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What Works in Mentalization-Based Treatment
Systematic case studies in personality disorder and addiction

João G. Pereira

Middlesex University and Metanoia Institute
Doctor in Counselling Psychology and Psychotherapy by Professional Studies
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Abstract

A review of the literature in personality disorders leaves no doubt that more research is needed for the understanding and management of this clinical condition. The frequent misuse of drugs and alcohol within this population adds an extra complication for the treatment of these individuals who are often neglected or mistreated by the health care system. The creation of specialist personality disorder teams following the National Institute of Mental Health (NIMH) report in 2003 gave new hope for both patients and professionals working in this area. Mentalization Based Treatment (MBT) is one of the promising psychological interventions for personality disorders, and there is evidence that it works for Borderline Personality Disorder.

The aim of this study was to investigate if MBT is effective in patients with various concomitant personality disorder types and with co-morbid addiction problems. Since most research has focused on whether MBT works, it seemed important to also find out 'what' is it that works in MBT i.e. what are the helpful therapy processes or 'ingredients' of change.

A research based MBT program was established in an outpatient setting, with six patients considered to be suitable; they engaged in twice weekly group psychotherapy, periodic clinical reviews with the consultant psychiatrist in psychotherapy and additional support from a psychosocial nurse, all within a mentalizing framework. Close links with the Community Mental Health Team and the Community Drug and Alcohol Service were maintained.

An adjudicated form of the Hermeneutic Single Case Efficacy Design method (HSCED) was used, aiming to gain deep, contextual, knowledge into a small number of cases undergoing treatment. A rich case record was obtained for each case, including quantitative and qualitative data. Following the collection of data two researchers have engaged in a reflexive process, trying to gather affirmative and sceptic evidence regarding the efficacy and effectiveness of

treatment. Nine 'judges' were then invited to give their expert opinion on each case resembling a legalistic trial.

The judges rated their conclusions on a scale from 0% (no change) to 100% (changed completely), indicating that after one year of treatment the patients have made *considerable* (60%) positive changes and that these changes can be attributed to the therapy programme to a *substantial* (80%) degree. A number of treatment 'ingredients' have been discovered but these appear to be common factors in many psychotherapeutic approaches rather than specific to MBT.

The HSCED method was considered to be an appropriate choice, showing that it can be of value in cases of severe disturbance within complex treatment programs. Nonetheless, some adaptations are recommended.

Keywords: mentalization; personality disorder; substance abuse; practice-based evidence; hermeneutics.

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INTRODUCTION

The interest in this area of study has arisen from my work in two different departments of a large Mental Health Trust in Greater London: the Community Drug and Alcohol Service (CDAS) and the Psychotherapy Department with its recently established Complex Needs / Personality Disorder service. The work of the Psychotherapy Department has a tradition of psychoanalytic and psychodynamic psychotherapy using both individual and group-analytic methods. The establishment of the Personality Disorder Service came from a need to respond differently to a population that has been traditionally neglected or subject to inadequate service provision (NIMH(E), 2003). The literature in mentalization processes (e.g. Fonagy et al, 2002), with its psychodynamic roots, has appealed to the managers and organizers of this department and started to be gradually integrated into group analysis and individual psychotherapy. The delivery of family / systemic therapy and art-psychotherapy, previously under different departments, had also become part of the same management structure, resulting on what was, at the time this research was planned, and still is today, a pluralistic Psychotherapy Department.

When I embarked on this project I was spending the majority of my time at the Drug and Alcohol Service, where I was confronted on a daily basis by patients with serious developmental and personality problems. Their extreme difficulties with affect regulation and mentalizing (e.g. Soderstrom and Skarderud, 2009) made me contemplate the usefulness of Mentalization Based Therapy (MBT) for this client group – even if, traditionally, severe drug and alcohol use has served as an excluding criteria for MBT programs (Bateman and Fonagy, 2004). Since psychoactive substances and mentalizing activate similar brain regions, it was seen as counterproductive to have someone actively using drugs and attending a treatment program that focus on the recovery of mentalization (Bateman and Fonagy, 2004; 2006). The substance would interfere and prevent the goals of treatment.

Despite these difficulties, the potential and relevance of using MBT for clients diagnosed with personality disorder and addictions has recently been acknowledged, not solely because of

the well know overlap between the two conditions but also due to the vicious circle occurring between mentalizing difficulties and use of substances (Philips, Kahn and Bateman, 2012; Bales et al, 2010; Bales et al, 2012). If, on the one hand, the substances would shut down mentalization and reflective function, mentalizing difficulties in stressful situations would also lead to drug use as a self regulation strategy, providing temporary comfort and *substitution* for a secure attachment relationship. Philips, Kahn and Bateman (2012) have, therefore, tried to find ways of including patients with dual diagnosis in treatment and have consequently embarked on researching the applicability of the original MBT manuals (Bateman and Fonagy, 2004; 2006) for patients with coexisting diagnoses of borderline personality disorder and opiate dependence (MBT-DD). Eighty patients were allocated randomly to two treatment conditions: Medication Assisted Treatment (MAT) alone using Methadone or Buprenorphine in a drug clinic *versus* MAT and MBT-DD together for 18 months. Results are not available yet.

The clinical reality is that a large proportion of patients attending substance misuse services also have a diagnosis of personality disorder. A review of studies among substance abusers undertaken by Verheul (2001) showed that a median of 56.5 % had at least one personality disorder.

Although there is evidence to support the effectiveness of standard substance misuse treatment approaches for patients with co-morbid personality disorders and no evidence to suggest that they should be excluded from mainstream addiction services (Welch, 2007), there is also data indicating that people with personality disorders have higher vulnerability of relapsing into drug and alcohol use (Welch, 2007).

In my daily experience at CDAS I frequently observed the impatience and powerless feelings of staff towards many service users with personality disorders. The help we often requested from mental health services (either in the community or in hospital) also seemed to provide little difference and, more often than not, the patients would not be accepted for treatment, with the justification that they did not suffer from 'severe and enduring mental illness' and that their behavioural problems were invariably caused by the substances.

Snowden and Kane (2003) stated that generic mental health services are 'psychosis designed' and not appropriate to people diagnosed with personality disorder. Research in this area led to the development of the guidance *Personality Disorder: No Longer a Diagnosis of Exclusion* published by the National Institute of Mental Health in England, NIMH(E) in January 2003. The main purpose of this guidance was to encourage the development of specialist services for those with personality disorder, designed specifically to meet the needs of this client group.

If MBT made sense and was well researched in borderline personality disorder, I started to wonder if it would also be useful for patients with co-morbid addiction problems. Pertinent to these purposes was the modification of MBT for dual diagnosis; this had not been tried at the time I embarked on this project, however, more or less concurrent to my ideas, two studies, already mentioned above, started to be implemented, one in Stockholm (Philips, Kahn and Bateman, 2012) and one in the Netherlands (Bales et al, 2010; Bales et al, 2012). My conviction is that the results of both these studies, combined with ours, will shed some light into the efficacy and effectiveness of this therapy, not just in group average terms (Stockholm and Netherlands studies) but also at the level of the individual and of the quality of the therapeutic process in naturalistic settings (our study).

If we think of borderline personality disorder alone, the existing research consistently points to the efficacy of Dialectical Behaviour Therapy and MBT. However, little qualitative research has been conducted to ascertain the reasons for its success, especially from the perspective of those undergoing the treatment (Martens, 2005). The recent study from Katsakou et al (2012), exploring the relationship between the goals of service users and the priorities of the treatment providers, is an exception.

Despite the efforts, there is still a limited amount of evidence into how and why these therapies work at the micro-level of analysis and from a qualitative perspective, particularly with clients diagnosed with mixed personality disorders and co-morbid substance abuse difficulties as confirmed by a number of experts.

Since I was also working as an Adult Psychotherapist in the Personality Disorder Service, the opportunity arose to answer some of the questions raised above and a decision was made to research the effectiveness of therapeutic programs for individuals with personality disorder where substance misuse was also a problem; according to the history and interests of the department and my own, and also following the evidence and recommendations in personality disorder treatment, a plan was formulated to establish a programme of Mentalization Based Therapy (MBT) formally, following Bateman and Fonagy's (2004; 2006) practical guides for Intensive Outpatient Treatment (IOT). Due to limited resources and the nature of the patient's diagnosis, which included addictions and mixed personality disorders, some adaptations were made whilst not losing the essential features of the treatment. The main modification consisted in having group psychotherapy (90 minutes) twice per week, instead of alternate individual (50 minutes) and group sessions (90 minutes). Bateman and Fonagy (2004: p.200) warned that the 'provision of individual and group therapy allows splitting of transference, softens the emotional intensity, and protects the patient from the consequences of too powerful an activation of their attachment process. The patient can take refuge within individual therapy when group therapy becomes frightening or seek sanctuary in the group when individual therapy becomes too difficult. The simultaneous provision of group and individual therapy is an ideal arrangement within which to encourage mentalization'. Despite not having the individual therapy option, the patients had access to a Psychosocial Nurse Practitioner that not just provided 'refuge' from group therapy but also offered practical help, allowing patients to make better use of group therapy. This model of psychosocial nursing has been widely supported (Pringle and Chiesa, 2001; Chiesa and Fonagy, 2002; Chiesa, Fonagy and Gordon, 2009).

