours. As participants were all well-educated psychology graduates – some fully qualified psychologists – and acculturated western Muslims, it made the sample less diverse and heterogeneous, and not representative of the larger Muslim community in the West. Hence, qualitative research including this grounded theory study does not aim to generalize (Willig, 2008). Perhaps a study with a larger and more diverse sample of Muslims might suggest dissimilar findings. However, despite the limitations of the current study, the findings still served as a first step
towards understanding the ways in which Muslims seek psychological help, and also provided a glimpse into possible perspectives on psychodynamic theory and practice. Given the mass migration from the Middle East to Europe, and with the Department of Health (2005) in the United Kingdom aiming to improve mental health service provisions for ethnic minorities, the current study might help identify some of the challenges and barriers European Muslims are facing when accessing service provisions. The preliminary theory might provide directions for further research, and help facilitate a better understanding of help-seeking behaviours and perspectives on psychotherapies. Additionally, due to the importance of cultural and religious contexts in understanding communication (Mohr et al., 2011; Netto et al, 2012; Pargament, 2007), the preliminary theory developed from the study outlines some of the common dilemmas and challenges that mental health providers might encounter when working with Muslim clients. The process of seeking psychological help may involve complicated interactions between religion, culture, education, and acculturation factors for the Muslim client. Therefore, it is important for mental health service provisions to create awareness, to be flexible, and to try to engage the Muslim community and clients, even if they are a hard to reach group, or if they do not attend their treatments regularly. Furthermore, more culture sensitive therapies, with some adjustments of techniques and approach, may effectively benefit the more traditional and conservative Muslim clients too.

Additionally, as the practice of theoretical saturation was not fully achieved on the various main and subcategories, recommendations for future research would encourage further empirical enquiries on these categories: aiming for further theoretical sampling and saturation with regards to the main category – ‘psychodynamic therapy’ – and its respective subcategories, we may further advance our knowledge on Muslim perspectives of such therapeutic approaches. Thus, this could help equip therapists – especially counselling psychologists who significantly value the therapeutic relationship and who aim to stay close to their clients’ phenomenological experience – to engage in a more culturally competent psychodynamic therapy with the Muslim client.
Reference


Appendix
Appendix A: Ethics Approval

Professor Bertram Opitz
Chair: Faculty of Arts and Human Sciences Ethics Committee
University of Surrey

Faculty of Arts and Human Sciences
Guildford, Surrey GU2 7XH UK
T: +44 (0)1483 689445
F: +44 (0)1483 689550
www.surrey.ac.uk

Jahangeer Sakhi
Trainee Psychotherapeutic and Counselling Psychologist
School of Psychology
University of Surrey

30th April 2013

Dear Jahangeer

Reference: 882-PSY-13 RS
Title of Project:

Muslim Clients’ Cultural Identity, and how this might Influence their Ways of Seeking Psychological Help: Towards a Grounded Theory Analysis

Thank you for your re-submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has now given a favourable ethical opinion.

If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.

Yours sincerely

Professor Bertram Opitz
Chair
Appendix B: Flyer

Muslim Research Participants Needed

My name is Jahangeer Sakhi, and I am working on a Grounded Theory research project for my doctoral degree in psychotherapeutic and counselling psychology at the University of Surrey. I am looking for Muslims, who are interested in reflecting on their experiences and perspectives on Muslim psychological help seeking behaviours and psychodynamic therapy.

If you have any questions or may be willing to participate in this study, please contact Jahangeer Sakhi at 07453285641 or email me at: jsakhi2010@yahoo.com. I will briefly communicate with interested participants through email or phone to see if they meet the required criteria.
Appendix C: Demographic Questionnaire

Demographic Questionnaire

Please answer all of the following questions as they describe you.

1. Gender (Circle one): Female/Male
2. Age: ______
3. Religious Affiliation (Circle One): Christian/Jewish/Hindu/Muslim/Other.
4. If Muslim, which school of thought do you belong to (Circle one): Shia/Sunni/Other.
5. What is your race (Circle one): White/Black/Asian/Mixed/Middle Eastern/Persian/Other
6. What is your highest level of psychology education (Circle one):
   Undergraduate/Masters/Doctoral/Other.
7. Have you ever been in therapy before (Circle one): Yes/No
8. If you have been in therapy before, what kind of therapy (Circle one):
   CBT/Humanistic/Psychodynamic/Other please specify:__________
9. What is your level of familiarity with psychodynamic theory (Circle one):
   Poor/Reasonable/Good/Very Good.
Appendix D: Interview Questions.

Provisional Interview Questions (Subject to Changes)

Open-ended Questions

8. What is your understanding of Muslim cultural and religious values?

9. In what way do you think the Muslim culture is, or is not compatible with western culture, can you explain that?

10. What about the religion of Islam, does the religion differ from the culture, what do you mean about that, can you elaborate?

11. What is your perspective on Muslims’ psychological help seeking behaviours?

12. What factors do you think influences Muslim psychological behaviours?

13. What is your understanding of Psychodynamic Theory?

14. How do you think the therapeutic model sits with Muslim cultural values?
Appendix E:

Provisional Interview Schedule

- My aim is to conduct the first three interviews in week 11 March 2013 and following interviews in May 2013.

- **Provisional Timetable:**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain all Literature</td>
<td>January 2013</td>
</tr>
<tr>
<td>Obtain First Sample</td>
<td>February 2013</td>
</tr>
<tr>
<td>Conduct first Interviews</td>
<td>March 2013</td>
</tr>
<tr>
<td>Transcribe &amp; Analyse</td>
<td>March 2013</td>
</tr>
<tr>
<td>Conduct further Interviews</td>
<td>April 2013</td>
</tr>
<tr>
<td>Transcribe &amp; Analyse</td>
<td>May 2013</td>
</tr>
<tr>
<td>Submit Research Project</td>
<td>15.07.2013</td>
</tr>
</tbody>
</table>
Appendix F: Information Sheet.

Participant Information Sheet

PROJECT TITLE: Muslim Clients’ Cultural Identity, and how this might Influence their Ways of Seeking Psychological Help: Towards a Grounded Theory Analysis.

Introduction

My name is Jahangeer Sakhi and I am a second year doctoral student on a counselling psychology program. I would like to invite you to take part in a research project. Before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully.

What is the purpose of the study?

This study seeks to explore Muslim client psychological help seeking behaviours and perspectives on psychodynamic theory and how compatible they are, if at all, with Muslim cultural and religious values.

Why have I been invited to take part in the study?

Because you have at least an undergraduate degree in the field of psychology and describe yourself as belonging to Muslim faith, and follow either the shia or sunni school of thought.

Do I have to take part?

No, you do not have to participate. There will be no adverse consequences in terms of your education, that is, there will be no impact on your assessment or class of degree. You can withdraw at any time from the study without giving a reason.

What will happen to me if I take part?

You will be asked to participate in an interview at the University of Surrey. All participants will receive £10 which they can donate to their preferred charity?

What will I have to do?

If you would like to take part please contact me either by email: jsakhi2010@yahoo.com or by phone 07453285641.
What are the possible disadvantages or risks of taking part?

Informed consent will be given to you by explaining the rationale of the research study, the procedure involved and length of the semi-structured interview and ask for their permission to take part. You will be informed that you can withdraw from the study at any point, and will be given access to any data they might be interested in during the process of the research. Additionally, all data analysed and processed will be sent to you to check the accuracy of my interpretations at the end. Moreover, all foreseeable risks such as stress and discomfort due to not wanting to speak will be outlined before the discussion session starts. You will be informed that you will not be pressurised to speak if not wanting to. Furthermore, all participants will be ensured protection against any physical or psychological harm by ensuring that if any psychological distress would occur during the interview, the participants can withdraw from the study at any time and I will use my counselling skills to deal with processes sensitively. In the start of the interview I will inform the ground rules, which will be (a) to respect the confidentiality of all the participants (b) not to discuss any information which may be disclosed during the session to others (c) to allow everyone who wants to speak and chance to speak (d) to be respectful of differing opinions (e) I will be setting the ground rules for the interview in order to allow a respectful tone to emerge and strive to maintain a relaxed atmosphere with open ended questions. Moreover, the protection of all participants’ confidentiality will be maintained through removal of identity information and assigning pseudonyms and all recordings will be erased after focus group discussions have been transcribed into verbatim.

What are the possible benefits of taking part?

Participants will be able to participate in a productive debate regarding Muslims’ psychological help seeking behaviours and perspectives on psychodynamic therapy and potentially contribute to future research. Furthermore, my intention to conduct this research study is to educate psychologists about how to better work with Muslims clients seeking psychodynamic therapy and to potentially modify this therapeutic model to be more applicable and culturally sensitive when used with Muslims.

What happens when the research study stops?

Participants will be given access to any data they might be interested in during the process of the research. Additionally, all data analysed and processed will be sent to participants so they can check the accuracy of my interpretations at the end. After the end of the interview all participants who have questions may address these and when the project is completed a copy of the thesis will be sent to interested participants if needed.

What if there is a problem?

Any complaint or concern about any aspect of the way you have been dealt with during the course of the study will be addressed; please contact Jahangeer Sakhi on email: jsakhi2010@yahoo.com or by phone 07453285641. Any concern will be dealt with seriously.

Will my taking part in the study be kept confidential?

Yes. All of the information you give will be anonymised so that those reading reports from the research will not know who has contributed to it.
Data will be stored securely in accordance with the Data Protection Act 1998. However, should you disclose that you or someone else is at risk then the researcher may need to report this to an appropriate authority. This would usually be discussed with you first.

**Contact details of researcher and, where appropriate supervisor?**

Add including work addresses and phone numbers

**Who is organising and funding the research?**

Jahangeer Sakhi

**Who has reviewed the project?**

The study has been reviewed and received a favourable opinion from the University of Surrey Ethics Committee.

Thank you for taking the time to read this Information Sheet
Appendix G: Example Verbatim (Participant M)

**Researcher:** What is your understanding of Muslim culture and values?

**Participant M:** Well I think the cultures differ based upon where you are from originally, but I suppose the values are quite traditional in general and quite conservative and not necessarily positive I would say…and not necessarily compatible with modern western life style in some ways…

**Researcher:** Okay, in what way do you think it is not compatible, can you explain that?

**Participant M:** hmmm…well I think people can be quite conservative, for instance with things like divorce and domestic violence, you know all these things can be widely practiced still amongst more eastern societies, but I still don’t think it is necessarily a part of Muslim values or culture, but because they originate from certain countries and that these things might be more difficult to talk about, sometimes it can be linked to sort of Muslim culture and values…but I think that the cultural aspects is different from the religion of Islam…

**Researcher:** So you think that the Muslim culture and religion of Islam differ from each other?

**Participant M:** Yes, I do think that in many aspects, Muslim culture in its own is very diverse, depending on which country you come from, whether it is Pakistan, Saudi Arabia or Iran, I think culturally they differ a lot, but I suppose they share certain values also, like how they centre around family and community. But then still I think that many of the Muslim scriptures do also sort of put a lot of important emphasis on the family and community, just like other more eastern culture, they also put a lot of emphasis on the family and put less emphasis on individual…I suppose Muslim culture is more collectivistic in nature…

**Researcher:** What about the religion, you said earlier that the religion differed from the culture, what do you mean about that?

**Participant M:** hmmm…well I suppose that more middle eastern culture differs from the actual religion in that culturally it’s a lot more conservative…well I can give you an example of Saudi Arabia, which is a strict Muslim country, with lot of restrictions, here women are not allowed to drive a car, but there is no reference to women not being allowed to drive a car in the religion, so I think maybe here culture plays part in creating boundaries in society,
compare to religion…hmmm and I think there are many examples like this in the middle east, where culture sort of reflects on how people live their lives, and how society controls through cultural values…

Researcher: hmmm…you mention society also, what do you mean about society controlling through cultural values?

Participant M: Yes, well when I say society I mean both family and community, and also extended family. I think when an individual makes decisions in Muslim countries or communities, they usually also think about how their choices will affect their families and how they will be viewed by their community, and how these will perhaps respond. Sometimes the choices for example a person coming from a Muslim background makes in terms of choosing a partner for marriage can be heavily influenced by the family and community…which is just one example, so that’s what I mean about how society and controls through cultural values, because the middle east is more collective culturally.

Researcher: hmm okay, so what is your understanding of psychodynamic theory and practise?

Participant M: hmmm…well I suppose that Freud was the first person that came with the idea that what happens in your early life defines in many ways what will happen in your later life…and nobody else kind of had ever said that…and to me it simply means taking a more lifespan perspective, rather than looking at a problem in isolation…but I know that some people almost get offended and overwhelmed by when they hear about the psychosexual stages, which is only a very small part of Freudian theory…what his theory is just basically implying is that look at the child aged 2 or before and then look at what and how he develops in his adulthood and find the links…so I think that in practise, the model puts emphasis on past early childhood experiences, and how this might influence later psychological development and difficulties…but then again, one cannot limit psychodynamic theory, as the model is so diverse in nature, and it’s been fractioned into so many theories now…but there are some common shared values, which is the unconscious and early life experiences, which is a framework in its therapy…well that my understating of it…

Researcher: Okay, interesting, so how compatible do you think Muslim culture and values are with psychodynamic theory and practise?
Participant M: hmm...I think...hmmm...I am not really sure if particularly psychodynamic work would clash with Muslim culture; I think potentially any kind of psychological work would be difficult...I don’t think that the Muslim culture if particularly are very receptive to outside work or interference...but with reference to psychodynamic work it could prove useful...I mean for someone who had to suppress their feelings about violence, divorce or domestic abuse, I think as a therapist saying to someone or just validating someone’s way of feeling can be very useful, someone who have always suppressed their feelings, because that it’s what they have been taught...” just to get on with it “ and that may be as I said violence or bereavement...it can help stop them feeling guilty, ashamed or weak, so in that sense I think it could be very helpful, and doesn’t need to be problematic culturally wise...but what I think can be problematic is seeking psychological help, because it goes against the way maybe some Muslims traditionally seek help, which is usually through the family or within the community, and doesn’t know or even trust the external services available, like mental health services.