Having the above in mind, and starting from a position of not-knowing, I proposed to study the effectiveness of the new MBT program established at the Specialist Personality Disorder Service and to gather practice-based knowledge in a naturalistic setting. I aimed to investigate whether MBT would work for clients with mixed personality disorders and substance

abuse problems and *how* this would work. I also searched for reasons into *why* it would work for this client group.

I opted for an intensive mixed methods study that could shed some light into the effective components of the treatment – a gap that even one of the original authors, Peter Fonagy admits (Fonagy, 2013) - whilst complementing other studies that are currently being undertaken, for example the Stockholm randomized controlled trial of opiate dependent, personality disordered clients (Philips, Kahn and Bateman, 2012).

Contribution

I expected the findings to be particularly relevant at a local level and for local services. The process of research by itself had the potential to influence service delivery within the specialist Personality Disorder Service and the Drug and Alcohol Services of this Mental Health Trust.

The nature of the study and the detail of analysis provided were thought to be crucial for individual practitioners looking to improve their practice as well as giving them tools to research their own work.

By influencing practitioners and local services in a significant way it was predicted that this research could contribute to larger discussions in the field of Counselling Psychology and Psychotherapy. Through wide dissemination of the process and findings of the research I aimed to also help shape national and international policy.

BRIEF OUTLINE AND PRINCIPLES OF MBT

Historical Background and Contextualization

One of the current accepted definitions of mentalization (Allen, Fonagy and Bateman, 2008) refers to the process of implicitly and explicitly interpreting the actions of oneself and others as meaningful on the basis of intentional mental states (e.g. desires, needs, feelings, beliefs and reasons).

The concept is rooted in Theory of Mind studies on philosophy as well as the later developments in cognitive science and developmental psychology; it has been used for some time in the study of autism and schizophrenia (e.g. Baron-Cohen, Leslie and Frith, 1985; Baron-Cohen, 1995) being empirically tested for the first time in 1983 when Wimmer and Perner (1983) ran a false belief experiment with three year old children.

Along the years, the psychoanalytic literature has described similar phenomena under different headings. Freud's *Bindung*, translated to English as binding or linking, was first formulated in 1895's 'Project for a Scientific Psychology' as the mental activity of linking psychic instinctual energy in primary process with mental 'representation' in secondary process (Freud, 1895). Reformulated along the years, this concept referred to the transformation of somatic *non-mental* activity into something *mental*, allowing 'thought' to mediate traumatic memories. Freud (1914) also stressed that this representation of internal states could fail in various ways, which is at least analogous to what is meant nowadays by mentalizing failures.

Other concepts, such as Melanie Klein's *depressive position* (Klein, 1945) or Wilfred Bion's (1962) *alpha-function* are comparable to the notion of the acquisition of Reflective Function (RF), a concept that overlaps with the construct of mentalization (Fonagy et al, 2002). For both authors, the mother-child relationship provided the basis for the development of this capacity to symbolize. Similarly, the emergence of the true self in Winnicott (1962) or the acquisition of empathy in Kohut (1977), were dependent on the caregiver's *psychological* understanding of the infant. Winnicott (1962) also recognized, alongside Kohut (1977) and

Fairbairn (1952) that the psychological self develops through the perception of oneself in another person's mind as thinking and feeling (Fonagy et al, 2002).

In the 1960's, French psychoanalysts applied the concept of mentalization to understand psychosomatic patients who displayed a lack of symbolization of mental states (Jurist, Slade and Bergner, 2008). The construct of alexithymia has also demonstrated some overlap with aspects of mentalizing, specifically relating to self-awareness (Goerlich et al, in preparation). A review of empirical evidence relating alexithymia with substance misuse was undertaken by Taylor (1997).

Allen (2006: p.7) defined mentalizing as 'perceiving and interpreting behaviour as conjoined with intentional mental states'. The focus on *intentionality* is rooted in Dennett's (1978, 1987, 1988) studies on the prediction of behaviour; a state of mind is necessarily *intentional* since it is impossible not to be *about* something or *directed at* something. The philosophers of mind then extended Dennett's approach to include Freud's theory of the unconscious (Hopkins 1992; Wollheim 1995). Understanding aspects of behaviour that usually make little sense, such as dreams or neurotic symptoms, in terms of unconscious beliefs, thoughts, feelings and desires would make them meaningful and possible of being understood (Fonagy et al, 2002).

Fonagy (1991: p.641) introduced mentalization into Anglophone psychoanalytic discourse by defining it as 'the capacity to conceive of conscious and unconscious mental states in oneself and others'. The contemporary application of mentalization has been developed in great part by Peter Fonagy and his colleagues from University College London (UCL) and the Anna Freud Centre. Fonagy and colleagues' current conceptualization of mentalization combine insights and ideas derived from (Jurist, Slade and Bergner, 2008):

- (a) neuroscientific research about the brain and the link between brain and mind, as well as about the way early relationships affect development;

- (b) attachment theory and research about the properties of early (and potentially also later therapeutic) relationships that promote, or hinder, the capacity for mentalization;
- (c) theory of mind studies in developmental psychology and in philosophy

Within the above principles, Bateman and Fonagy (2004; 2006) have developed a treatment programme for Borderline Personality Disorder, a problem intimately linked with attachment difficulties, affect dysregulation and mentalizing failures. This treatment programme was given the name of Mentalization-Based-Treatment and, more recently, Mentalization Based Therapy (MBT).

MBT is a psychodynamic treatment focusing on the here and now dynamics of the therapeutic relationship, as well as the value of understanding the nature of resistance in therapy. It draws, nonetheless, on a number of different approaches and perspectives. It relies on cognitive behavioural therapy in the attempt to understand the relationship between thoughts, feelings and behaviour; on systemic therapy through the consideration of family members and their behaviours, as well as the impact these have on each other; and on social and ecological principles via an understanding of the impact of context upon mental states (deprivation, hunger, fear, etc).

MBT is, therefore, an integrative and pluralistic treatment, providing a unique space for dialogue and collaboration between psychoanalysis and related disciplines.

Fonagy and colleagues main claim is that trauma impairs mentalization (Jurist, Slade and Bergner, 2008). Not having the experience of being thought about in a contingent way impairs the capacity of the infant to feel safe to think about the social world; mentalizing and the healthy development of intersubjectivity allows for the expansion of *epistemic trust* in relationships, a necessary key to open up the wish to learn about the World (Fonagy, 2013).

In MBT the attachment system is seen as a survival mechanism, interpersonally built, and serving as moderator for genetic expression (Fonagy et al, 2002). The capacity to *mentalize*

(i.e. reflective function) is assumed to develop from the experiences of attachment and the ability of the caregiver to appropriately represent and mirror the emotional states of the infant.

This intimate process, allowing the infant to gradually pay attention to, and understand, what he/she is feeling or experiencing, was described in Gergely and Watson's (1996) social biofeedback model of parental affect-mirroring and then later developed by Fonagy et al (2002) under the name of *contingent marked mirroring*.

Disorganized or insecure attachment styles have been linked to failures in mentalizing during adult life (Fonagy et al, 2002). In traumatic experiences of abuse, for example, it is safer for the child not to understand (mentalize) what goes on in the mind of the abuser, as this could be too frightening. Attachment trauma, in this way, promotes a defensive withdrawal from the mental world (Fonagy and Target, 1997). Later in life, close interpersonal situations leading to the activation of the attachment system will interfere with mentalizing as they can trigger overwhelming affect. This becomes, however, a double-bind problem as mentalizing is also needed to help regulate difficult emotions.

One of the 'revolutionary' aspects of these discoveries is the assumption that classical analytic technique will not work for patients with attachment disorders and personality problems as they may induce severe instability and regression (Jurist, Slade and Bergner, 2008). The same can be inferred for interventions currently used in addiction services, like Motivational Interviewing, CBT, or any other intervention that activate the attachment system without paying attention to the mentalizing deficit of the patient. Many of these interventions do not provide the patient with the necessary mentalizing skills to be able to use and internalize that attachment (Jurist, Slade and Bergner, 2008). The therapist must be able to create in his/her mind a representation of the mental world of the patient and then bear to communicate it in a way that helps the patient organize his/her mind. In MBT the activation of attachment is carefully monitored, running alongside the development of mentalizing skills within the framework of treatment and of the transference.