Researcher: Ok...you mention how Muslims traditionally seeks help, can you elaborate on that?

Participant M: Yes, well I guess I mean that it is not really normal for a Muslim to seek psychological help from a psychologist or other mental health professionals, yet...usually when they are facing psychological problems, they seek help internally from their family members, usually the elders within the family, or community leaders, or maybe the Imam in the Mosque, if it is more serious problems...I don’t think psychological difficulties are very recognized amongst Muslims...they more have an attitude of ; just get on with life, life is meant to be difficult...or even when there is internal problems within the family, usually extended family members are contacted for help and not for example a family therapist...and sometimes even the Imam from the mosques are called in to assist and help...but seeking help out of the more traditional ways I think are quite rare still...

Researcher: okay, but do you think that the psychodynamic model might clash with Muslim culture and values in some specific areas compared to other therapeutic approaches? Or that it can go hand in hand together?

Participant M: hmm...do I see a clash with this model specifically...hmmm...well that’s hard to answer...but I think with the psychodynamic model it is very much about nature and maybe a bit about instinct as well, and the therapy itself sort of frags out through a long
period of time, and culture wise that can be perceived as something self-indulgent. Like many times in Muslim culture there is a way or a structure for many things, like if someone dies, there is a certain mourning period and after that you just get on with it…and I see it on my family all the time, and sometimes when someone dies, maybe they can be a bit unsympathetic towards the whole issue, like you have the funeral and then you have the three days of mourning and then that’s it, and then you are a man and you just get over it…and then you put your trust in God’s hands and then God will sort everything out kind of thing…but sometimes you can’t just let everything in God’s hand as most Muslims would argue that one should probably do…but I find that quite childish and immature, I think we have to sort of also take responsibility for our own lives and how we manage to create it, we can’t just leave everything in God’s hands…and in that way it can create some dilemmas in that if you are depressed, some would argue ohh so you don’t have a strong faith in God or you don’t trust him, in those aspect it might create some problems I think…and with psychodynamic work it can be dragging things out one or two years of work, and maybe some Muslims would might think or question themselves if they are not a good enough Muslim…

Researcher: So you think that using the psychodynamic approach might put the Muslim client questioning themselves and their faith?

Participant M: Yes…well in some aspects, depends on the person, but I suppose something like CBT, which is more structured and just straight to the point, that would probably be easier to manage with individuals from this cultural background…the CBT model is more concrete and it would perhaps be more applicable in certain aspects, but still this I think have to be judged on an individual basis…like the CBT approach would deal with anxiety with probably 5 or 6 sessions, but with more psychodynamic therapy its more long term, and does that imply to certain clients that there is a failure in them…I mean I had 4 years of psychodynamic therapy, and I think only 2 of my Muslims friends know about this, but all my non-Muslim friends know about it, but not my Muslim friends…(laughing).

Researcher: That is interesting, how come that is?

Participant M: hmmm…I don’t think I am ashamed or embarrassed about being in psychodynamic therapy…but I worry they might think badly of me, or that they might judge me…or maybe it is myself judging…(laughing)…because I think I am a fairly strong and tough person, and if I tell them, my Muslim friends that I actually see someone every week,
would they think I am a weak person, or would they think that I can’t cope with life, or am I being self-indulgent…but if you ask me if I think I am like that, I would say NO, I am not, but I might worry they will perceive me like that…especially if they find out I was in psychodynamic therapy, then immediately would think would about Freud and all his sexual theories… I don’t think that would resonate well amongst some Muslims…

**Researcher:** hmmm…you mention Freud and his sexual theories; do you think that would be a problem with Muslims?

**Participant M:** well I suppose…sex and sexuality are considered something very private amongst Muslims, or that’s how I perceive it, many times there some taboo about these subjects. So I guess it is not really discussed openly…and in psychodynamic therapy, a lot of it is about one’s unconscious desires which include sexual desires and letting oneself free…which might not respond well with Muslims…or Muslims from more conservative backgrounds…

**Researcher:** Do you think this a general view in the Muslim culture and community?

**Participant M:** hmmm…well I suppose yes, or it is definitely like that in my family and extended family…there are certain things we do not talk about, and it is very much like the show must go on, and whatever happens you will overcome it and not dwell in it, and very much the notion that leave it all in God’s hands and he will sort it out…and let’s say something would happened, I think most would seek help within the family, extended family or then the community, rather than mental health services or a psychologist…I think asking for help outside is not done very often….asking for help is not very good in most Muslim cultures…

**Researcher:** okay, you mentioned you have been in psychodynamic therapy before, did you find it difficult at some points being a Muslim?

**Participant M:** No…hmmm but I suppose, we’ll let me put it this way, I think it comes down to the whole thing about culture vs. religion and I have never been very much attached to my culture, but more to my religion and I identify myself as a Muslim very strongly, but I never identified myself with the cultural aspects of it, so I think it is about time that we sort of try to break those taboos and talk about our social problems, which is more encouraged by our religion compared to the culture, but then again I do not come from a traditional Pakistani family…so maybe due to my circumstances it was easier for me to go through
psychodynamic therapy, because I do have a better understanding of the therapy itself, compare to a more traditional and conservative Pakistani person…hmmm I am not sure, I mean sometimes religion can also be culturally defined…I don’t think there is one correct answer to this….i think it is important to look at a person’s culture and the way they make sense of their religion…and this should be applied when working with any kind of therapeutic model and any person…not really only working with Muslims…

Researcher: So you think it was easier for you to go through psychodynamic therapy because you identify with your religion, but less with your culture and that made it easier?

Participant M: Yes…I think for people who are very strongly bound to their cultural values rather than religious values, it could potentially be very difficult for them to have more psychodynamic therapy…hmmm maybe because aspects of sexuality is explored and perhaps maybe negative feelings against certain family members comes up towards the surface…all this might create more conflict rather than solutions….so in some aspects maybe more solution focussed therapy might like CBT might be appropriate….but then again this is not only in the case of Muslims, but everyone…

Researcher: Ok that’s interesting…would you use psychodynamic therapy with Muslim clients in the future, or would you rather use a different therapeutic approach? Or would you maybe modify it when working with this client group?

Participant M: Hmmm…well I think that depends on the individual, you know psychodynamic therapy can be quite though, I mean all your defences are being exposed really, and I think you need to be quite resilient to be able to take that and psychologically minded, and not everyone is that…I am not sure if would do full blown psychodynamic work with a Muslim client who is very traditional, maybe I would incorporate some psychodynamic elements into the therapy, in the sense that I would maybe link certain childhood experiences to current behaviours…but I would probably be cautious about pure psychodynamic work…and be aware of what might be acceptable and not acceptable and pay close attention to their family relations…because I think for many Muslims, family is a very sensitive issue and one have to be careful with these topics, but then again I think I would be cautious with all my patients, not only Muslims…

Researcher: Okay…thank you for your time.
Appendix G: Europe’s Journal of Psychology, Notes for Contributors.

Insert Running Head Here (no more than 50 characters)

Insert Article Title Here

Author information has been removed for blind review.

Abstract

Insert an abstract of 150 to 250 words here.

Keywords

Insert keywords here. 5 to 7 keywords, lowercase (except nouns), separated by commas, no period after the keyword sequence.
Acknowledgements, funding information and declaration of competing interests have been removed for blind review.
Manuscript Style

Use the current APA Style for the following elements of your manuscript:

- Capitalization (in titles, reference list and text body)
- Numbers (decimal fractions) and statistical symbols
- Tables and figures
- In-text citations and reference list

For more information consult our PsychOpen Author Guidelines.

MS Word Styles

Use only the most common MS Word built-in styles for formatting article elements such as headings, paragraphs, and words (e.g., “Heading 1”, “Normal”, “Emphasis”). Do not define custom styles.

Headings

Organize your manuscript by headings into an unambiguous hierarchy with no more than three levels and at least two headings at each level. Use MS Word standard styles (Heading 1, Heading 2, Heading 3) to indicate heading level. Alternatively you may use the decimal system of headings (e.g., 1.3.1, 1.3.2). Note: The decimal system will be replaced during production by appropriate layout styles.

Tables

Tables are inserted in-text in their normal position and not at the end of the document (unless they are considered as appendices). Use the MS Word table editor (“Insert > Table”) to create tables. Every column/row in your table structure should correspond to one column/row in the definition of the respective word table. Avoid any other means to define tables (e.g., by setting tab stops or spaces, or by importing Excel tables). Table footnotes are required to be positioned below the table. All tables must be referred to in the text, e.g., “(see Table 1)” or “as shown in Table 2”.

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Figures

First-time submission: You may either embed screen-optimized, low-resolution (< 100 ppi) versions of your figures into the main body of your article, or supply print-ready, high-resolution versions as separate image files (step 4 “Uploading Supplementary Files” of the 5-step submission process).

Accepted articles: For accepted articles all figures have to be supplied as separate, high-resolution (300 ppi), print-ready files. File format: PNG.

Create your figures using a white background and no image borders. Text within figures must be in Arial font (exceptions: symbols not available with Arial), between 8 and 12 point. Figure captions and footnotes have to be included in the main body of the article (below the figure), not as part of the figure. Capitalize only the first word (exceptions: proper nouns and the first word after a colon or em dash). In contrast, figure legends are an integral part of a figure and must be placed within it. Major words in legends should be capitalized. All figures must be referred to in the text, e.g., “(see Figure 1)” or “as shown in Figure 2”.

Diagrams, Formulas, Special Characters

Submit diagrams and complex formulas as images (instead of importing them from other software or by using the Word formula editor). Do not include special characters as miniature images. Instead, use designated Word fonts (e.g., Symbol) or the Word Symbol Function under “Insert > Symbol”.

Further Information and Guidelines

- PsychOpen Author Guidelines
An Exploration of Therapists’ Experiences of Conducting Mentalization Based Therapy with Borderline Personality Disorder Clients: An Interpretive Phenomenological Analysis.

Jahangeer Sakhi

Supervisor: Dr. Ben Rumble

University of Surrey

2015
Abstract

This study looks at the MBT model’s core principle of mentalization and aims to explore and produce an in-depth understanding of the therapist’s experience of conducting MBT with borderline personality disorder (BPD) clients. The study also explores the therapist’s own understanding of the mentalization process and how they make sense of the MBT model. In doing so, the study investigates and explores the benefits and challenges of applying such therapy and working with BPD presentation. **Method:** Six qualified MBT therapists were interviewed using a semi-structured format, and the resulting transcriptions were analysed using Interpretive Phenomenological Analysis (IPA). **Results:** The analysis identified four super-ordinate themes. Overall, the results indicated that most of the participants experienced the concept of mentalization as something difficult, broad, and hard to define, often referring to it as a ‘reflective’ and ‘communicative’ conception in a relational context. There was, however, unity in the value placed on the MBT model – that it was experienced as positive in the context of working with a difficult and complex client presentation such as BPD. **Conclusion:** The overall findings highlight the importance of the therapists’ experiences and sensemaking of the MBT model and BPD, which have positive implications for both personal development and potential future research.

**Keywords:** Mentalization, MBT model, psychotherapy, BPD.
Introduction

The past decade has generated multiple encouraging therapeutic modalities for the treatment of Borderline Personality Disorder (BPD), and the efficacy of these therapeutic interventions has been supported through a variety of research studies. Included in these are the Dialectical Behavioural Therapy (DBT) and Mentalization Based Therapy (MBT) (Bateman & Fonagy, 2004, 2008, 2011; Linehan, 2006), the latter of which has received considerable support for treating individuals with a BPD presentation. Consequently, the National Institute for Clinical Excellence (NICE, 2009) have described MBT as a useful treatment for BPD, and have further encouraged its implementation in mental health services for this purpose. The MBT model familiarises itself with some ideas from cognitive psychology theory, in particular contingency theory, and is closely associated with attachment theory and neuroscience (Bateman, Ryle & Kerr, 2006).

This study explores the MBT model’s core principle of mentalization and aims to explore and produce an in-depth understanding of the therapist’s experience of conducting MBT with clients suffering from BPD. The study also explores the therapist’s own understanding of the mentalization process with the initial research question: how do MBT therapists practise psychotherapy and how do they make sense of the model and BPD? In doing so, the study investigates and explores the benefits and challenges of applying such therapy and working with a BPD presentation.

According to research studies conducted on mental health practitioners’ experiences of working with BPD clients, most reveal that attitudes and experiences tend to be negative and derogatory (Bowers & Allan, 2006; Trealor & Lewis, 2015). However, by exploring therapists’ experiences of MBT with BPD, the current study provides some illustrations as to the difficulties they may experience, and whether or not these experiences deviate from the indications within the current literature. It is of interest to investigate if these experiences differ of BPD presentation in an MBT context, as well as if narratives are more neutral and positive, as MBT has been specifically tailored for BPD presentation (Bateman & Fonagy, 2012). Hence, this could further enhance clinician-client interaction and treatment outcomes.