As I argued elsewhere (Pereira, 2011a; 2012b), the above considerations augur a paradigm shift in psychoanalysis as they discredit (at least for some patients) one of the major analytic techniques: transference interpretation. To avoid inducing states of instability and severe regression, the here and now therapeutic relationship must be modelled on early development and the delicate processes of co-regulation of affect that occur in secure attachment interactions. Thereupon, the concept of mentalization is unique in its particular emphasis on development. The process of treatment in MBT is also connected with psychoanalysis as it focuses on the dyad therapist-client and on the process of therapy; however, the focus is not on insight or interpretation but on current mental states.

Within the multi-disciplinary milieu described above four central concepts have grown in the MBT tradition that is worth mentioning briefly (Bateman and Fonagy, 2006; Allen, 2006).

Mentalized Affectivity

This is defined as the simultaneous 'experience' and 'knowledge' of emotion. It is a major aim of MBT.

Psychic Equivalence

This is described as one of the prementalistic modes of functioning, antedating the development of mentalization. In this mode of functioning, mental representations are not distinguished from external reality. The internal has the power and importance of the external. For example, if a young child *thinks* there is a monster in the closet, a monster *is* in the closet (world=mind). Equally, if an adult patient reverts to a psychic equivalence mode they may assume, for example, that they know what the therapist is thinking and alternative perspectives will not be considered. There is a strong conviction of being right. This may also be the case in flashbacks or paranoid delusions where mental states are experienced as real.

Pretend Mode

In this prementalistic mode there is a separation between psychic and physical reality to a point where the connection between the two can no longer be achieved. Whilst this mechanism can help children liberating themselves from the frightening experiences of psychic equivalence, the relationship with reality is lost and, at the extreme, this can resemble dissociation.

Teleological Mode of Functioning

In this prementalistic mode of functioning changes in mental states are assumed to be real only when confirmed by physical observable action contingent upon the patient's wish, belief, feeling or desire.

The teleological mode arises in circumstances where the use of the intentional stance (mentalization) is only partially accessible (Fonagy et al, 2003). Gergely and Csibra (1997) have shown the opposition between a teleological mode and an intentional one; in the teleological mode the behaviour of the other is interpreted in terms of its observable consequences, not as being driven by desire (Fonagy, 2000).

A useful example of the teleological mode of functioning can be found in the following statement from Bateman and Fonagy (2006: p.23): 'a commitment by a psychoanalyst to be available several times a week at an early hour is not experienced as an indicator of commitment. It is taken for granted as a standard template of therapeutic support. It is deviating from this template in accordance with the patient's wishes (giving them the illusion of control) that is experienced as meaningful; special acts such as checking in with patients between sessions, emailing offering weekend appointments, allowing between sessions contact, etc are demanded as physical proofs of commitment'.

A similar example could well be applied in the day to day running of drug and alcohol services: a patient who arrives late for his appointment is denied his methadone prescription and given another appointment. The patient protests violently threatening the staff member who

as a result becomes even more defensive. Such acts of violence may arise because the patient is unable to monitor their own internal state and is incapable of taking the perspective of the other, who is considered hostile until proven otherwise. If the member of staff is only focused on the violent act itself, the underlying mental processes that led to the outburst will remain unchecked and unaltered, ready to fuel the next action (Bateman and Fonagy, 2004).

Fragile mentalizing will be evident when the patient regresses to earlier psychological modes of functioning: teleological, psychic equivalence and pretend mode. The aim is to develop *mentalized affectivity* states, particularly in the face of difficult interpersonal situations that activate the attachment system.

Treatment Structure

Structure is needed to form a framework around therapy that is neither intrusive nor inattentive and which, much like a benevolent uncle, can remain in the background but be around to catch things when they get out of control (Bateman and Fonagy, 2004: p.184).

The description of the treatment structure I will use was gathered mainly from Bateman and Fonagy's (2004, 2006) treatment manuals. These manuals have been developed specifically for the treatment of Borderline Personality Disorder. However, MBT has transferable features that can be adapted to other disorders and settings. The Anna Freud Centre and University College London (UCL) are at the forefront regarding new applications of MBT in the UK. Other sites, like the Menninger Centre in the US and other international projects, for example in the Netherlands and Finland, are actively working on the development of this approach. Although I took inspiration from Bateman and Fonagy's (2004, 2006) guidelines, I aimed to research the applications of MBT to several concomitant personality disorder types presenting with co-morbid substance addiction. That was a major aim of this research project

and one that represented the clinical reality. Whilst I was undertaking this research, I became aware of a new MBT study for dual diagnosis (MBT-DD) that was underway in Stockholm (Philips, Kahn and Bateman, 2012). This meant that my ideas made sense and that others were also exploring similar concepts (see 'Introduction' for further details).

Bateman and Fonagy (2006: p.37) state that 'the overall aim of MBT is to develop a therapeutic process in which the mind of the patient becomes the focus of treatment'. They describe two variants of MBT: The first is a day hospital programme in which patients attend initially on a 5-day per week basis. The maximum length of time in this programme is 18-24 months. The second adaptation of MBT is an 18-month intensive out-patient treatment which consists of one individual session of 50 minutes per week, and one group session of 90 minutes per week. In both programmes the group therapist is different from the individual therapist.

Both variants include the use of medication and regular psychiatric reviews (within the treatment team to avoid splitting) as well as the involvement of all relevant external agencies or parties (e.g. GP, CMHT).

In their treatment programme, Bateman and Fonagy (2006) make the general point that anything that reduces the capacity to mentalize is in clear opposition to the programme. Sexual relationships between group members ('pairing of minds'), the use of violence and aggression (taking too much 'mind space') or the use of drugs and alcohol are all seen as incompatible with engaging in the programme. 'Drugs and Alcohol alter and interfere with exploration of mental states and as such negate the overall aim of treatment' (Bateman and Fonagy, 2006: p.47). There is even some overlap between the areas of the brain responsible for mentalizing and those that are affected by drugs and alcohol (see Bateman and Fonagy, 2004; 2006).

Although I agree unreservedly with Bateman and Fonagy (2004; 2006) regarding the difficulties created by the use of drugs and alcohol, I challenge their view on addiction as exclusion criteria for treatment. I believe MBT has potential to treat these patients, who are otherwise excluded from most psychotherapeutic programmes. As a matter of fact, the authors (at least Anthony Bateman) have actually changed their minds very recently, since they are now

testing MBT in patients diagnosed with BPD and Substance Use Disorder (Philips, Kahn and Bateman, 2012). Of course their inclusion in treatment must be done in a thoughtful and bounded way and the present study is just a preliminary attempt to include some level of substance misuse in an outpatient mentalization-based psychotherapy programme. MBT programmes are also being expanded in many arenas outside the borderline constellation, and there are some interesting attempts of working with substance misusing mothers and their babies (e.g. Soderstrom and Skarderud, 2009). However, MBT had not been used, thus far, in mainstream drug and alcohol services. The randomized controlled trial under study in Stockholm is the first serious attempt of testing whether MBT works for this population and what variations are required. Another attempt, already described earlier, was made in the Netherlands, although not specific to drug addiction and delivered without modifications (Bales et al, 2010; Bales et al, 2012).

Strategies of Treatment

The mentalizing stance is an ability on the therapist's part to question continually what internal states both within his patient and within himself can explain what is happening now
(Bateman and Fonagy, 2004: p.203)

Four main strategies are recommended in Bateman and Fonagy (2004): (1) enhancing mentalization, (2) bridging the gap between affects and their representation, (3) working mostly with current mental states, and (4) keeping in mind the patient's deficits.

The task of the therapist is to facilitate the patient's understanding and identification of emotional states whilst helping him to locate them within a present context with a linking narrative to the recent and remote past.

The gap between inner experience and its representation engenders impulsivity (Bateman and Fonagy, 2004). The therapist's work is to assist in the 'elaboration of theological modes into intentional ones, psychic equivalence into symbolic representation, and linking affects to representation' (Bateman and Fonagy, 2004: p.206)

Transference

Transference interpretations undertaken in a classic fashion are likely to generate anxiety and be experienced as abusive. It is only safe to use the 'heat' of the therapist-patient relationship and to explore different perspectives towards the middle or end of therapy or once a strong therapeutic alliance has been established and stable internal representations recognized. Even then, Bateman and Fonagy (2004) caution that change in borderline patients is engendered by brief and specific interpretations rather than complex statements about the repetition of past relationships.