Compared to other treatment programs for BPD, the MBT model requires a somewhat different approach and different therapeutic interventions, hence necessitating different skills from clinicians (Hutsebaut & Bales, 2012). The model’s theoretical hypothesis suggests that improving mentalization recovers symptoms and interpersonal functioning in clients with
BPD presentation. Hence, the core treatment component in MBT emphasises improving the client’s mentalizing capabilities, thus reducing BPD symptomatology. However, the idea of mentalization has been appropriately critiqued as being too extensive and multi-faceted to be put into practice as therapeutic treatment due to its formulation for BPD (Choi-Kan & Gunderson, 2008; Holmes, 2005). In general, the model highlights the development of an attachment relationship with BPD clients, encouraging them to remain mentally close even at times of crisis, and embracing a not-knowing and curious attitude for the clinician involved in MBT treatment (Bateman & Fonagy, 2006, 2012). Furthermore, MBT involves significant levels of transparency and relies upon concentrating on affective matters within the therapist-patient relationship.

These essential features in MBT entail some degree of diverse personality characteristics from clinicians working within such clinical settings. Yet, whatever influence attachment systems have on the evolution of mentalization, this multi-faceted concept is of much importance with regards to what it might entail within the context of the MBT model. Hence, this study will aim to further elaborate and enhance a better understanding of the MBT model, and of BPD. Additionally, the topical significance of mentalization within psychotherapies and counselling psychology is important and, despite the recent surge of interest in MBT over the past decade, qualitative empirical studies on mentalization in psychotherapy remain limited. As a result, our understanding of the clinicians’ experiences when conducting such therapy is partial, thus making this study appropriate within the current research climate.

**Mentalization**

Broadly speaking, helping individuals to stand back from their instant reactions, and being able to reflect on the intentions and processes of the minds of others and their own, is very significant in many therapeutic modalities (Bateman & Fonagy, 2004; Dimaggio & Lysaker, 2010). Given that the MBT model is mentalization-based, it is critical that we demonstrate the concept of mentalization as it is defined as the mechanism for change within this model (Bateman & Fonagy, 2006, 2011). This, however, provides various challenges, as the concept of mentalization is complex and multifaceted (Choi-Kain & Gunderson, 2008; Sharp, 2006).

The idea of mentalization has been labelled in various ways: it partially stems from recent human social evolution and is also closely associated with the theory of mind, metacognition, and empathy (Byrne, 1995; Choi-Kain & Gunderson, 2008; Hardy, 2009). Hence,
Mentalization signifies a family of diverse and overlapping processes that require further description and research. However, mentalization is broadly defined as collectively referring to a higher order ability, allowing a person to infer and think about the mental states of both themselves and others (Fonagy & Bateman, 2004, 2012). Moreover, the MBT model hypothesises that the evolution of mentalization and its motivational system during individual development is significantly influenced by attachment (Fonagy, Gergely, Jurist, & Target, 2002). More recent research studies involving brain imaging indicate that the activation of the brain regions controlling attachment behaviours influence the regions of the brain that facilitate mentalization (Fonagy & Luyton, 2009). When these are further elaborated upon with reference to the MBT models of theoretical suggestion, activation of the attachment system when threatened hinders the capability to mentalize, which likewise hinders cognitive processes. In contrast, if an individual is feeling safe, with the availability of an attachment figure, this provides secure attachment and close proximity, promoting and encouraging the development of mentalization capabilities (Liotti & Gilberts, 2011). In general terms, the MBT model hypothesises that attachment processes permit the recovery of mentalisation capabilities via contact with an attachment figure capable of delivering secure attachment, help, and guidance (Fonagy & Bateman, 2004).

**Mentalization Based Therapy (MBT)**

MBT is a psychodynamic-oriented therapy treatment primarily rooted in attachment theory, but it is also associated with cognitive theory (Bateman & Fonagy, 2004, 2006). MBT is an evidence-based treatment approach for BPD (Bateman & Fonagy, 2004, 2006; NICE, 2009) and, as argued previously, broadly encompasses the approach of mentalization, or the capability to interpret the internal mental states such as feelings, emotions, wishes, desires, and attitudes of others as well as oneself. The idea of mentalization has been appropriately critiqued as being too extensive and multi-faceted in order to be put into practice as therapeutic treatment due to its formulation for BPD (Choi-Kan & Gunderson, 2008; Holmes, 2005). Hence, the core treatment component in MBT emphasises improving the client’s mentalising capabilities, thus reducing BPD symptomatology.

The efficiency of MBT for BPD presentation has been verified in several randomised control trials (RTCs), indicating that MBT has a greater effect in reducing self-harming behaviours and suicide attempts, and in refining interpersonal functioning compared to other treatments (Bateman & Fonagy, 1999, 2009). However, most research regarding the efficacy of MBT
for BPD has used randomised controlled trials (RCTs) in partial in-patient hospital programmes, which have often been conducted by the developers of the treatment model. Furthermore, only a few independent studies have been conducted to investigate the efficacy of MBT in outpatient settings, which highlights a gap in the research regarding the treatment model (Laurensen & Feenstra, 2013). Hence, it is debatable whether a conflict of interest has led to publication bias, resulting in the importance of the current study and its contribution to our understanding of the MBT model from a therapist’s perspective.

This model requires the therapist to receive a small amount of training – with modest levels of supervision – for application by mental health clinicians (Bateman & Fonagy, 2004, 2012). Generally, MBT treatment is offered as an 18-month treatment phase involving both group and individual MBT therapy on a weekly basis. During the course of the treatment, the aims are to reinforce the clients’ abilities to understand their own and others’ mental states within an attachment context, and to enable the clients to express their problems with affect, impulse regulation, and interpersonal functioning, thereby lessening self-harming behaviours and suicide attempts (Linehan, 1993). Moreover, the therapeutic meeting between therapist and client is assumed to be stimulating the attachment system. The therapist prudently monitors their own non-mentalizing states and the influence of these on the client, and is encouraged to maintain a stance of curiosity, and avoid taking an all-knowing position by maintaining an active emphasis on understanding and misunderstanding the self and the other (Bateman & Fonagy, 2006, 2012). The aim of MBT treatment is not to achieve insight, but to develop a sense of stimulating mentalization by constructing and reconstructing narratives of the client’s experiences in a relational context within the current presumed difficulties that the client might be experiencing.

During the course of treatment, the aim is to make the client obtain greater mentalizing capabilities, hence improving interpersonal functioning, affect, and emotional control, and consequently decreasing self-harming behaviours. In light of this notion, the integration of the client’s experience of mind with alternative perspectives and interpretations provided by the psychotherapists is the basis upon which change can be enabled, as well as providing the ability to comprehend behaviours in terms of the related mental states of self and others.

Although transference is viewed as a significant mechanism for change in psychodynamic-oriented technique, questions remain about its therapeutic use in MBT (Higa & Gedo, 2012). While the MBT model proposes a comparable understanding of the transference, it diverges
in its applicable use by avoiding transference interpretation with the client (Bateman & Fonagy, 2006, 2012). As such, it is argued that this may have the consequence of alienating the client from their experiences. As the MBT model significantly overlaps with other models (Bateman, Ryle & Kerr, 2006), this avoidance may be associated with the controversial negative effectiveness of transference interpretation in clients with BPD (Higa & Gedo, 2012; Gabbard & Horwitz, 1994).

**Borderline Personality Disorder (BPD)**

BPD is considered to be a severe condition with a prevalence of around six percent (Grant et al., 2008), with its frequency amongst the outpatient and forensic populations being between 25-33 percent (Thabane & Webb, 2008; Black et al., 2007). Consequently, with its significant prevalence in the population, BPD has become an important area for research and debate (Cohen, 2008; Rogosh & Cicchetti, 2005). Although there is a common consensus that the core characteristics of BPD presentation are not isolated but rather interrelated on numerous levels, there is an increased understanding that the core features of BPD consist of emotional dysregulation and increased levels of impulsivity (Linehan, 1993; Grootens et al., 2008; Bateman & Fonagy, 2012). According to the MBT model, the ability to understand the self and others as being guided by aims and intentions is suggested to be crucial to developmental attainment, and any disturbance of this is considered to be the central disruption and main problem in BPD presentation (Bateman & Fonagy, 2006, 2012).

As the MBT model is closely associated with attachment theory, it can be suggested that an important source for this disruption resides within childhood psychological trauma, which thereby weakens the ability to think about mental states. This inhibited ability to mentalize in BPD is suggested to be due to the vulnerable individual’s tendencies in identifying with the aggressor in order to attain illusive control over the abuser and to internalise the intent in an alien part of the self by ‘disassociating’, hence providing temporary relief of emotional pain. Moreover, any kind of trauma stimulates the attachment system resulting in the exploration of attachment security, further hampering the mentalizing capacities due to seeking proximity to the traumatising attachment objects (e.g. parental figures).

The phenomenology of PBD presentation is the result of this mentalization disruption, as well as the continuous trend to externalise the self-destructive alien part in the context of an attachment relationship. Consequently, these disruptive characteristics in BPD presentations lead to intolerable experiences within the other via this externalisation process of the alien
self (the abuser), resulting in an overwhelming and unbearable experience and response in the other (e.g. therapists, parents, friends). This might also explain the significant challenges often experienced by therapists and other clinicians when working with BPD presentations (Linehan, 1993; Bateman & Fonagy, 2012). In relation to this difficult involvement that therapists often describe experiencing with complex client presentations, Skovholt (2012) explains that this is because as therapists, we are required to gather information and understand the other, in a way that goes against our own basic nature. Hence, trying to understand the other’s subjective experience – which is required by therapists – might become a difficult and exhausting experience, especially with complex client presentations such as BPD.

In relation to the complexities of BPD presentation, various research studies investigating health professionals’ attitudes towards BPD clients reveal rather negative and derogatory perspectives (Commons Treloar & Lewis, 2008; Bowers & Allan, 2006). Furthermore, a more recent qualitative study using thematic analysis of 140 clinicians on their experiences of working with BPD clients was rather consistent with current literature that has verified the existence of these attitudes towards BPD amongst health professionals (Commons Treloar et al., 2009). The participants in the study described their experience of working with BPD as ‘frustrating’ and would prefer not to work with such presentation, hence making the current study significant, as it provided six MBT therapists the opportunity to present their experiences of BPD in an MBT context. It would be of interest to investigate if a different narrative and experience emerges of BPD within an MBT context, as this would provide the ground for more positive clinician-client interactions, which could improve treatment services.

Furthermore, many BPD clients report that mental health professionals are not willing or interested in becoming involved with treating them, and often describe their experience as negative (National Collaborating Centre for Mental Health, 2004). Therefore, exploring therapists’ experiences of MBT with BPD is important, as it might help change attitudes and improve treatment outcomes.

**Current Study**

The current study aimed to produce an in-depth understanding of therapists’ experiences of conducting MBT with BPD clients, and their own understanding of the process of mentalizing with the initial research question: how do MBT therapists practise psychotherapy
and how do they make sense of the model? This study adopted an exploratory, qualitative position. The impact of personal experiences of mentalization and BPD, as well as perspectives about the benefits and challenges of MBT when working with BPD presentation, was explored by utilising Interpretative Phenomenological Analysis (IPA) methodology (Smith, Flowers, & Larkins, 2009). IPA enabled an insightful interpretation of the therapists’ experiences and attribution of sensemaking in relation to the MBT model. Furthermore, the study is unique in that it emphasises the therapists’ phenomenological position and explores their processes of sensemaking in relation to the MBT model. Thus the study explores how therapists orientate themselves to a therapeutic model such as MBT.

Moreover, as the MBT model also emphasises the phenomenology of BPD, as well as encouraging the therapists to take a ‘not knowing’ and non-expert position with the clients, the current study and the MBT model both sit well within the core philosophy of counselling psychology. Furthermore, the MBT model is rooted in attachment theory, which has a unique position as it both resembles and differs from the cognitive approaches of BPD. Attachment theory proposes that the experience of being understood, loved, accepted, and supported by another human being sets out the psychological underpinning for confronting hardship and preserving equanimity in times of trauma and distress. This notion sits well within the humanistic paradigms of counselling psychology (Elvis & Green, 2008).
Method

Reasons for Using a Qualitative Approach

This study adopted an exploratory and qualitative position, thereby aiming to produce an in-depth understanding of the therapist’s experience of conducting mentalisation based therapy (MBT) with BPD clients, as well as their understanding and sense-making of the mentalising process with the initial research question: How do MBT therapists practise psychotherapy and how do they make sense of the model working with BPD presentation? Analysis of the data was carried out using a qualitative approach given that the current research study focuses on phenomenology and aims to provide rich descriptions and possible explanations of people’s meaning-making and how they experience particular events (Lyons & Coyle, 2007). On its most basic level, qualitative research is considered as comprising the collection and analysis of non-numerical data, and through a psychological lens, it provides the tools for in-depth description and explanation of certain experiences and conditions (Willig, 2008). In the case of the current study, the aim was to explore the subjective experiences of therapists working from a MBT framework in a BPD context. Therefore, a qualitative inquiry seemed most suitable.