With borderline patients, transference is not used in the clinical situation as a simple repetition of the past or as displacement and should not be interpreted in this way.

Transference is experienced as real, accurate, and current by the borderline patient and needs to be accepted by the treatment team in that way (Bateman and Fonagy, 2004: p.207)

Retaining mental closeness.

This process resembles the infant-caregiver relationship and the provision of empathic responses by the caregiver, offering feedback to the infant on his or her internal state and enabling developmental progress. The job of the therapist is to represent accurately the feeling state of the patient and its accompanying internal representations (Bateman and Fonagy, 2004)

Working with current mental states.

MBT puts emphasis on the present and the 'here and now' in considering the influence of past events. This is different from continually focusing on the past; the task of the therapist is to bring the patient back to the present and link the events described with the 'here and now' (Bateman and Fonagy, 2004).

The classic technique of conflict interpretation will distance the treatment from a focus on current mental states. A difficulty with second order representation in the mind of the borderline patient is likely to make him respond to terms such as breast or penis not as metaphors but as the objects themselves (Bateman and Fonagy, 2004). I confirmed this several times in clinical practice and common sense has gradually and intuitively moved my stance closer to the mentalizing position.

REVIEW OF THE RELEVANT LITERATURE

As clarification for the rest of the study, the term 'personality disorder', its classification into clusters or categories, as well as all other uses of psychiatric 'labels', are applied to facilitate understanding and recognition of the problems presented. It is important to clarify at this stage, that DSM categories (DSM-IV-TR, 2000) or diagnoses are not accepted as 'givens' or 'true' representations of the patients' difficulties. It is my view that mental health problems are better seen as *dimensional* rather than just divided into *categories*. It is not only a question of 'yes' or 'no' but also of 'how much'. It is also true that the classificatory system neither contemplates the causes or the origins of the problem nor takes into consideration important pieces of research (e.g. Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013).

I now turn to the focus of our discussion. A review and interrogation of the literature in personality disorders leaves no doubt that more research is needed for the understanding and management of this disabling clinical condition; a particular focus on assessing the response of different personality disorder types to different treatment programs and the conditions that are needed to sustain the changes is important (Lieb et al, 2004; Alwin et al, 2006).

Personality disorders can be defined as variations or exaggerations of normal personality traits, leading to extreme and persistent difficulties for the person diagnosed and interfering significantly with their ability to cope with life and social interactions. 'People with personality disorders have a very low tolerance for and difficulty in containing any increase in a number of affective states: anxiety, frustration, aggression, grief or loss, love or intimacy' (Johnson, 1994: p.14).

There is no single known cause of personality disorders: they result from complex interactions of biological, psychological and social factors (Alwin et al, 2006). Learning experiences in early development and the quality of the attachment with care givers are thought to be a crucial aetiological root. Fonagy (1998), for example, suggests that borderline personality disorder is a disorder of attachment, separation tolerance, and ability to understand

others' mental states ('theory of mind'). In a similar token, Johnson (1994) considers that the *interaction* between the individual changing and basic needs and the ability of the environment to meet them is critical to any individual adjustment. For Johnson, this 'interaction makes personality and produces psychopathology' (1994: p.2).

More weight is currently being given to the genetic influence (Kendler et al, 2008; Siever et al, 2002; Oldham, 2009; Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013) and to the importance of *mentalization* as moderator of the effects of the environment upon the unfolding of genotype into phenotype (Fonagy et al, 2002). The intersubjective capacity to mentalize the mind of the other - already present in babies as small as seven months (Kovács, Téglás and Endress, 2010) – is thought to be impaired or at least not so *automatic* in borderline patients (Fonagy, 2013).

Public mental health outpatient services have traditionally focused on the treatment of schizophrenia or bi-polar disorders, and seem to be inappropriately designed to meet the needs of these patients (Lieb et al, 2004), who are often seen as difficult to engage, demanding or disruptive.

Aware of the above problems, and consistent with the research findings at the time, the National Institute for Mental Health in England (NIMHE) produced guidelines for the treatment of personality disorders (NIMHE, 2003). From the various recommendations in this report I would like to emphasize a) the inclusion of those with personality disorders in mainstream mental health services b) the recognition that personality disorders are treatable conditions and c) the creation of specialist personality disorder teams.

It was within this framework that the Specialist Personality Disorder service that is the focus of this study was created.

A significant part of the work of these specialist teams involve the provision of psychological therapies, which research suggests can be successful in treating individuals with personality disorders (Bateman and Tyrer, 2004). Over the last 20 years a number of structured psychotherapy interventions for borderline personality disorder (BDP) have emerged as

effective, with MBT and Dialectical Behaviour Therapy (DBT) being the ones with the strongest empirical support (Paris, 2010). These tailored and structured forms of therapy were shown to produce better results than treatment-as-usual (Bateman and Fonagy, 1999; 2001; 2003; 2008; Linehan et al, 1991; 1993; 1994). Despite the positive evidence there are still shortcomings in the quality of these investigations and further questions to answer. The highly experimental nature of these study trials, as well as the lack of *clinical reality* in the treatment conditions, who often exclude other co-morbidities, raise particular concerns (De Vylder, 2010; Seligman, 1995). Also, when compared with other structured treatments specifically designed for personality disorder the findings suggest similar results (Paris, 2010), although MBT has shown to be moderately superior (Bateman and Fonagy, 2010).

In sum, there is no clear evidence (Alwin et al, 2006) suggesting the superiority of one type of treatment approach over another or for a particular method of service delivery (inpatient, outpatient, or day programme). Instead, a number of common effective elements were identified when reviewing the literature on psychological therapies for personality disorders (Bateman and Fonagy, 2000; Rawlings, 2001; Bateman and Tyrer, 2002 as cited in NIHM(E), 2003: p.23):

- be well structured
- devote effort to achieving adherence
- have a clear focus
- be theoretically coherent to both patient and therapist
- be relatively long term
- be well integrated with other services available to the patient
- Involve a clear treatment alliance between therapist and patient.

Although most of these points are consistently found in effective treatments, the evidence supporting 'long-term' treatment is dubious. This choice appears to be based in the experience and preference of practitioners rather than in research findings.

Symptomatic improvement started as early as four to six months in some cases (Bateman and Fonagy, 1999), however, it is difficult to assess whether this improvement would be sustainable if the therapy had stopped at that point. Other studies have found benefits in the use of briefer intensive interventions followed by *step-down* programmes (Chiesa et al, 2004).

Another promising therapy for personality disorder, adding to DBT and MBT, is Transference Focused Therapy (Clarkin et al, 2001). However, this therapy needs more research.

The picture gets a lot more complicated if we add problematic substance use to the frame. Although this is a common feature in personality disorders (Taylor, 1997), particularly within the antisocial, borderline and paranoid types (Verheul, 2001), very few specialist programmes have been designed for patients with both personality disorder and addiction to substances. The reality of CDAS services is similar to CMHT's, with staff feeling unprepared to deal with such problems. While the recommendations from the National Treatment Agency for Substance Misuse (NTA) and the National Institute for Health and Clinical Excellence (NICE) are to deliver 'structured psychosocial interventions' (e.g. NICE-51, 2007), like Motivational Interviewing or Contingency Management, these are not disorder specific and are often focused on the addictive behaviour, leaving behind other important aspects of the individual. Johnson (1994: p.15), talking about personality problems, reminds us that 'understanding, catharsis, CBT, etc... will be inadequate unless this basic internal structure is matured and the polarities that determine the character style are integrated'.

In my daily clinical experience I realized that cognitive behavioural explanations or psychoanalytical interpretations are often felt by patients with borderline personality disorder as direct attacks to the self since these patients cannot mentalize the other and, consequently, understand the intervention as a subjective exercise (Pereira, 2010). This is not a new clinical finding however, since authors like Balint (1979), for example, were already speaking about this phenomenon!

The NTA and NICE also recommend CBT and behavioural couple's therapy to treat co-morbid anxiety and depression disorders of patients with substance misuse problems (NICE-51, 2007). What seems to fail on these recommendations is the acknowledgement of the specific mentalizing difficulties on patients with personality disorder and, therefore, the potential inability to 'understand' these types of treatments. For these patients, a mentalizing collapse is likely to occur under high arousal states and situations that activate the attachment system, as it would be expected in most forms of therapy or key-working. Accumulated evidence demonstrated that intense activation of the neurobiological system underpinning attachment is associated with both the deactivation of affect regulation systems (Luyten et al, 2011) and neurocognitive systems responsible, for example, for the mediation of interpersonal suspicion (Bartels and Zeki, 2000; 2004; Lieberman, 2007; Mayes, 2000, 2006; Satpute and Lieberman, 2006 as cited in Fonagy, Bateman and Luyten, 2012: p.38).