Various research studies conducted on mental health practitioners working with clients of BPD presentation often indicate negative and derogatory experiences and attitudes (Bowers & Allan, 2006; Treloar & Lewis, 2015). Although, both qualitative and quantitative research have been conducted around mental health practitioners’ experience of working with BPD presentation, there is limited qualitative research on clinicians’ experiences of working with BPD presentation from a mentalisation based therapy (MBT) approach. Hence, it is of interest to investigate if their experiences of working with BPD presentation differ in an MBT context, and whether or not narratives are more positive, as MBT has been specifically tailored as a treatment for BPD clients (Bateman & Fonagy, 2012). Moreover, the current research study – in contrast to most studies conducted around MBT on BPD presentation – is quantitative. These studies narrow the focus away from the experience and sense-making of the MBT model by the therapist, and do not include broader factors that might have a significant influence on both therapists and clients, and treatment. Consequently, a positivist epistemological approach, such as a quantitative method, was not deemed suitable with the current study, due to its hypothetico-deductive orientation (Lyons & Coyle, 2007). The lack
of empirical literature in the topic area moved the study away from a hypothesis-led approach and closer to an interpretive and inductive orientated approach.

Hence, the study explores therapists’ subjective experiences of mentalisation in a BPD context, and emphasises their perspectives about the challenges and benefits of MBT, when working with BPD presentation. Therefore, the study took a qualitative approach outside of the positivist paradigm by focusing on an in-depth exploration of the meaning of events and experiences, and how they might inter-correlate. This allows the study to achieve a more contextualised understanding and to permit the data analysis to capture the processes of these contextual reflections communicated through the subjectivities of the participants in this study (Lyons & Coyle, 2007; Willig, 2008). Secondly, as the study focused on individual experiences and processes – for example, in the current study, the therapists’ subjective experience of mentalisation and MBT in a BPD context – then a qualitative approach was considered well suited in order to facilitate understanding of variation between individuals (Yardly, 2000).

*Using Interpretative Phenomenological Analysis*

On a basic level, IPA is a qualitative method in social science comprising an ideographic approach, which emphasises the participants’ subjective lived experiences of a particular phenomenon (Smith & Osborne, 2003). As mentioned previously, there is scarce qualitative literature concerning phenomenological aspects of mentalisation in a BPD context, and even more limited is any insight into therapists’ experience of such model (MBT). Hence, in seeking to explore and answer the research question, an interpretative phenomenological analysis (IPA) methodology (Smith, Flowers & Larkin, 2009) was deemed most suitable and was used to inform the data collection and analysis. As IPA is an appropriate method to utilise when exploring phenomenology, it seemed suitable as a method of inquiry due to the nature of the current study, which was to understand individual experience. IPA – which has an idiographic orientation – hence facilitates this process of understanding the individual experiences of the therapists working from an MBT framework with BPD presentation.

IPA uses a structured approach and aims to balance phenomenological description with interpretative insight through an inductive hermeneutic procedure (Smith et al., 2011). Moreover, in IPA the researcher is engaged in double hermeneutics, as this recognises the potential influence of researcher perspective on the analysis (Smith, Flowers & Larkin,
2009). However, IPA is also vulnerable with reference to double hermeneutics. Hence, the researchers’ interpretations of the data may also be dependent of their own subjective world experiences, resulting in biased interpretations (Pringle & Drummond, 2011). Therefore, interpretation from two different researchers might develop two different viewpoints. Consequently, in IPA, good practice consists of the researcher practising a balancing act, attempting to both involve themselves in the process of double hermeneutics as well as being cautious with imposing their own meaning to the texts. This process seemed to be the most challenging part of the IPA methodology (Brocki & Wearden, 2006).

Nevertheless, IPA was considered an appropriate method to utilise, as the aim of the research study was to explore and investigate individual subjective experience, whereby IPA can facilitate this process by its idiographic orientation (Willig, 2008). Additionally, the approach also overlaps the epistemological grounds of counselling psychology (CP), as IPA focuses extensively on phenomenology (Woolfe et al., 2003). CP is also embedded in the exploration of the meaning of events and experiences (BPS, 2014), therefore, there is a significant overlap between CP and IPA epistemology, which equally focuses on phenomenology and subjective meaning-making, in contrast to quantitative research, which adopts a more positivist approach (Cox, 2012).

**Other Qualitative Approaches**

Several other methods of analysis were considered, including Grounded Theory (Charmaz, 2006) and Discourse Analysis. However, IPA seemed most suitable from the myriad of qualitative methodologies available for the current study, as the core principles of IPA fitted well within the paradigms of the current study, emphasising therapists’ subjective experience and making sense of the MBT model in the context of working with BPD presentation. In contrast to GT – which concentrates on connecting emergent categories and generating theoretical explanations of a given phenomenon (Charmaz, 2006) – IPA was preferred due to its idiographic approach, which focuses on phenomenological inquiry on subjective experience (Smith, Flowers & Larkins, 2009). IPA seemed most appropriate, as the study aims to investigate and explore the therapists’ subjective experiences and narratives, and whether or not these differ working with BPD presentation in a MBT context.

Discourse Analysis (DA) was also considered as a tool for analysing the data, as like IPA, it too partly aims to identify subjective experience (Smith et al., 1996). However, in DA the
primary emphasis is on the importance of language and how this shapes identities and activities, placing less importance on subjectivity (Wiggins & Riley, 2010). As subjectivity and a person’s lived experience was an important factor in the current research, IPA was utilised as it operates within the paradigms of phenomenology and is extensively concerned with exploring a person’s lived experiences and the meanings that people attribute to these experiences (Shinebourne, 2011).

Participants

The sample of participants was determined to have a homogeneous sample between 4-10 participants in accordance with IPA guidelines (Smith, Flowers, & Larkins, 2009). All participants were sought out through the British Psychological Society’s (BPS) webpage for accredited MBT therapists, and recruited via email. Staff members from the researcher’s previous clinical placement with the complex personality disorder service were also contacted and recruited. As such, the inclusion criteria required that participants had achieved both the basic skills of MBT training and advance MBT training at the Anna Freud Centre, and had also been working within a personality disorder service, preferably an MBT mental health service for BPD clients.

Six participants took part in the research study; three men and three women aged between 35 and 62 years. All participants except one lived and worked in London; the latter lived and worked in Copenhagen, Denmark, but completed the MBT training at the Anna Freud Centre in London. Moreover, all participants were Caucasian and were accredited MBT therapists, but they came from diverse therapeutic training backgrounds and clinical experiences prior to becoming MBT therapists. Three were clinical psychologists, one was a group analyst, one was a CAT therapist, and the remaining participant was a psychodynamic psychotherapist. All of them incorporated the principles of MBT in their understanding of clients and in the process of therapy, as well as in the techniques they practised. Depending on the clinical settings they worked in, they occasionally used therapeutic techniques derived from other approaches (e.g. CBT, CAT & Psychodynamic), which they implemented into their MBT practice. All participants had worked in mental health services in the context of BPD clients prior to the interviews, and one held a private practice. All of the participants had experience in providing both individual MBT and group MBT for BPD. Table 1 provides an overview of the participants – however, their names have been changed in order to safeguard confidentiality.
Table 1. Study Participants (N=6)

<table>
<thead>
<tr>
<th>No.</th>
<th>Pseudonym</th>
<th>Professional Background</th>
<th>Work Setting</th>
<th>Client Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Michael</td>
<td>Psychologist</td>
<td>MBT Clinic</td>
<td>BPD</td>
</tr>
<tr>
<td>2.</td>
<td>Adam</td>
<td>CAT Therapist</td>
<td>MBT Clinic</td>
<td>BPD</td>
</tr>
<tr>
<td>3.</td>
<td>Mary</td>
<td>Psychologist</td>
<td>MBT Clinic</td>
<td>BPD</td>
</tr>
<tr>
<td>4.</td>
<td>Jacob</td>
<td>Group Analyst</td>
<td>Private Practice</td>
<td>Mixed</td>
</tr>
<tr>
<td>5.</td>
<td>Julia</td>
<td>Psychotherapist</td>
<td>PD Clinic</td>
<td>BPD</td>
</tr>
<tr>
<td>6.</td>
<td>Tanya</td>
<td>Psychologist</td>
<td>PD Clinic</td>
<td>BPD</td>
</tr>
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</table>

**Procedure**

Interviews were conducted by the researcher at a place mutually agreed upon between researcher and participant – these were mostly within hospitals and the clinician’s own clinics. However, one interview was conducted through Skype, as the MBT therapist resided in Denmark. This interview was conducted in Danish, whereby the transcript was translated from Danish to English by the researcher, who is fluent in both languages. A short demographic questionnaire (Appendix A), along with a participants information sheet (Appendix B), was emailed to each clinician before the scheduled interview. The information sheet provided them with an overview of the study and requested that they agree to participate, allowing informed consent to be obtained. Additionally, a consent form (Appendix C) was signed on the day of the interview, which provided details regarding confidentiality and the participant’s right to withdraw at any time if they wished to do so.

**Data Collection**

The study used one-to-one semi-structured interviews as recommended by Smith (1995), ranging from 45-60 minutes in length, and including open-ended questions (Appendix D) related to the participants’ experiences and how they made sense of the MBT in the context of working with BPD patients. Questions explored the experiences associated with how they conceptualised mentalization and how they had been attracted to the MBT model. Further
questions explored the participants’ encounters with BPD clients, their experiences, reactions, and feelings, as well as the MBT techniques used to cope with a complex client presentation. The orientation of the open-ended questions were influenced by relevant literature and were grounded in forming an understanding of the participants’ subjective experiences of MBT in the context of BPD. Probing questions were also used to embolden additional exploration around the research topic.

**Interview Schedule**

1. What is your understanding of mentalizing and how would you describe the concept of mentalization?

2. What is your understanding of mentalization based therapy and what are the most important characteristics of this therapy (MBT)?

   **Prompt:** What might you find different about it compared to other therapeutic approaches? What do you in particular like / not like about MBT?

3. What is your experience of conducting mentalization based therapy (MBT) with clients/or in a clinical context?

   **Prompt:** What is it the experiences like for you? How do you perceive the benefits of MBT and what do you think is the most challenging part of conducting such therapy?

4. Do you think there is a relationship between mentalizing capabilities and BPD/or generally mental health?

   **Prompt:** Can you tell about experiences you had that supports this idea?

5. Have you worked with MBT on Borderline Client? What was your experience of that?

6. How do you describe clients’ potentials symptoms improvement when undergoing MBT therapy and what is your experience of client’s improvements? What is your experience of what is going on?

7. Have you come across any thoughts or ideas that would suggest any possible need for modification with MBT?
Ethics

According to the University of Surrey’s ethics flowchart (see Appendix E), ethical approval was not considered necessary for this study. The flowchart requires that psychological research with human participants is guided by certain core principles, and that ethical approval is sought when the following criteria are met:

a) Procedure(s) involving any risk to a participant’s health (both psychological and physical);

b) Surveys, questionnaires and any research, the nature of which might be offensive, distressing or deeply personal for the particular target group;

c) Proposals for research that intends to use undergraduate students as participants;

d) Research proposals to be carried out by persons not connected with the University, but wishing to use staff or students as participants;

e) Proposals wishing to use children under the age of 16.

These core principles of the flowchart were discussed substantially and evaluated with the research supervisor. Additionally, ethical matters were further discussed with the University’s senior qualitative research lecturer and deemed not necessary. As a result, all participants were aged between 35 and 62 years, all highly trained accredited MBT therapists from diverse training backgrounds (psychotherapists & clinical psychologists).

As the participants were mature consenting adults, ethically aware, self-care minded, not vulnerable and not recruited from the Surrey academic institution, ethical approval was not deemed necessary for the current study. Although ethical approval was not required for the research, ethical considerations and possibilities were still deemed significantly important. The researcher’s ethical obligations and potential ethical implications were carefully considered prior to the study. However, as with any study consisting of human participants, ethical considerations are complex and have multifaceted implications for the practice and research in the given area and counselling psychology (Cross & Wood, 2015).

Although no ethical approval was required from the institution’s ethics committee, the research study took care to adhere to the BPS Code of Human Research Ethics (BPS, 2009) and paid special attention to the Division of Counselling Psychology (DoCP) Professional Practice Guidelines (BPS, 2013). The Code of Human Research Ethics (BPS, 2009) requires
psychological research with human participants to be guided by certain core principles such as respect for autonomy and dignity of a person; scientific value; social responsibility; and maximising benefit and minimising harm (Code of Human Research Ethics, 2009). Adherence to these core principles is considered essential when conducting psychological research with human participants, and there is a clear duty for the psychologist towards the participants. An indispensable component of the guided principles in the Code of Human Research Ethics (BPS, 2009) is the psychologist’s respect for the participants’ dignity and autonomy, whereby caution is applied to making rational judgements about any actions in the course of conducted research which will have an impact on the autonomy and dignity of the participants.

Other protocols required by the Code of Human Research Ethics (BPS, 2009) are risk assessment, obtaining valid consent, debriefing participants and confidentiality in line with the Data Protection Act (1998). Congruent with the Code of Human Research Ethics (BPS, 2009) and the Data Protection Act (UK Legislation, 1998), all participants in the study were debriefed with regards to the nature and value of the research, and had the right to withdraw from the study at all times, if they wished to do so. Additionally, a consent form was given to and signed by the participants on the day the interview was conducted, which provided details regarding confidentiality and the right to withdraw from the study at any time if they wished to do so. Furthermore, all data recorded was saved on an encrypted USB drive, kept securely, and destroyed after transcription. Transcripts were kept under pseudonyms in order to protect the identity of the participants.

In addition, the researcher always aimed to guide his research model according to the values expressed in counselling psychology. This was conducted by following the Division of Counselling Psychology (DoCP) Professional Practice Guidelines (BPS, 2013). The DoCP was used in addition to the BPS’s Code of Conduct, Ethical Principles and Guidelines and Code of Human Research Ethics, which both set the minimum standard for which behaviour should not cross both in generic professional practice and in research ethics with human participants. One of the core principles of counselling psychology (CP) promotes a phenomenological model of therapeutic practice, and is significantly influenced by a strong psychotherapeutic tradition (DoCP, 2013). The researcher aimed to design his research model in accordance with the DoCP principles. This was done as the researcher always tried to engage with the phenomenology of the participants, as well as respecting their perspectives, and kept an anti-discriminatory attitude to the emerging narratives.
Although ethical approval was not deemed necessary, the current research study was not excluded from ethical possibilities due to the potential sensitive nature of the research topic and the methodological approach chosen. The study therefore followed the *Code of Human Research Ethics*, the DoCP *Professional Practice Guidelines* and also provided participants with the opportunity to give valid informed consent, assured confidentiality and debriefing opportunities.

As the study touched on potentially complex issues by exploring the therapist’s experience of conducting mentalization based therapy (MBT) with borderline personality disorder (BPD) clients and their understanding of the model, ethical challenges were probable. The exploration of topics such as personal experiences of MBT and working with patients who have complex presentations such as BPD has the potential to create discomfort in participants and this therefore needed to be considered whilst conducting the study. As BPD presentation often includes factors such as suicidality, emotional switching points and boundary pushing behaviours, even the most highly trained therapists can experience emotional distress. Many studies exploring mental health practitioners experiences of working with BPD presentation reveal attitudes and experiences to be predominantly negatively orientated and rather difficult (Bowers & Allan, 2006; Trealor & Lewis, 2015). As the research touched on possible difficult experiences therapists might have had with their BPD clients, the interview process had the potential to cause emotional discomfort and distress in the participants. However, as the participants were mature, consenting and had several years of clinical experience working with BPD presentation, it was felt that they had greater self-awareness to stop the interview should they feel distressed. Therefore, the researcher did not consider the interview process likely to cause serious emotional harm or distress to the participants, but made himself available to react to any queries or concerns the participants might have. Furthermore, some ethical awareness was also given to the absent clients, whom the participants were including in the interview conversations. Consequently, awareness of both the participants and clients confidentiality was taken into consideration as conversations around a particular vulnerable client group was evident during the interviews.

The researcher, himself a trainee counselling psychologist, strived to minimise participant discomfort and emotional distress when talking about possible difficult experiences they might have had with BPD clients by using gentle introductory questions and using his basic counselling skills, such as empathy, genuineness and providing a safe environment. This is
known to be able to minimise participant distress when dealing with difficult and sensitive
topics and experiences (Sen Gupta, 1998; Abrahams, 2007).

Furthermore, qualitative research can expose the researcher to certain ethical dilemmas due to
the fluidity and inductive uncertainty of the research method (Birch, Miller, Mauthner &
Jessop, 2012). The complexities of utilizing a qualitative approach to research private lives,
perspectives and world views can raise multiple ethical issues for researcher. This cannot
exclusively be solved by the application of abstract rules and guidelines being put forward by
ethics committees in academic institutions and the Code of Human Research Ethics (BPS,
2009). However, the researcher was aware of his ethical obligations at all times, and if any
distress was observed the participants would be offered a break, the potential to continue the
interview another day, or could completely withdraws from the research at any time.

**Data Analysis**

The study employed IPA methodology suggested by Smith, Flowers & Larkin (2009), and
transcripts were analysed for emerging super-ordinate and respective sub-themes. Initially, all
interviews were read through numerous times in order to increase familiarity with the data,
and preliminary ideas about the data and any interpretations were noted separately.
Additionally, a table was developed containing three columns: the middle column included
the original transcript, the right column included the exploratory comments, and the left
column included emergent themes (see Smith, Flowers & Larkin, 2009 for guidance). This
constituted the first phase of the data analysis that consisted of descriptive, linguistic, and
conceptual comments around the data obtained. A similar table was developed for each of the
five interview transcripts, and further emergent themes were then gathered into clusters of
themes demonstrating possible higher order themes and accompanying subthemes,
whereupon emergent themes were then transferred into a separate table. Possible higher order
themes throughout all of the interviews were then associated with and gathered into super-
ordinate and sub-themes, which were displayed in a final table (see Table 2).

The unique characteristics of IPA include the fact that it is informed by the researcher playing
a communicative part in the dynamic interview process, interpreting and making sense of the
participants’ narratives. The researcher’s experiences and sensitivities also play a significant
part in the development of themes and the process of interpretation, which is defined as a
‘double-hermeneutic’ process by Smith (1996). However, by frequently attending research
supervisory meetings, the researcher consequently checked the validity of emerging themes and was in conversation with the supervisor in order to avoid bias. Additionally, the research adopted the following guidelines from Elliot, Fisher, & Rennie (1999):

1) “Grounding in examples: Participants’ quotations are involved within the analysis section of this report; the potential reader can draw on their own viewpoints on the correctness of the analytic interpretations of the data”;

2) “Providing credibility checks: give methods for checking the results such as checking with research supervisor”;

3) “Coherence: understanding is presented in a 'narrative' or other structure that maintains the nuances of meaning through integration of the data and answering the research question”;

4) “Resonating with readers: the account provides "resonance" or meaning for the reader/reviewer as an accurate portrayal of the phenomenon”.

Moreover, the researcher’s personal interest in the MBT model and BPD comes from personal experience of having gone through the basic skills training at the Anna Freud Centre and having to struggle with BPD within the family, as well as the empowering experience of working with the complex cases team for BPD within an NHS setting. Hence, continuous awareness of the author’s own level of subjectivity during each phase of the research had to be preserved, due to the IPA being a significantly interpretative procedure.

Results

Following the research question of how MBT therapists make sense of the MBT model, the analysis of the data identified four distinctive but interrelating super-ordinate themes, each with their respective sub-themes. The first super-ordinate theme identified how participants conceptualised mentalization. The second related super-ordinate theme explored how participants experienced the distinctiveness of the MBT model and how it was also similar to other modalities. The third super-ordinate theme emerging identified how the participants experienced and conceptualised BPD, with the final super-ordinate theme examining and identifying the experience of how MBT had an impact on BPD presentation. These super-ordinate themes and the corresponding sub-themes are all summarised in Table 2. A further
in-depth exploration and analysis of each super-ordinate theme will be presented in the following section of this report.

**Table 2. Summary of Themes**

<table>
<thead>
<tr>
<th>Super-ordinate Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| 1. Conceptualising Mentalization | Difficult to conceptualise  
Wide & broad concept  
Conception broadened following reflection  
The ability to reflect and understand one’s own mind and the mind of others |
| 2. Distinctiveness and similarities of the MBT model | Assisting reflection in a relational context  
Stimulating reflective thinking  
Working with the present  
Excluding transference techniques  
Liberating and freeing when working with BPD  
A stance rather than a model  
Overlapping other modalities |
| 3. Conceptualising BPD | Difficult patient group  
Lack of mentalizing capacity  
Concrete thinking  
Described as a ‘mindless bottle’ of person |
| 4. MBT and its impact on BPD | Described as varied, but positive  
Reducing self-harm  
Assists reflective thinking  
Precursor for other therapies  
Perception of MBT training |

### 1. Super-ordinate theme – Conceptualising mentalization

The first super-ordinate theme elaborated on how participants made sense of the concept of mentalization. Through this understanding of the mentalization concept, this then influenced their experiences of their BPD patients, as well as the other related super-ordinate themes and sub-themes. This key super-ordinate theme also influenced the following super-ordinate
themes and their respective sub-themes, and seemed to influence how participants navigated experiences of both the model and their BPD clients. Most of the participants experienced the concept of mentalization as something difficult, broad, and hard to define, often referring to it as a ‘reflective’ and ‘communicative’ conception in a relational context. Notably, all of the participants developed their conception of mentalization further as the interviews progressed, and although most participants considered mentalization as hard to describe and as a multi-integrated concept, it was given a particular meaning that was echoed amongst all participants. The extracts below signify some of the participants’ conceptions of mentalizing and the processes it involves. In Jacob’s narrative, he first explains how he finds the concept of mentalization to be quite difficult, before referring to a fellow MBT trainee as an example:

   Jacob: “Hmmm...(silence) I think it is quite a difficult concept actually, and I do remember when on one of the courses when Anthony Bateman, this person who was on the course and he took a great interest in it, and went through the whole course and training and right at the end this chap asked them: ‘well what is mentalization actually?’...and it is quite a difficult question to answer, and initially it looks like it’s quite a rational question to answer, but actually I think it is quite complicated”.

A similar response was made by another participant, Adam, who did not specifically describe the concept of mentalization as difficult, but shared the idea that mentalization is a broad phenomenon involving many processes.

   Adam: “Well that’s quite a wide area to describe, but I think it’s about understanding one’s own emotional states and the emotional states of others”.

Most participants shared the perception that individuals can differ in the clarity and conception of mentalization, and that it was challenging to describe it in a shared language. However, in general, participants viewed mentalization as having a reflective function involving the ability to understand and make correct interpretations of one’s own thoughts and feelings, as well as those of others in a relational context.

   Michael: “Hmmm, okay, I think it means a lot of things, but hmmm, well so, mentalizing is I think is the ability to reflect on one’s own mind, and to be able to experience, understand and questioning feelings, thoughts and desires, and I think we call these mental states, and to be able to do all of that in the context of relationships”.
Michael’s narrative and language when describing mentalization includes various pauses, and his use of language such as ‘I think it means a lot of things’ indicates his lack of clarity on what mentalization entails, something that is echoed in most participant narratives. All of the participants’ use of language when conceptualising mentalization included long pauses and starting their phrases with ‘I think’, which might indicate confusion and a lack of confidence in the precise nature of the phenomenon. However, their perception of mentalization was also strongly related and echoed to each other’s.

2. Super-ordinate theme – Distinctiveness and similarities of the MBT model.

In making sense of the model, participants highlighted how they found the MBT model distinctive from but also similar to other modalities. Amongst participants, there was a majority belief that mentalization based therapy and the model itself distinctly assisted patients to be more reflective, and that treatment had a highly relational focus. Mary describes this position below:

Mary: “Well my impression of MBT is, hmmm, well I guess it is different in the sense that it has a highly relational emphasis, and most of what we work around in treatment is what patients might be experiencing as difficult in a relational context”.

This notion of MBT as having a highly relational focus as part of its treatment was echoed in Adam’s narrative (below), in which he uses the phrase ‘we explicitly ask patients’ to bring relational issues to treatment. This indicates how the participants find the MBT model different from other modalities, in that it focuses significantly on stimulating reflective thinking in a relational context.

Adam: “I think it is a therapy that has a highly relational focus, and I am more the therapist, who runs the group MBT, and my role mainly is to, or what we explicitly ask patients to bring to the group is the key relational issues that are happening at that moment with them”.

For many of the participants, the MBT model was viewed to be distinctive in terms of its focus on the present rather the past, despite being perceived as a psychodynamic therapy. Many participants emphasised that it would not be helpful to explore the past in too much detail due to the complex presentation of BPD patients. Below is an extract of Michael’s narrative in which he reflects on his experience of how he negotiates the MBT model as a
psychodynamic rooted model, but at the same time tries to abstain from exploring too much of the past:

*Michael:* “…but I mean in MBT we do not tend to go much into the past, but rather focus therapy and treatment on the current and present, but if we were to do some individual work and putting together a formulation, we might explore an internalized object as well, and this is perhaps the bit where the integration comes in, but we would not use the more psychodynamic kind of language of course, even though the MBT model is rooted in attachment theory, which is kind of psychodynamic”.

Although there was a shared acknowledgement that the MBT model was rooted in attachment theory and that it had a more psychodynamic orientation, participants conversely reported that the model refrained from more mainstream psychodynamic techniques, such as working within transference and counter-transference, and exploring the past. This form of distancing from mainstream psychodynamic techniques was, however, frequently discussed and experienced as a positive quality when working with complex presentations in the MBT model. Below is Mary’s description of her experience in abstaining from certain psychodynamic interventions and how she finds it:

*Mary:* “I think the model does not bring the idea of the transference into therapy, or not really that I know of, and I think that would not be very helpful either, which is good especially not with this kind of presentation, hmmm and we have to remember, that initially the model was tailored specifically for BPD”.

Mary predominantly associated MBT with BPD presentations, and her narrative acknowledges that working within the transference would not be very useful with this patient group. This notion is also echoed in Jacob’s narrative (below), who spoke of MBT as being a very active therapy, and stated that therapists would not spend much time on making interpretations of the transference:

*Jacob:* “…but you have to be prepared to be quite active in a MBT sessions, I don’t think you can spend a lot of time worrying about the transference and counter transference and I don’t think one should make interpretations of the transference… Hmmm”.