Difficulties in appraising the state of mind of the therapist can prompt further attachment behaviours of proximity seeking in the patient; if the therapist is unable to aptly soothe or relax the patient the result can be the disorganization of the therapeutic relationship and the repetition or enactment of early attachment trauma.

Despite the limitations, a narrow number of specialist treatments have been adapted for people with personality disorder and substance use problems, a combination that is particularly frequent but historically treated separately. An adapted form of Dialectical Behaviour Therapy (DBT) has shown promising results in reducing substance misuse and improving global adjustment but was no better than the control group in reducing suicidal behaviour and social adjustment (Linehan et al, 1999; Linehan et al, 2002). Other problems could be raised regarding the small sample size used in the studies as well as being resource intensive and not aimed at all personality disorders (Welsh, 2007).

Dual focus schema therapy (DFST) is a manualized approach and is aimed at people with any personality disorder category and with substance addiction (Ball, 1998). Despite the good results shown in reducing substance use frequency when compared with 12-step

facilitation therapy, DFST is still in early stages of development and, if successfully implemented, will have considerable implications for therapists' training.

Other psychotherapies showing good results with patients with personality disorder and addiction were SEP Supportive Expressive Psychotherapy (Woody et al, 1995); 12 step facilitation therapy when compared to CBT and Motivational Enhancement Therapy (Project Match Research Group, 1998); and Dynamic Deconstructive Psychotherapy (Gregory and Remen, 2008).

Notwithstanding the modest amount of studies in this area, a review of the available research has consistently found that psychosocial treatments help patients with addictive disorder, being psychotherapy or drug counselling (Woody, 2003).

No study has specifically addressed the common elements of these therapies but it is easy to suspect that they exist and that they are likely to be similar to the ones identified by Bateman and Tyrer (2002, as cited in NIHM(E), 2003: p.23) for personality disorders or even the ones discussed at 'The Great Psychotherapy Debate' (Wampold, 2001) and other studies of common factors. Also, it is worth pointing out that extra concern is often given to the patients that participate in these researched treatments and the effect that this may have was previously highlighted by Elliott (2002), who suggested qualitative interviews as a possible strategy to tease out these effects.

MBT seems to lack equivalent support for the treatment of personality disorder when combined with substance abuse, although one treatment package is currently being developed and studied in a randomized controlled trial with opiate-dependent borderline personality disordered patients in Stockholm (Philips, Kahn and Bateman, 2012).

Interesting developments within mentalization based parent-infant programs with personality disordered mothers who abuse substances have also been reported by Soderstrom and Skarderud (2009). Treatment projects such as 'Minding the Baby' in the USA (Slade, 2005; Sadler, Slade and Mayes, 2006), 'Holding Tight' in Finland (Hyytinen and Kuorelahti, 1998; Pajulo et al, 2006) and 'Towards a Secure Base' in Norway, attempt to demonstrate that

'persistent parental abstinence is achieved especially through intensive treatment focus on the parent-child relationship rather than (or in addition to) the converse, that abstinence facilitates more effective parenting' (Pajulo et al, 2006: p.460).

At the onset of this project, only one study (now printed) was found reporting MBT in personality disorder and addictions (Bales et al, 2010; Bales et al, 2012). This study, conducted at the Viersprong Institute for Studies on Personality Disorders (VISPD) in The Netherlands, was run in a naturalistic setting allowing for the investigation of multi-comorbidity prevalence, including substance misuse, and its relation to treatment outcomes in MBT patients with the main diagnosis of borderline personality disorder. It was a cohort study of 45 Dutch patients with severe BPD and no modifications were made to the original manualized version of day hospital MBT (Bateman and Fonagy, 2004; 2006). The prevalence of substance abuse (alcohol, cocaine and/or cannabis) was 79% and it was concluded that significant improvements were also possible in these patients, despite being less accentuated than in non-abusers.

Grounded in the current literature, as well as my own professional experience, I highlight a number of reasons that could explain the lack of research in this area (MBT for dual diagnosis): strict exclusion criteria for substance misuse preventing the access of these patients to treatment and/or research programmes that aim to eliminate this influence; lack of resources and staff with both mental health and addictions training; services for mental health and addictions frequently working separately; traditional high drop-out rates and poor attendance; physical complications in severe addictions (e.g. the need for detoxification); chaotic lifestyle often associated with crime and anti-social behaviour; difficulties keeping boundaries and complying with the 'rules' of treatment; and patients 'too unstable' to be able to make use of therapy or participate in research.

Adding to these problems there is the paradoxical fact that drug use impairs mentalization, and therefore, negates the aims of treatment (Bateman and Fonagy, 2006).

Despite the above projects, there are still limited numbers of scientific texts discussing substance use disorders explicitly with reference to mentalizing. It is also a recurring difficulty to find evidence for other personality disorder types other than borderline.

Mentalizing difficulties may arise in different contexts for different personality disorders but they all share difficulties with emotional regulation, a problem that is assumed to arise from insecure early attachment experiences. Since mentalization is thought to be an elementary coping skill for emotional regulation it seemed pertinent to study the effectiveness of MBT in patients with mixed personality disorders (of any type) and substance use difficulties, as this study proposed.

The classification system of the DSM is also very often inadequately translated to the clinical reality, which frequently shows combinations of personality disorder types and strong interdependence between them. Accordingly, it was imperative to bridge the gap between research and practice and to work from a scientist-practitioner perspective instead of focusing only on evidence from 'clean' clinical trials. Seligman (1995), for example, has argued that Randomized Clinical Trials (RCTs) are the wrong research method for counselling psychology and psychotherapy since they do not reflect the reality of routine clinical practice. The evidence in this area is mostly from RCTs and there is very little qualitative research in Dialectical Behaviour Therapy (Martens, 2005) and none in Mentalization Based Therapy as Marco Chiesa (2010), Director of Research at the Cassel Hospital, recently emphasized via personal communication. It was also argued elsewhere (Alwin et al, 2006) that because psychological therapy is based on individuals the effectiveness of an intervention should be assessed at a more-individual level research design, such as single case studies.

Elliott (1999) argues for the usefulness of qualitative research into both new phenomena and areas that have received substantial quantitative research. According to the above literature review, the amount of quantitative research in MBT has grown in recent years, particularly using randomized control trials with BPD patients. These studies have, amongst other things, shown a number of *common factors* (Paris, 2010) between therapies that are important to engender

change (e.g. treatment structure and well defined boundaries). However, even authors like Bateman and Fonagy (1999; 2006) admit that they do not know what the therapeutic factors are that explain *how* and *why* psychotherapy in general, and MBT in particular, effects change. On the same token, Bateman and Tyrer (2004), after reviewing the evidence on psychological treatments for personality disorder, concluded that the effective components of the interventions remain unclear.

These are indeed important problems when using randomized controlled trials to evaluate psychotherapy and other areas of social life, leading authors such as Elliott (2001; 2002) to describe them as *causally empty*. RCTs assess the effectiveness of therapy-as-a-whole, but have nothing to say about the minutia of the therapy package and the causal processes that are taking place (McLeod, 2010). The knowledge gap is even greater at the level of the individual; in particular for patients with personality disorder types other than BPD and with co-morbid substance addiction.

The limitations of the RCT design, when used as a single form of evidence, have been widely noticed (Haaga and Stiles, 2000; Barker, Pistrang and Elliott, 2002; Shadish, Cook and Campbell, 2001; Seligman, 1995). Within other problems, such as the ones already raised, this design has been criticized for its poor statistical power, differential attrition, and poor generalizability as a result of restricted samples (Elliott, 2002). Furthermore, the locus of causal inference in RCTs should move from the group to the single case to avoid an 'inference gap' (Elliott, 2002); in other words, it is only through tracing and understanding each client's distinctive change process that meaningful and logical conclusions about groups can start to be made.

STATEMENT OF PURPOSE AND AIMS

The overall aims of this project were: to evaluate the effectiveness of the Mentalization Based Therapy program established within the Complex Needs / Personality Disorder service of this large Mental Health Trust; to measure its impact on patients diagnosed with mixed personality disorders who also had difficulties with substances; and to make recommendations for similar projects running within the Trust, other parts of the country, and abroad. The implications for the treatment provision of Drug and Alcohol Services were also considered.