Both Mary and Jacob’s narratives indicate that the use of traditional psychodynamic techniques, such as transference, would not be useful. Their use of language such as ‘Not be
very helpful’ and ‘I don’t think one should’ clearly indicates their objection to the use of these techniques with BPD patients.

However, when describing their introduction to the concept of mentalization and the MBT model when working with a very complex patient group, most participants related to this experience as a positive one, and commented that the concept of facilitating reflective thinking should be a part of all therapies:

Julia: “I think the whole concept of the MBT model is to facilitate reflective thinking, to individuals who struggle with it, which is quite typical with borderline patients, it is part of their pathology in my experience, hmmm so being introduced to the MBT model by Bateman and Fonagy I think was quite a release in some ways, and I think many feel the same, as you can easily feel stuck when working with BPD”.

This is further echoed by Jacob:

Jacob: “It is a very active and pragmatic therapy, and how you deal with certain kinds of very difficult patients in a more effective way... I think it is very liberating way of working with some patients and that it shows it is quite possible to work in a very creative way with very difficult people”.

A recurrent sub-theme was the experience of the MBT model being viewed as an effective treatment approach when working with patients who had a BPD presentation. Moreover, in terms of distinctive subjective experiences of using the model, most participants described MBT with words such as ‘freeing’, ‘liberating’ and ‘release’ in the context of working with BPD patients. For many of the participants, mentalization was seen as being part of a reciprocal process between cognition, emotions, and behaviours and, ultimately, MBT was seen to play an important role in reversing the decreased reflective capacity in BPD patients. However, one participant conversely reported that his experience of conducting MBT individual therapy compared to MBT group sessions sometimes felt constraining:

Michael: “Hmmm resistance is not in the model, and I thought to myself this is resistance, so yes I think that tightened me up a little bit, I felt constrained, well I am not sure if I answered your question, well mentalization did not work very well in this case... or not one to one MBT”.
Participants also made sense of the model in terms of its similarities to other models, and a further sub-theme emerged, with the likelihood of the participants conceptualising the model as overlapping with other therapeutic models. Notably, there was a universal acknowledgement amongst the participants that MBT overlapped with most modalities, and each participant reported the model to be similar to previous treatment modalities they had worked with. Below is how Tanya, Jacob, and Adam described their experiences of how the MBT model overlapped with other models:

_Tanya: “I don’t think that MBT is very different from certain basic CBT principles, I mean the idea of changing cognition is also a part of MBT, hmmm I guess it just approaches this somewhat differently”._

_Jacob: “And I do think it is quite a useful idea, and it overlaps interestingly in my experience with group analysis”._

_Adam: “Yes, hmmm, well my initial thought is that there is a lot of similarities, and when I actually think back to my CAT work, and with that I could describe as I was also trying to mentalise with them”._

From a subjective standpoint, most participants aimed to make sense of the MBT model by comparing it to the model they were predominantly trained in. In addition, some participants took this view further and perceived MBT as a stance that borrowed therapeutic techniques from other modalities, rather than as a model:

_Michael: “Well it’s funny isn’t it, that it’s funny as a therapy, I think it’s more of a stance and a limited amount of technique, but yes specifically to MBT I think it borrows techniques from many modalities”._

Analysis of the narratives also highlighted a seemingly contradictory viewpoint that the MBT model was overlapping with certain modalities respective to each participant’s therapeutic training background. Julia, who is trained as a psychodynamic therapist, reported experiencing the MBT model as being closely related to Interpersonal Therapy (IPT), but reported that MBT was not overlapping cognitive behavioural therapy (CBT). Contrary to Julia’s narrative, Tanya and Michael – who are clinical psychologists predominantly trained in CBT – described their experience of MBT as similar to that of CBT:
Julia: “No I wouldn’t say that MBT is similar to CBT, hmmm well not that I am a CBT therapist (laughing), but a lot of my colleagues are, and that is not my impression of the MBT model, but I would say that it is similar to IPT and perhaps also DIT”.

Michael: “I think it is a bit like CBT, in that we are testing someone’s thoughts against reality here, in more like CBT basic language, so yes I think that if someone can actually grasp that idea, then yes I would say that it overlaps with CBT”.

From the extract above, it appears that both Julia and Michael’s narratives contradict each other, thereby potentially indicating that the MBT model’s multi-integrated foundation and tendency to overlap most mainstream therapeutic modalities is perhaps why clinicians from diverse backgrounds have been attracted to MBT. Moreover, this contradictory narrative also highlights the experience of making sense of the MBT model through the process of comparison.

3. Super-ordinate theme – Conceptualising BPD.

The MBT aetiology of BPD was reflected through the participants’ experience of BPD. The majority of the participants described working with BPD patients as difficult and challenging, due to their complex presentation, and most clinicians highlighted instances of the patients responding with significant resistance, suspicion, and sometimes hostility during treatment. However, there was also a general sense that the divergent BPD presentations impacted on the patients’ receptivity to MBT work. Below is how Julia described her experience of working with BPD patients:

Julia: “It is very challenging to work with borderline patients, if I can call them that, just making them attend therapy is a struggle itself, and then trying to build up an alliance with them is another chapter... hmmm and they often meet you with hostility and immense suspicion, but I think once the trust have been built the hostility slowly dies off, but usually it will always be present at some level”.

In relation to this, Jacob and Adam echoed similar experiences of working with BPD patients:

Jacob: “You very often have borderline paranoid individuals as your patient, who often automatically mistake your behaviour, they will think you are doing it
intentionally to try to drive them mad, or because you hate them and do not want to speak with them”.

Adam: “Borderline patients, who are very complex, I think it is a huge challenge to build up a therapeutic alliance with them, and I mean often they are very disturbed patients, I think it is just a huge task to be able to form some sort of trust with them and just being able to sit alongside them”.

A further sub-theme of the concrete way of thinking and lack of reflective thinking within a relational context in relation to BPD presentation became evident within the data. Participants also reported using caution when working with patients:

Mary: “They have a very particular way of thinking and relating to others, often unable to filter and be insightful at a deeper level I guess, and I think that is why they often face significant relational challenges, hmmm (silence), and this also plays out in therapy very often, which is why you also have to be cautious when working with them, as things can quickly become overwhelming”.

From Mary and Jacob’s narratives (above), they perceive there is apparently a lack of functional mentalizing capabilities in patients with BPD presentations, which is consistent with the MBT model itself (Bateman & Fonagy, 2004). Although the present research is focused on the therapists’/psychologists’ subjective experiences of MBT and BPD, a conversation surrounding the practical applications of MBT emphasised a number of themes offering a broader awareness into participants’ meaning-making. In most participants’ narratives there seemed to be an apparent acceptance of the medical model through their defining clients as ‘patients’. Additionally, there was a tendency to use negative vocabulary or deficit words like ‘lack’, ‘limited’, or ‘mistakes’ to make sense of the patient group, and there were no debates around questioning the diagnosis of BPD. This might be an effect of the MBT model being too closely associated with the medical model and with a diagnosis itself, thereby objectifying and pathologising the client group.

Furthermore, some participants used metaphors in order to describe their experience of BPD presentations, theorising the lack of appropriate mentalizing capabilities as being part of BPD pathology:

Michael: “But they are very limited about what other people might be thinking and feeling and the things that they say themselves and about other people, and that kind
of very concrete way of thinking can be quite infectious, they sometimes come across as a mindless bottle of person”.

Julia: “Sometimes they can enter the therapy room like a tsunami, full of uncontained emotions, and other times they can be the opposite, completely detached”.

The participants’ use of metaphoric language such as ‘mindless bottle of person’ and ‘like a tsunami’ draws upon their subjective experiences of BPD presentation, and signifies the complex, overwhelming, and challenging experiences that they have with this patient group.

4. Super-ordinate theme – MBT and its impact on BPD.

One of the strongest themes identified throughout this project was the variation in personal experiences of MBT and its impact on their BPD patients. The narratives indicated dichotomous effects of MBT on BPD, reflecting the perception that patients varied in their capabilities and willingness to engage in MBT treatment. Receptivity to MBT depended on the severity of BPD symptomatology, but all of the participants reported experiencing an improvement of self-harming behaviours during the early phases of MBT treatment:

Adam: “But one thing which I find significant is that most of the patients are doing a lot of self-harm, and some do it almost every day, and as they go through treatment, it becomes less and less, but it never completely disappears, or sometimes it does, but it becomes much less”.

Michael: “Specifically in terms of symptoms I think in terms of self-harm and other destructive behaviours, I think we work well in stopping these and very often significantly reducing it, and quite often completely stopping it, I actually think that very early on in therapy the first symptoms that becomes less prevalent is probably the self-harm”.

Michael’s narrative also uses the word ‘we’ when describing how he works from an MBT frame of reference, which might reflect an ideology of MBT therapists as a unified group reducing BPD ‘symptoms’. However, positive experience of MBT and its impact on BPD presentation by participants was often hypothesised as a relevant reason for their attraction and clinical application of MBT for such complex presentations. Such experiences provided participants with a sense of confidence in the relevance of mentalization techniques, and the increased frequency of its use in services for borderline patients:
Jacob: “But I really enjoyed the training and working as a MBT therapist, so perhaps I do unconsciously, I think the MBT model is very refreshing, and I think now, because I am not working nearly so much with complex personality disorders for the moment, so I would rather regard myself as being influenced by it, and I hope I am integrating it to my normal practice”.

Julia’s narrative echoes this positive experience, and she describes the ability to become more reflective, thereby becoming able to assist patients in improving the relational aspects in their lives and reduce self-harming behaviours:

Julia: “One thing that I often notice in most patients is their ability to become more reflective in the later stages of treatment, and this really does help them improve the relational dimensions in their lives with the people they have around them, hmmm this may also explain why their self-harming behaviours also take a turn, because they are more able to contain overwhelming emotions”.

Noticeably, some participants viewed MBT as a transitional treatment method, a form of ‘stepping stone’ for patients to undertake before being referred to more mainstream NHS talking therapies. This notion was evident in Michael’s experience of MBT:

Michael: “We sometimes refer them to other services, where they can use other therapies with them, because MBT is more of a precursor to be able to move on to and make use of other more mainstream therapies, so sometimes it happens that after they finish their 18 months’ treatment with us we refer them other treatments”.

As discussed above, the participants’ appreciation of the MBT model with borderline presentation was broadened as the interviews progressed, and a final related sub-theme emerged. This reflection by participants was the first time many of them had considered their MBT use in more depth, and thus insecurities began to emerge in their narratives. If MBT training was discussed, many often felt that the lack of clear guidelines and a sense of unstructured procedures were a source of frustration:

Adam: “Hmmm well I think my main criticism is probably very thin training in MBT, I don’t think there is not any proper training to equip clinicians, I think something more comprehensive in terms of the MBT training would be more helpful, I mean I did the basic and advanced training years ago now, and of course I do the regular supervision, but sometimes I do feel Oh my God am I going off the model here... and I
think that I’m probably free float around the model sometimes, but I also think that it is also a part of the model”.

Michael: “Hmmm I suppose, hmmm as a CBT therapist, I think I would like a bit more skilled focus in MBT, and I think that is just to make it a bit more concrete for me and my colleagues, just make one a little bit more aware of what we are actually supposed to do and what we are actually doing here”.

Discussion

The current study aimed to produce an in-depth understanding of the therapists’ experiences of conducting mentalization based therapy (MBT) with borderline personality disorder clients (BPD). In order to explore their own understanding of the process of mentalizing, the initial research question of ‘how do MBT therapists make sense of the model and what are the benefits and challenges of such therapy working with clients with BPD presentation?’ was posited. In order to understand the implications of the main findings presented in the previous section, this discussion will aim to draw the results together and collate them with the current literature on this subject.

As presented in the introduction, the concept of mentalization has become more noticeable in MBT theory and research during the past decade (Bateman & Fonagy, 2006, 2012; Choi-Kain & Gunderson, 2008; Sharp, 2006). The current research study found that qualified MBT therapists shared the estimation of mentalization’s significance in BPD and appreciated the ability to mentalize as an integral component of MBT practice. The study also found substantial differences in therapists’ sureness and conceptual understanding of mentalization and practical utilisation of MBT. Various reasons were given for such differences, including personal, clinical, and professional reasons. The shared meaning and variation of mentalization, clinical understanding, and the application of MBT in the context of BPD is explored below.

The analysis of the participant narratives supported MBT’s theory of conceptualisation of mentalization in psychotherapy as suggested by Bateman & Fonagy (2004, 2006, 2012). The super-ordinate theme of ‘conceptualisation of mentalization’ and its respected sub-themes appears to accommodate the MBT model’s understanding of mentalization, or an individual’s ability to stand back from their instant reactions and reflect on the intentions and processes of the minds of themselves and others (Bateman & Fonagy, 2004, 2006, 2012; Dimaggio &
Lysaker, 2010). However, similarly to the views presented by Choi-Kain & Gunderson (2008) and Sharp (2006), participants describe uncertainty surrounding their conception of mentalization and the MBT model itself. This is consistent with the notion that mentalization signifies a family of diverse, overlapping processes that require further description and research, due to its complex multi-faceted dimensions (Byrne, 1995; Choi-Kain & Gunderson, 2008; Hrdy, 2009). These identified processes and experiences further accommodate the critiquing of mentalization as being too extensive and multi-faceted to be effectively put into use as a therapeutic treatment (Choi-Kan & Gunderson, 2008; Holmes, 2005).

Moreover, the idea of whether stimulating mentalizing capabilities through an attachment relationship between therapist and client resembles repairing mentalization inhibition due to childhood trauma is an interesting one (Bateman & Fonagy, 2006, 2012). In the current research study, this concept was echoed by most participants, who often took such a psychodynamic position regardless of their training background, suggesting that the non-judgmental and non-directive stance taken by participants not only increases mentalizing capabilities, but also fosters a corrective experience related to childhood damage. These findings further acknowledge how MBT therapies approach the client in a flexible way, allowing for the client’s needs and phenomenology to be emphasised. However, despite this notion of the MBT model being predominantly psychodynamic due to its close association with attachment theory, all participants agreed that the model refrained from using more traditional psychodynamic techniques, such as working within the transference. This notion is in line with the views presented by Higa & Gado & (2012) and Bateman & Fonagy (2006), suggesting that whilst the MBT model proposes a comparable understanding of transference, it diverges in its use by avoiding transference-interpretation with the BPD client.

Furthermore, participants described MBT as overlapping with other therapeutic modalities – something which is consistent with the MBT model’s theoretical orientation (Bateman, Ryle & Kerr, 2006). These findings can also be considered a result of ideas from cognitive psychology theory – in particular contingency theory – and neuroscience being amalgamated into the model (Bateman, Ryle & Kerr, 2006).

The super-ordinate themes of ‘conceptualisation of BPD’ and ‘MBT’s impact on BPD’ appeared to relate strongly to existing theory and research studies involving MBT’s impact on BPD symptomatology. Additionally, all of the participant narratives echoed similar
experiences as found in one of the most recent research findings regarding MBT’s positive impact on self-harming behaviours, improvements of inter-personal functioning, and quality of life (Laurensen et al., 2013). Participants frequently described how they experienced a gradual decrease in self-harming behaviours, followed by better inter-personal functioning with their clients who underwent MBT treatment with them. Additionally, current findings support existing literature (Commons Treloar et al., 2009) suggesting that working with BPD presentation can be experienced as rather difficult and challenging. The current study revealed that participants often reported a sense of frustration and felt restricted when working with BPD clients.

**Limitations**

The varied identified super-ordinate themes and their respective sub-themes in this exploratory study establish the potential of phenomenological research in the lived experiences of therapists, when making sense of a psychological model and its principles in relation to a certain client presentation. However, recognising the small sample size in this study restricts the generalisability of the current findings. According to Smith (2009), sample size is considered appropriate when using between four and ten participants for professional doctorates. Hence, the current study adjusted itself within this range by consisting of six participants. Furthermore, as the literature has emphasised (Smith, Flowers, & Larkins, 2009), as IPA studies are attentive to explicit qualities of individual and shared subjective experiences, perhaps future research could comparatively focus on an in-depth case study.

With respect to the homogeneity of the sample size, participants in the study were predominantly clinical psychologists and psychodynamic therapists, and largely adhering to the medical model. Hence, future research could emphasise if themes and factors identified are stable and valid across a broader population of qualified and experienced mental health practitioners. As the sample consisted of no counselling psychologist, it would be of significant interest to explore the emergent themes and factors with counselling psychologists, and to determine whether their experience of MBT and BPD is influenced differently by their more humanistic and non-medical-oriented training. As the participants’ narratives in the current study were significantly influenced by the medical model, it would be of interest to explore whether counselling psychologists would describe a different experience and use a different discourse that was less medical-oriented.
Additionally, the core philosophy of counselling psychology emphasises the therapeutic relationship, thus it would be interesting to explore if experiences differ from other mental health professionals with regards to BPD presentation. This could further aid clinicians’ mindfulness of effective relational factors and advance therapeutic interventions in both individual and group MBT. Perhaps a more pointed research question – which emphasises solely an in-depth IPA case study investigation of either BPD or the mentalization concept with a counselling psychologist – would prove valuable to draw on specific processes in more detail.
References


Appendix
(Appendix A) Demographic Questionnaire

Demographic Questionnaire

Please answer all of the following questions as they describe you.

10. Gender (Circle one): Female/Male

11. Age: _______

12. What is your race (Circle one): White/Black/Asian/Mixed/Middle.
   Eastern/Persian/Other

13. Professional Occupation:

14. Therapists’/Psychologists theoretical background:

15. What is your highest level of psychology or related education (Circle one):
   Undergraduate/Masters/Doctoral/Other.

16. Years of Experience:

17. What is your level of familiarity with the MBT model (Circle one):
   Poor/Reasonable/Good/Very Good.

18. Completed MBT training: Yes/No

19. Level of MBT training: Basic/Advanced

20. Have you worked with Borderline Personality Disorder Patients: Yes/No
Appendix B: Information Sheet:

Participant Information Sheet

Principal Investigator
Jahangeer Sakhi
email: js00317@surrey.ac.uk
mobile: 07459622926

The purpose of this sheet is to provide you with the information that you need to consider in deciding whether to participate in this research study. The study is being conducted as part of my professional doctorate (PsychD) in Therapeutic and Counselling Psychology at the University of Surrey.

Research Study Title:
An Exploration of Therapists’ Experience of Conducting Mentalization Based Therapy (MBT) with BPD clients’, using Interpretive Phenomenological Analysis (IPA).

Research Study Description
The research aims to explore psychotherapists’/psychologists’ experience of practicing psychotherapy, in particular to reflect on their experience of the Mentalization Based Therapy (MBT). The first step the study recruits therapist whose practice is partly informed by mentalization.

The study will involve about five one-to-one semi structured interviews with participants lasting no more than 45 minutes, with a short debriefing.

As a participant you will be asked to talk about your experiences of practicing mentalization based therapy, in response to broad and open interview questions, which will be used as a guide. The current study aims to produce an in-depth understanding of the therapists’ experience of complementing mentalization based therapy (MBT) with clients’ and their own understanding of the process of mentalizing with the initial research question: how do MBT therapists practise psychotherapy, and what are the benefits and challenges of such therapy, in addition the secondary research question is how can therapists’ experiences of conducting MBT assist its implementation and help identify factors which might need modification? The interview will be audio-recorded for the purposes of research transcription and analysis.

Due to the limited literature on therapists’ experience of conducting MBT and the process of this, a qualitative research design is used, in which the subjective experience of the participants is the primary focus of this study. Interpretive Phenomenological Analysis (IPA) methodology will be utilized to facilitate a reflective account of therapists’ experience.

Confidentiality of the Data
Names and contact details of participants will be stored in a password protected computer to which
only the researcher has access to. This information will not be shared with anyone else. Once the recorded interviews have been transcribed the original voice recordings will be erased.

All names and identifying references will be omitted from transcripts and from the research paper. The researcher’s supervisor and examiners will be able to read extracts only from the anonymous transcriptions of interviews. To enable potential follow-up interviews the individual data will initially be coded with a number. Once this need has passed the separate sheet linking codes with contacts will be destroyed.

Location
The interview will take place in a convenient, private, comfortable and safe location, which will be mutually agreed between the participant and researcher in advance of the interview.

Disclaimer
You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw, you will have the option for your data to be withdrawn and deleted from the study if you so wish, otherwise your anonymised data may be used in the study write-up of the study and any further analysis that may be conducted by the researcher.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this information sheet for reference.

If you have any questions or concerns about how the study has been conducted, please contact the researcher’s supervisor, Dr Ben Rumble, School of Psychology, University of Surrey, Guildford, Surrey (email: b.p.rumble@surrey.ac.uk).

Many Thanks!
Jahangeer Sakhi
email: js00317@surrey.ac.uk
mobile: 07459622926
(Appendix C) Consent Form:

Consent Form

- I the undersigned voluntarily agree to take part in the study on ……………….

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I consent to my personal data, as outlined in the accompanying information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (BLOCK CAPITALS)

......................................................

Signed ......................................................

Date ......................................................

Name of researcher/person taking consent

......................................................

(BLOCK CAPITALS)

Signed ......................................................

Date ......................................................
(Appendix D) Interview Schedule:

1. What is your understanding of mentalizing and how would you describe the concept of mentalization?

2. What is your understanding of mentalization based therapy and what are the most important characteristics of this therapy (MBT)?

   **Prompt:** What might you find different about it compared to other therapeutic approaches? What do you in particular like / not like about MBT?

3. What is your experience of conducting mentalization based therapy (MBT) with clients/or in a clinical context?

   **Prompt:** What is it the experiences like for you? How do you perceive the benefits of MBT and what do you think is the most challenging part of conducting such therapy?

4. Do you think there is a relationship between mentalizing capabilities and BPD/or generally mental health?

   **Prompt:** Can you tell about experiences you had that supports this idea?

5. Have you worked with MBT on Borderline Client? What was your experience of that?

6. How do you describe clients’ potentials symptoms improvement when undergoing MBT therapy and what is your experience of client’s improvements? What is your experience of what is going on?

7. Have you come across any thoughts or ideas that would suggest any possible need for modification with MBT?
(Appendix E) Ethics Flowchart:

**Ethical Review of Research Projects**

Does my Research Project require Ethical review?

- **a)** procedures involving any risk to a participant’s health (for example intrusive physiological or psychological procedures);  
  - YES ☐  NO ☐

- **b)** research involving the donation of bodily material, organs and the recently deceased;  
  - YES ☐  NO ☐

- **c)** surveys, questionnaires and any research, the nature of which might be offensive, distressing or deeply personal for the particular target group;  
  - YES ☐  NO ☐

- **d)** proposals which involve financial payments or payments in kind to participants above reimbursement of expenses;  
  - YES ☐  NO ☐

- **e)** proposals for research that intends to use undergraduate students as participants;  
  - YES ☐  NO ☐

- **f)** proposals wishing to use children under the age of 16 or those over 16 who are unable to give informed consent (e.g. people with learning disabilities; see Mental Capacity Act 2005) as participants;  
  - YES ☐  NO ☐

- **g)** research proposals to be carried out by persons unconnected with the University, but wishing to use staff and/or students as participants (see 4.4);  
  - YES ☐  NO ☐

- **h)** proposals which investigate existing working or professional practices at the researcher’s own place of work (including staff surveys);  
  - YES ☐  NO ☐

- **i)** research involving access to records of personal or sensitive confidential information, including genetic or other biological information, concerning identifiable individuals;  
  - YES ☐  NO ☐

- **j)** research where the safety of the researcher may be in question;  
  - YES ☐  NO ☐

- **k)** proposals which require participants to take part in the study without their knowledge and consent at the time;  
  - YES ☐  NO ☐

- **l)** research involving prisoners and young offenders.  
  - YES ☐  NO ☐

If the answer to any of the above questions is yes then your project requires an ethical review.
(Appendix F) Verbatim Example:

Researcher: What is your understanding of mentalizing and how would you describe the concept of mentalization?

Participant: hmmm, okay, I think it means a lot of things, but hmmm well so, mentalizing is I think is the ability to reflect on one’s own mind, and to be able to experience, understand and questioning feelings, thoughts and desires, and I think we call these mental states, and to be able to do all of that in the context of relationships, and to talk about what is happening in your mind and other people’s minds, and I guess try to make sense of social interactions, just that whole process…hmmm, but I also use the term mentalizing, because it is a fashionable thing as well now, because it is an ongoing process and mentalizing as a term seems to imply a continues process versus mentalization which sound more like something that stops and finishes, and I think that is also something that we try to encourage our patients as well, is to keep thinking about what is going on in their minds and keep on thinking about it…

Researcher: Okay, you also mentioned about mentalizing in amore relational context, what do you mean about that?

Participant: hmmm, well I suppose that if people are mentalizing well, their understanding of their own states of mind and how that changes in relation to others, and that for example if someone triggers a certain experience in them and they are actually able to reflect on that experience, or just being able to reflect on the processes of a relationship, or it may have been a relationship from their past that have left them with a certain relationship to themselves…hmmm well we might want to make them think about their relationship to themselves, but generally that would be kind of working backwards from issues that is present across relationships, and ask them hmmm I wonder where this might come from, but I mean in MBT we do not tend to go much into the past, but rather focus therapy and treatment on the current and present, but if we were to do some individual work and putting together a formulation, we might explore an internalized object as well, and this is perhaps the bit where the integration comes in, but we would not use the more psychodynamic kind of language of course, even though the MBT model is rooted in attachment theory, which is kind of psychodynamic, but still work a little around it…
Researcher: Okay, well second question overlaps quite with the previous question, but that is interesting, and what is your understanding of mentalization based therapy? And what do you think is the most significant characteristic of such therapy?

Participant: hmmm, well I suppose, well its funny isn’t it, that its funny as a therapy , I think it’s more of a stance and a limited amount of technique, but yes specifically to MBT I think it borrows techniques from many modalities, but of course with the aim of getting someone to be more reflective, and with the ability to be more accurately reflective I would say, as to what might be happening in someone’s else’s mind I suppose, and also with the aim of being able to doubt one's own perceptions, and sort receiving for and against evidence in particular about the hypothesis they have about what is going on in someone else’s minds and also their own minds, hmmm I know I am talking very theoretically here right now but…

Researcher: hmmm, you mentioned something about challenging thoughts before, do you think MBT sort of overlaps with CBT, and it sounded a bit like CBT to me?