To achieve these I undertook a series of systematic case studies based on Elliott's (2002) Hermeneutic Single Case Efficacy Design (HSCED). I attempted to answer the following questions for each individual patient (Stephen, Elliott and MacLeod, 2011):

- Did the patient change substantially over the course of MBT?
- Is this change substantially due to the effect of MBT?
- What factors (including mediator and moderator variables) may be responsible for the change?

A number of secondary goals were also anticipated:

- Measure the level of therapist adherence to the MBT model (Bateman and Fonagy, 2004, 2006);
- Produce a final report detailing the results and conclusions of the study as well as recommendations for future service delivery and research;
- Disseminate the knowledge gained to the wider community (through publications, conference presentations, clinical teaching, etc);
- Shape service provision at local and global level;
- Inspire and Influence future research.

METHODS

Researcher Epistemology and Philosophical Underpinnings

Scientific psychology has been particularly reliant on realist ontology, with positivism and, more recently, post-positivism as dominant epistemologies. My bias is, however, to view counselling psychology and psychotherapy as human sciences. According to McLeod (1994: p.191), 'in human science there is no objective truth. All of us, therapists, clients, researchers, are engaged in negotiating and co-constructing shared understandings of events. These understandings are best seen as local knowledges rather than universal truths. The starting point and well-spring of this type of inquiry is in the fundamental human experience of not knowing: the best researchers are those with the best questions, not the best answers'.

My view on counselling psychology is aligned with post-modern thinking and the 'new paradigm' of research in counselling and psychotherapy that has grown in the past 30 years (e.g. Reason and Rowan, 1981). This paradigm stands from an epistemological position that emphasizes the value of subjective experience, heuristic discovery and hermeneutics (Woolfe and Strawbridge, 2003) providing, in this way, the kind of detail and depth of analysis that makes its findings relevant to practice (McLeod, 1994).

Rationale for the use of systematic case studies and the HSCED methodology

It was my conviction that a naturalistic approach, reflecting actual practice, would shed some light on the above research questions and, more importantly, generate new ones (theory building) that could then be refined and tested via new RCTs for example.

As Barlow (2010) argues, we need both nomothetic and ideographic methods, including single-case design studies, to develop psychological interventions.

Case study research, on the other hand, has also been the focus of harsh criticisms over the years for being 1) vulnerable to *biased* views of the publishing authors, 2) difficult to *generalize*, 3) merely descriptive and saying nothing about *causality*, 4) *ethically problematic* in

terms of confidentiality breaches, 5) hard to *summarize* in a way that allows for accumulation of evidence and 6) informative for practitioners but not relevant for *policy-making*. McLeod (2010), responding to these criticisms, provides comprehensive and relevant counter-arguments showing how contemporary case study research is a valid choice in counselling psychology and psychotherapy, allowing even for a number of strong advantages in relation, for example, to the RCT design. The author (McLeod, 2010) stresses a number of important procedures for the rigour of case study research, such as: the *researcher(s) reflexivity* and the transparency of his own assumptions and processes leading to the results; the use of *independent 'objective'* evidence such as quantitative measures that can be replicated by others; making use of *multiple researchers* giving space for different views to be expressed; and following standards of good practice in the analysis of data. The issue of generalizability can be addressed in a number of ways; a good example is the combination of purposeful case selection, use of standardized measures and theoretical sensitivity (McLeod, 2010).

A large number of influential authors have called for caution regarding the inclination of policy makers and commissioners to give attention solely to 'evidence based research', arguing for the need for more 'practice based evidence' and the importance of the clients' perspective regarding their use of therapy (Barkham et al., 2001; Foskett, 2001; Macran et al, 1999; Mellor-Clark and Barkham, 2003; Thomas, Stephenson and Loewenthal, 2008). By bridging the gap between research and practice there is a call for methodological pluralism and the representation of both quantitative and qualitative methods in an integrative paradigm (Marshall and Rossman, 2006; McLeod, 2000; McLeod, 2001; Sells, Smith and Sprenkle, 1995; Thomas, Stephenson and Loewenthal, 2008).

In this specific case, conducting an RCT could shed some light on the first two research questions. However, I would lose the richness and complexity of 'practice-based evidence' as I would have to generate homogeneous groups (diagnostic wise) to be able to compare at least two conditions (MBT vs. no intervention). This would also be problematic in financial, operational and ethical grounds. On one hand, the department of psychotherapy did not have

the funding or operational capacity to conduct an RCT. On the other hand, it would be unethical to have a number of highly distressed people on a 'waiting list' solely for research purposes. Finally, the RCT would be unable to answer the third research question as well as a number of important sub-questions: how does MBT impacts different individuals? How does it help a particular patient? Why does it work? What other factors, other than therapy, have contributed to the change?

Since I was looking for the particular journey of individuals, I would have to search for other methods. Interpretive Phenomenological Analysis or Grounded Theory, for example, would be excellent choices in capturing the patients 'lived experience' of treatment but would not be able to say much about outcome or the questions I was asking.

A case study methodology, on the other hand, had the potential to track individual treatment journeys in a longitudinal way, enabling me to capture helpful aspects of treatment as well as the interplay of other factors. The end result of many case studies is, nonetheless, a detailed account of a particular aspect of the treatment process, for example, the experience of patients around the end of therapy or an exploration of shifts in the working alliance (McLeod and Elliott, 2011). This type of enquiry could, indeed, be very useful but would not address all my questions. In this way, the case study method that seemed to fit best with my intentions was the Hermeneutic Single Case Efficacy Design or HSCED (Elliott, 2002), since it would allow me to make a detailed investigation of therapy outcome as well as answer a number of other secondary questions about process.

The hermeneutic single case efficacy design (HSCED) 'uses a mixture of quantitative and qualitative methods to create a network of evidence that first identifies direct demonstrations of causal links between therapy process and outcome, and then evaluates plausible non-therapy explanations for apparent change in therapy, including non-improvement, statistical artefacts, relational artefacts, client expectations, self-correction, extra-therapy events, psychobiological factors, and reactive effects of research' (Elliott, 2002a).

To enhance the validity of my findings and in order to include the richness of clinical judgment it would make sense to use a qualitative 'research jury method', drawing on Art Bohart's studies (Bohart, 2000; 2008). In their 2011 paper, Bohart and colleagues (Bohart et al, 2011) make a convincing case that the 'research jury method' is scientific and that science itself relies on the method (e.g. journal peer reviews). Important decisions about real life, for example, leading to life or deaths sentences, are indeed adjudicational. One of the main arguments for the adjudicational method is that if the observers have access to a sufficiently rich case record they will be able to draw 'plausible' conclusions as to whether a patient has changed and if therapy had played a substantial contribution towards the change (Bohart et al, 2011). Inferences could also be made on what aspects of the therapy would have caused the change.

The HSCED, developed by Elliott (2002), has been refined a number of times in different studies (e.g. Elliott et al, 2009; Stephen, Elliott and Macleod, 2011; Stephen and Elliott, 2011; Carvalho et al, 2008). It follows specific steps in a systematic fashion (Elliott, 2002):

1. Rich and comprehensive collection of information about the patient's therapy, including:
 - Basic facts about the patient and the therapist
 - Quantitative Outcome Measures, including the Personal Questionnaire (PQ; Elliott, Shapiro and Mack, 1999)
 - Change Interview (CI; Elliott, Slatick and Urman, 2001)
 - Weekly outcome measure
 - Helpful Aspects of Therapy (HAT; Llewelyn, 1988)
 - Records of therapy sessions

2. Direct Evidence: clear links between therapy process and outcome (at least two of the following must be present):
 - Retrospective Attribution

- Process-outcome mapping
 - Within therapy process-outcome correlation
 - Early change in stable problems
 - Event-shift sequences
3. Indirect Evidence: competing explanations for apparent client change (all eight to be examined in 'good-faith'):
- Trivial or negative change
 - Statistical artefacts
 - Relational artefacts
 - Expectancy artefacts
 - Self-correction processes
 - Extra-therapy events
 - Psychobiological factors
 - Reactive effects of research
4. Conclusion about the likelihood that therapy was a key influence on client change

Further details about each of these steps can be found either in the original study (Elliott, 2002) or by following the process of analysis shown in full in Appendices E, F and G.

It was my conviction that a combination of empiricist with hermeneutic methodology would shed more light than any methodology alone (Anchin, 2008). Anchin (2008) describes this as a process of weaving together otherwise disparate epistemologies and methodological elements creating a holistic picture of clinical science.