Participant: actually yes, absolutely, hmmm, well you see I think that if all therapies if they are working well, is to also make the patient being able to reflect on others minds rather than staying on a psychic equivalent kind of state, I think it is a bit like CBT, in that we are testing someone’s thoughts against reality here, in more like CBT basic language, so yes I think that if someone can actually grasp that idea, then yes I would say that it overlaps with CBT, and we even use CBT techniques in our service in individual therapy, or that is what I actually do, but obviously it would be with the view that I am trying to make the person mentalize, like to make the patient being able to reflect and see different ways of thinking, and that their experience of a certain kind of behavior or feeling might not be so spot on…

Researcher: hmmm, okay, that’s interesting; do you think you can give an example of how you stimulate this process with a patient?

Participant: Ahhh okay, let’s think of an example, hmmm I am trying to think of a representable example (laughing), yes I can give you an example of a patient I saw earlier this week, and we were running a group, and they had an argument with another patient, and they felt this other patient was rude and really criticized by them, and that was sort of her conclusion, but then the other patient said she did not mean to criticize her, but that she was just trying to make a point, and the other patient said I don’t care, to me that was being rude and critical, and I think what we had there was a patient that was in a psychic equivalent
mode and saying this is exactly the case, rather than saying I felt criticized and felt it was rude and hurt by it, and rather than asking and exploring the intention of the other patient to why she said that, and ohh gosh, yes what did I try to do about that situation, hmmm I think first I was just trying to gentle point out that okay now we are talking about it and something strikes you and that it is your experience of it, but that doesn’t mean that it is what the other persons intensions were and meant by it, and we would try to make the others in the group come with their perspectives of it, so in that sense MBT group can be quite good, in the sense that there is others perspectives constantly being applied to the patients thoughts, and looking at what did the others make of it, and try to make use of the group to feed back to other person who was feeling criticized, and had a mixed response from the group, and I said that yes, if someone said that to me I would probably also feel that I was criticized and someone was being rude to me, but that was not the intention of the other person, so with that and other patients coming with their views of the situation, we slowly start the process of mentalizing I think, so I also think that a group can be really great, because a person who is not mentalizing well I think like this person, who was like in a psychic equivalent mode made benefits from the group with her mentalizing and let us challenge this view with other perspectives from the group, and say let us look at reality now, this is what other people have in their heads, and what do you think about these new perspectives, so I think that in a group, MBT work very well, because if you are a psychologist I think the power dynamics is much more even in a group and it doesn’t look like you are actually enforcing your view on them, and other people can underneath the defenses, or just the defenses against the psychologist, because they might say that you just want us to believe this so we can move on, and that you just want to challenge my thinking and say that I am wrong, that is potentially the response you might get back from this particular patient group…

**Researcher:** Okay, so one to one MBT how is that different then, do you find it more challenging than group?

**Participant:** Hmmm, you see it really can be actually, and I had a patient I had earlier this week and I did not really get very far with her, and it was clear to her that, well we had a situation, I am meeting with her fourth nightly and that has been considered quite carefully and she has had weekly meeting before and it quickly seemed to get very overwhelmed, so we discussed the situation with her at some meetings, and that she might be too much in danger and feel too activated by MBT, and she was a serious self-harmer, so three sessions into her treatment we decided she would be seen fourth nightly, but she said that she was not
having enough support and wanted to be seen every week, and she said this right at the end of
the session after we talked a lot about how suicidal she was, and I said to her look my view is
that it is best we do MBT one to one fourth nightly, but let me have a think about this and we
will talk about it next time we meet, and this was partly because I was not willing to say just
at that time, that absolutely not, the timing was not right for that, so let me hold that thought
and we could talk about it next time we meet when we also have more time to go through it
and why I think it was not a good idea, but she took that as no I would not meet with her
weekly, and that was not what I said at all from my point of view, (laughing) well maybe I
am pretty psychic equivalent about that too, and that was not what I said, but because I
withdrew from her point of view, according to her I was being manipulative and untrust
worthy, and in a case like that I felt a bit constrained by the model actually, in part because I
was trying to mentalize with her, and trying to reflect back with her about what was actually
said in this case, but we did not really get far with it, and she stood by her thoughts and
conclusion, hmmm so I think the patient was trying to, hmmm well from a psychodynamic
point of view, that she was using her mentalizing difficulties almost as a defense against
engaging with me and engaging with her feelings, and that it was easier for her to say well
you are untrusting and you are manipulative and she wanted to get out of therapy, I mean
there is probably ways in MBT that would get you there, but I felt a bit constrained and I
think she was trying to use it as an excuse to get out of therapy, I mean you would not say
that to a borderline patient, unless you both have a good mentalizing relationship, where you
can challenge someone, I felt a bit trapped by the model, or I was probably not equipped
enough to use the model, hmmm and I think she has a sense about the way the model works,
and could use her deficits in mentalizing to get out of her way, well that was my view
(laughing), but I mean I was trying to mentalize with her and try to look at alternative ways
of thinking and making interpretations of the situation, but she just stood by her stance…so
that was quite difficult….hmmm resistance is not in the model, and I thought to myself this is
resistance, so yes I think that tighten me up a little bit, I felt constrained, well I am not sure if
I answered your question, well mentalization did not work very well in this case…or not one
to one MBT…

Researcher: hmmm…did she withdraw from treatment?

Participant: I am not sure yet, I’ll have to wait and see if she will still be willing to come for
treatment…hmmm let’s see it is still a working progress.
**Researcher:** hmm okay, well the other question overlaps with this question also, what is your experience of conducting MBT with BPD patients?

**Participant:** Hmm, I think it can be very helpful, I mean the stance might not look very different from the outside, in terms of being curious about your mind and my mind, and about being empathic and being non-judgmental, and sort of limited self-disclosure, I mean all this is standard stuff, but I guess it does have a special meaning within the model in terms of when you are being empathic it means you are focusing on thoughts and feelings versus behavior and situations, and I think with BPD patients, I think they can talk about behavior and other peoples behaviors and situations, and have big judgements about how other people are like, but are very limited about what other people might be thinking and feeling, and the things that they say themselves and about other people, and that kind of very concrete way of thinking can be quite infectious, they sometimes come across as a mindless bottle of person where situation responses are all you get from them, hmm they are very behavioural, so I think MBT is a very useful way of permitting yourself to be empathic in an effective way with BPD, and we often ask patients okay let’s talk about how it felt to be in a situation like that, and how does it fell now when you are talking to me about it, so you ask lots of questions about what was it? How was it? Where did that come from? You keep a very curious mind, I mean I think MBT frees you up a little bit when working with these complex difficulties,

**Researcher:** Hmm, okay, so you think that the model frees you up?

**Participant:** yes, I think the stance that MBT takes frees you up, I think that helps and I think it is a very useful focus it has with BPD presentations, so my intentions is always to stimulate them to think about how come they are saying this now, and what particular feelings are behind that, and try to make them reflect better, so then there is a chance of intervening in the process of thinking of alternative ways of the situation, so it sort of frees you up, so I really like that part of the stance, about the empathic bit, I know it doesn’t sound very special to just this model, but it actually is, and it has certainly helped me…

**Researcher:** okay have you worked within other modalities?

**Participant:** Yes I have worked with Schema mode therapy and DIT with borderline presentations, but not specifically with BPD, but I have not used them in a strictly BPD service…
**Researcher:** And what was your experience of that?

**Participant:** I think that schema mode therapy can be helpful with borderline presentation, as it does present some structure of the mind, like the concept of the detached protector and if people have some overwhelming experiences that needs to be dealt with, and personifying it to an extend helps the person to see things in alternative ways, and I remember that could be very helpful, and help them sort of gain a more mature and adult mind, if I can say it like that, so that they don’t only think like a vulnerable child, which I think you see very often with BPD patients, but I think one of the dangers with this approach is that it can be a bit too concrete, I think although it does have some mentalizing values, I think it only takes the patient to a certain point and then it stopped, but then there is also DBT, hmmm I have not worked in a DBT service yet, but my experience of using bits of it is that it also becomes a bit concrete for a very complex presentation, and it’s also less about reflecting within your mind in a relational context, which I think is important for people to be able to manage their feelings, so that’s my experience of it, and that it is more only focused on stopping people self-harming, but from my experience of it, it does not really help people reflect and move on and get going, but anyway that is my experience of it… so with MBT I feel it is also more about freeing up some space for them to actually feel things, opening up a mentalizing space for them, rather than just an action response to behaviors such as self-harm…so yes…

**Researcher:** Hmmm, okay, do you think there is an association between mentalizing capabilities and BPD?

**Participant:** yes I do very much so, whether it is specific to only BPD is another question, but I do not work with many other presentations in this ward than BPD, but I do often, especially when I am assessing the client, and when they do show some good capacity for mentalizing, and even if they have been referred to us, so if they have good capacity of mentalizing, we are less likely to take them on to this treatment, so if the patient shows a good capacity in showing a curious mind and a mental capacity to process their mental states, then we are unlikely to take them in, and then we sometimes refer them other services, where they can use other therapies with them, because MBT is more of a precursor to be able to move on to and make use of other more mainstream therapies, so sometimes it happens that after they finish their 18 months treatment with us we refer them other treatments…but coming back to your question, I do see an associated link between BPD and mentalizing, yes I do…
Researcher: Okay, hmmm, what’s your experience of the patient’s symptoms improvement when undergoing MBT? Can you describe that?

Participant: hmmm, well I think that varies quite a lot, there are some patients who you think to yourself that they did not get very far, but that is probably our fault in the assessment process, but then again you see patients who really come a long way with MBT, and I think it is quite interesting that sometimes the ones that you think are going to do very well, they do less good and some who you think won’t do very well, end up reaching very far with MBT, that’s always very interesting, but then again specifically in terms of symptoms I think in terms of self-harm and other destructive behaviors, I think we work well in stopping these and very often significantly reducing it, and quite often completely stopping it, I actually think that very early on in therapy the first symptoms that becomes less prevalent is probably the self-harm although it can also accelerate in the early stages of treatment, but then it sort of takes a turn, so yes I think MBT have a really good effect on that, and I think that sets the stage for being able to think, feel and reflect, so even though they find it difficult to feel and think at a deeper level, they can see that it is beneficial for them and that it is actually good for them…but I also think that in terms of stabilizing relationships, I think we have some good effect on that, in terms of somebody being able to respond less extreme ways to other people, so we also very much put on the target how the patients can be able to put their point across to others in a less destructive and overwhelming way, so we focus on that very closely, so you very much try to make them reflect on that, and ask many questions, curious questions, but we actually also focus a little about the patients functionality, just to help them and encourage them to do some voluntary or paid work as well…so we focus on quite a few things, and we do use some test batteries in order to measure symptoms and their well-being in some respect…I mean we used to use tests in regular intervals, but now it is more before and after MBT treatment program, but I think we are going to increase the use of these tests, because of IAPT, so we are going to use some of the same measures in secondary care also…so there is also a lot of competition between us now…(Laughing)...so basically I think in a good number of cases we have good effect with MBT.

Researcher: Hmmm, okay we have come to the last question now, have you come across any ideas for modification within the MBT model? Or have you identified anything that perhaps does not sit well with you?
Participant: hmmm, well…hmmm I suppose, hmmm as a CBT therapist, I think I would like a bit more skilled focus in MBT, and I think that is just to make it a bit more concrete for me and my colleagues, just make one a little bit more aware of what we are actually supposed to do and what we are actually doing here, hmmm probably being able to break down mentalizing better, and to take it further perhaps, but yes I really do think that a bit more skills focus is missing in the model, I mean for me coming into a MBT service which is six years ago now, I do think that in the early phases, I was really thinking to myself, hmmm what is this therapy about and what are we actually doing, so I think there is less of a focus on the doing, there isn’t really a protocol that says this is the way you mentalize or a building block you follow like in CBT, but then again I guess there isn’t a concrete way of dealing with a very complex patient group like BPD on how they can build up their minds and a more reflective capacity, I don’t really know, I just feel that sometimes there is not a step by step way of doing it in MBT, if you know what I mean…I think there is not a clear structure on how to operationalize MBT like there is with other models, perhaps like in CBT….well that is what I think (laughing).

Researcher: Okay, that was my last question for you, thank you very much.
Manuscript preparation

1. General guidelines

- Manuscripts are accepted in English. Any consistent spelling and punctuation styles may be used. Please use double quotation marks, except where “a quotation is ‘within’ a quotation”. Long quotations of 40 words or more should be indented without quotation marks.
- A typical manuscript will not exceed 10000 words including tables, references, captions, footnotes and endnotes. Short communications and case reports for rapid publication are limited to four journal pages (approximately 2,000 words including tables and references). They can cover matters of topical interest or work in progress. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- Abstracts of 200 words are required for all manuscripts submitted.
- Each manuscript should have 5 to 7 keywords.
- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance here.
- Section headings should be concise.
- All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.
- All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.
- Please supply a short biographical note for each author.
- Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:
  - For single agency grants: "This work was supported by the [Funding Agency] under Grant [number xxxx]."
  - For multiple agency grants: "This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx]."
Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.

For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.

Authors must adhere to SI units. Units are not italicised.

When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

2. Style guidelines

- Description of the Journal’s article style.
- Description of the Journal’s reference style.
- Guide to using mathematical scripts and equations.
- Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk.

3. Figures

- Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.
- Figures must be saved separate to text. Please do not embed figures in the manuscript file.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
- All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly.
- The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

4. Publication charges

Submission fee

There is no submission fee for Counselling Psychology Quarterly.

Page charges

There are no page charges for Counselling Psychology Quarterly.

Colour charges
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