I consider HSCED to be somewhere between a post-positivist and a constructivist-interpretative philosophy of science. HSCED highlights the importance of context in generating

meanings (hermeneutics) and therefore does not assume the existence of a single universal truth. It stresses the significance of holding tensions between different views and the commitment to a reflexive stance. It is, at the same time, a method that follows the rigorous and systematic procedures advocated by McLeod (2010) and Kazdin (1981) for example. Contrary to pragmatic or narrative case studies, HSCED is specifically designed to provide clear-cut summary statements, generating conclusions that are similar in form to the conclusions of randomized clinical trials. If repeated overtime these studies can eventually be used in meta-analysis (Faith, Allison and Gorman, 1996) allowing for the accumulation of evidence.

Due to the small number of cases participating in the MBT programme, and because of its consistency with my view of counselling psychology and psychotherapy (I am here assuming my bias) I considered the HSCED to be an appropriate methodological choice.

In this way, the methodology was pluralistic, using a mixture of qualitative and quantitative sections. The qualitative information gathered (from interviews with patients, therapist notes, etc) was compared and contrasted with outcome measures undertaken throughout treatment in an overall process of *triangulation* or cross-examination.

In addition to the use of triangulation, and in order to make a plausible argument regarding the influence of the MBT programme in patients' change, I used an *adjudicative* approach (Bohart, 2000; Miller, 2004; Elliott et al, 2009). This included a *jury trial* and the recruitment of nine independent *judges* to infer on the reliability of the researchers arguments (see more details under 'Procedures for Data Analysis').

Adaptations to the original HSCED method

Although Elliott's (2002) HSCED was considered to be an appropriate choice of method, some adaptations seemed to make sense for this particular setting. HSCED has been originally developed as a way of increasing the amount and quality of research evidence in Humanistic therapies, in particular Person Centred and Process Experiential Emotion Focused Psychotherapy (PE-EFP). Nevertheless, a flexible framework has been considered to allow its

use across different theoretical orientations (Elliott and Zucconi, 2005). Some examples of this flexibility can be found in Craig's (2010) study comparing CBT, existential and personal construct modalities or in Carvalho's et al (2008) research on systemic therapy.

HSCED has also been used more broadly in short term therapies although in some cases the therapy has lasted for up to a year (e.g. Elliott et al, 2009).

The use of the HSCED in the current setting was unmapped territory. The intensity and duration of the intervention, the complexity of the cases and the group intervention as well as the strong psychodynamic basis of the therapist and the MBT model called for a number of pragmatic alterations. In collaboration with the Head of Department, and following consultation with several professionals, I decided to make the following changes to the original HSCED:

- Monthly, rather than weekly, use of the Personal Questionnaire (PQ) and Helpful Aspects of Therapy Form (HAT) - see 'Measures' for details.
- The HAT form only asked for details from one session per month rather than every session, as in the original form.
- The Change Interview (CI) was undertaken twice during the first year of treatment rather than only at the end of treatment.

This adaptation has inevitably led to losing important data whilst also creating additional difficulties in linking therapy process with outcome since patients were only giving details of one session per month. The use of the change interview twice during the first year of treatment was aimed at filling these gaps whilst also decreasing the likelihood of having insufficient data in case of an early drop-out.

Even with some clear disadvantages, the following arguments were thought to justify the adaptation:

1) A weekly outcome measure could create false expectations of rapid change on severely disturbed clients with personality disorder diagnosis 2) I could potentially be measuring impulsivity rather than change if the research team used a weekly measure - due to the nature

of the client's diagnosis – although, as Elliott (2010a) argued, this could be corrected by using a three week running median to smooth out the *noise* 3) The therapist and the service have a psychoanalytic tradition. The common belief in the department is that it would be inappropriate and disrupting to ask the patients to complete weekly outcome measures. The strong resistance of the therapist and the consultant could create ethical difficulties since it could affect the treatment negatively 4) After two years of twice-weekly therapy, three-monthly reviews and the other features of the programme, I would end up with enormous amounts of data which would be very difficult to analyse 5) It is a habit in psychodynamic treatment to see every event - i.e. phone calls; missing appointments, etc - as significant and as part of the therapy, becoming useful material to analyse, or to *look at*. A weekly completion of outcome measures would potentially take too much *space* in the group and divert the attention from other important aspects of the group process. This could not be ignored on ethical grounds.

Another adaptation I proposed, aligned with the ideas of Elliott and Zucconi's (2005) 'star design', was the use of modality specific measures (mentalization tools in this case).

Description of the MBT programme and variations from the original Bateman and Fonagy (2004, 2006) format

The work was carried out in the Complex Needs / Personality Disorder Service which is a consultant led service, part of the wider Psychotherapy Department of the NHS Trust.

The MBT programme consisted of:

- Preparation stage (series of consultations and assessment appointments)
- 24 months of twice-weekly, mentalization based, group psychotherapy with a senior psychotherapist (an art-therapist and group-analyst with MBT specialist training);
- Three monthly reviews and intermittent crisis management appointments with the Consultant Psychiatrist in Psychotherapy;

- Additional support from a Psychosocial Nurse Practitioner attached to the programme;
- Periods of stabilization at CMHT or CDAS and close liaison with the professionals external to the programme (with particular emphasis on the CMHT psychiatrist responsible for the management of medication).

For more details see the Map of Medicine in Appendix D.

Variations from Bateman and Fonagy's (2004; 2006) out-patient program:

- 24 months instead of 18 months;
- Twice weekly group of 90 minutes instead of one group session (90 minutes) and one individual session (50 minutes) per week;

Bateman and Fonagy (2004) have clearly discouraged the use of a single form of therapy:

‘(...) often borderline patients believe that they have to tackle a problem head-on when in fact reflection elsewhere on the problem may produce the solution and reduce emotional volatility. Patients learn this quickly and commonly discuss problems encountered within group therapy during an individual session’ (Bateman and Fonagy, 2004: p.193)

‘(...) in qualitative feedback, patients, almost universally, report that the individual sessions are the most prized part of the programme during the early stages of treatment but are equally clear that the group sessions become more important during the later stages of treatment (...) It is part of our rationale for a combination of joint individual and group therapy rather than either alone’ (Bateman and Fonagy, 2004: p.95)

As explained under 'Introduction', the clinical and research teams decided to introduce these variations despite Bateman and Fonagy's (2004) advice, not just due to the lack of resources for provision of individual therapy but also due to our trust in the psychosocial nursing model (Pringle and Chiesa, 2001; Chiesa and Fonagy, 2002; Chiesa, Fonagy and Gordon, 2009). Specialist MBT training was provided to the Nurse to allow for the consistency of interventions.

Variations in the structure of MBT are now common and many services have adapted the model according to their service configuration.

Individual contributions and members of research team

I was the principal investigator on this study, taking a lead role in the conceptualization of the project, the choice of methods and sampling strategies as well as the literature review and write up. Some of my ideas arose from discussions with the Consultant Psychiatrist in Psychotherapy and Head of Department who was also my clinical supervisor at the time. The consultant has developed interest in my research ideas and has eventually become an essential collaborator for this project as explained below. The main focus within this collaboration was to make sure that the project would be useful for the development of the department and that it would contribute to significant improvements in service delivery.

This project has two components (the arguments for this decision are laid out in 'Data Collection' :

- 1) The academic side (one year data collection plus analysis) which led to this doctoral dissertation;

- 2) The post-doctoral, organizational side (continuation of data collection until the end of treatment and at 6 months follow up).

The individual contributions can be summarized as follows:

Principal Investigator

- The conceptualization of the project (from beginning ideas to formal research proposal).
This includes the constant discussion / liaison with relevant professionals and researchers.
- The choice of methodology, instruments and sampling strategy.
- The writing up of the proposal and final dissertation
- The analysis of the data (quantitative and qualitative).
- The preparation of the favourable argument for the adjudication process
- Administration of qualitative interviews with participants and working alliance inventory (see Table 2 in 'Procedures for Data Collection')
- Systematic evaluation of the evidence and interpretation of results
- Dissemination of the findings to the wider field
- Leading all aspects of the research

Co-researcher:

The co-researcher was a qualified counsellor and sociology PhD student, working as an honorary therapist in the Psychotherapy Department at the time of the research. She had an MA in social research methods and had previously worked as a visiting tutor in UK Universities teaching research methods. Her role was:

- Preparation of the sceptic argument for the adjudication phase
- Support in the organization of the data and transcribing of interviews
- To co-operate with the dissemination of results

Consultant Psychiatrist in Psychotherapy (Head of Psychotherapy and Specialist Personality Disorder Service):

- Assessment and allocation of patients into treatment, making the necessary clinical decisions regarding who is appropriate to integrate the MBT group.

- Administration of outcome measures during assessment and reviews (see Table 2 in 'Procedures for Data Collection')
- Clinical supervisor of the psychotherapist delivering the MBT group, the co-researcher and the Principal Investigator (the consultant stopped the clinical supervision of both researchers shortly after the program started since both researchers stopped seeing clients in the department).
- To make sure that the group psychotherapist adheres to the MBT model
- To co-operate with the dissemination of results

Group Psychotherapist

She was an Art Psychotherapist by background and a Group Analyst with specialist MBT training. Her role in the research was:

- Monthly administration of the Helpful Aspects of Therapy form (HAT) and the Personal Questionnaire (PQ)
- Monthly completion of the MBT Adherence Checklist in discussion with the clinical supervisor
- Completion of three monthly individual reports for each patient with a focus on mental states whilst also including her views regarding patient change, influence of therapy and factors responsible for the change.

Psychosocial Nurse Practitioner

She was a qualified psychiatric nurse with additional specialist training following the Cassel Hospital model. Her role was:

- Provide individual practical support when necessary, including home visits
- Facilitate the patient's engagement in the programme through psychosocial support and individual sessions

Research Assistants

There were two research assistants, a psychiatric nurse studying for a counselling diploma and a graduate psychologist in post graduate counselling training. Their role was:

- Help with organization of research folders
- Proof reading
- To co-operate with the dissemination of results

HSCED Judges

The judges were all senior practitioners and researchers with many years of experience in counselling and psychotherapy. They volunteered to take part because of their interest in case study research (see Table 1).

TABLE 1 – Experience and Background of the HSCED Judges

Ms A	Mr Z	Mr X
<p>Judge A</p> <p>Consultant Psychiatrist in Psychotherapy and Director of Psychotherapy Services in another NHS Trust. He had an Interest in personality disorder, psychodynamic psychotherapy, eating disorders and Mentalization Based Treatments</p>	<p>Judge D</p> <p>Psychologist and senior lecturer in psychotherapy. His research interests were linked with person-centred and experiential psychotherapies.</p>	<p>Judge G</p> <p>Counselling psychologist, research consultant in the NHS and University lecturer. Her main approach was phenomenological-existential.</p>
<p>Judge B</p> <p>Clinical Psychologist and University Lecturer. Her current research interests were linked with</p>	<p>Judge E</p> <p>Chartered psychologist and University lecturer. She defined her main approaches as integrative</p>	<p>Judge H</p> <p>Clinical psychologist, group analyst and researcher in neuroscience. Her main approach was psychoanalytical.</p>

emotion-focused therapy, the finding of meaning and narrative change.	and person-centred	
Judge C Counselling Psychologist working in the NHS. She had several years of clinical and research experience and defined her main approaches as Cognitive-Behavioural and Person Centred	Judge F Clinical psychologist and University professor. She was trained in family and systemic therapy and had a special interest in mental health and the use of ideographic research instruments in experiential psychotherapies.	Judge I Graduate psychologist working as an NHS counsellor and studying for a doctorate in psychotherapy. She had a diploma in CBT and current research interests in sexual health. She defined her approach as Integrative.

The openness of the department to find out ‘what works’ and its commitment to the improvement of service delivery meant that the dissemination of findings was an important concern at all times and in any case, even if the results would show the negative or trivial influence of therapy.

Sample/Participants

Participants were referred via GP’s, secondary care services like CDAS or CMHT or via A&E. After the referral was accepted the patient was sent a self-report questionnaire and offered a consultation service (average 3 sessions). They were then assessed by a senior psychotherapist or the Consultant Psychiatrist in Psychotherapy (Head of Department) to define whether they were appropriate for the programme. If they were deemed as not appropriate they would either return to the care of the referrer or offered another form of psychotherapy (individual psychodynamic, group-analysis, arts or family-systemic). The allocation to different therapies and levels of intensity would depend on the patient’s commitment and motivation as well as on their ability to tolerate the intensity of the program. The level of external support, as well as the risk for the self and others, was also considered during allocation.

Six patients were thought to be appropriate for the MBT programme and, at that stage, a further diagnostic assessment was carried out to define or confirm the presence of personality disorder, as defined by the DSM-IV-TR (2000), and the respective cluster (A, B or C). The Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First, et al., 1997) was used to facilitate this process. A treatment recommendation was then made followed by a risk assessment and crisis plan.

The MBT programme started with six participants. All the participants had several concomitant types of personality disorders, with the most common being borderline (5 out of 6), depressive (5 out of 6), paranoid (3 out of 6) and avoidant (3 out of 6). Two members also met the criteria for antisocial PD and one member had additional Dependent and Obsessive Compulsive PD's. The research team is collecting information from all the patients until the end of the programme and also at 6 months post-discharge. However, for the purpose of this doctoral project, and in order to answer the research questions, I used a purposive sample and only selected the patients who also had significant difficulties with substances (alcohol and/or drugs) ending up with three cases for systematic analysis. Only data from the first year of treatment was used for this dissertation.

All the patients engaged in a series of consultations whilst they were waiting for a vacancy to join the intensive MBT programme; in some cases, some other form of therapy was offered first (e.g. individual therapy, open art psychotherapy group) serving in itself as a trial period for their capacity to engage in this more intensive treatment. This meant that the Head of Department started to make an initial triage of the possible participants for the MBT dual diagnosis research program whilst they were in this initial preparation stage.

Since attrition was a strong possibility in research of this type, I aimed to collect data from all the group participants from the start (regardless of their use of substances), with the intention of ending up with three patients to use for the present systematic case studies. By not ruling out participants from the start I was also taking pressure off both patients and therapist.

The Department's retention rate for group psychotherapy is in the region of 85% (on average - depending on the therapist) which was also a good indicator to help achieve the target of three case studies. This was the minimum number of case studies needed to be able to declare the treatment as 'probably efficacious' (Chambless et al, 1998).

As mentioned above, it was not a criterion that the group participants belonged to the same PD category in order to take part in the treatment. In fact, the clinical reality is that the majority of the patients in the Personality Disorder Service are diagnosed with several personality disorders at the same time and it was difficult to establish which particular category I would end up studying. The categories emerged as a result of the assessment and allocation procedures. However, in order to avoid a potential dilution of the results, I selected three cases of similar personality disorder types to present here. All the three patients analysed in this study share the diagnosis of borderline and depressive personality disorder types. Ms A was also diagnosed with avoidant personality disorder whilst Mr X had additional diagnoses of anti-social and paranoid personality disorders.

Data Collection

Part of the data gathered for this study was collected from the previously established routine evaluation procedures. This was taken as important in the sense that it could help causing minimum disruption for practitioners and the overall running of the service, as well as not generating additional strains on service users. Despite this concern, I decided to add a number of new instruments as the ones used routinely were insufficient to answer all the questions posed (see table 2 under 'Procedures for Data Collection'). These were also integrated in the routine practices as much as possible.

Measures

The following instruments were used, based on an adapted version of Elliott's (2002) HSCED. Table 2 explains the procedures for data collection:

Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First et al, 1997). The SCID-II is a semi-structured interview for making DSM-IV Axis II Personality Disorder diagnoses. It is also compatible with the DSM-IV-TR. This interview was undertaken by the Consultant Psychiatrist in Psychotherapy before the start of the program helping to form a diagnostic impression.

Clinical Outcomes in Routine Evaluation (CORE-OM; Connell et al, 2007). The CORE-OM is a 34-item self-report measure designed to assess levels of psychological distress and outcome of psychological therapies. The 34 items comprise of four domains: specific problems; functioning; subjective well-being; and risk. Each domain contains equal numbers of high and low intensity/severity items to offset possible floor and ceiling effects. All items are scored on a five-point scale from 0 to 4 (anchored 'all or most of the time' 'not at all', 'only occasionally', 'often' and 'sometimes') and relate to the previous week (Connell et al, 2007).

Totalling the individual item scores and dividing by the total number of questions answered will yield a mean score ranging from 0 to 4. The recommended clinical cut-off for the general population is 1.25 above which a patient is said to be in the clinical range (Elliott, 2012).

The internal consistency of the CORE-OM has been reported as $\alpha=0.94$ and the 1-week test-retest reliability as Spearman's $\rho=0.90$ (Evans et al, 2002).

The reliable change index (RCI) - how much change was required for it to exceed measurement error (Jacobson and Truax, 1991) - was defined as a decrease of 0.43 at $p<.2$ or 0.66 at $p<.05$ (Elliott, 2012).

Work and Social Adjustment Scale (WSAS) (Mundt et al, 2002). The Work and Social Adjustment Scale (WSAS) is a simple 5-item patient self-report measure, which assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social leisure, private leisure and personal or family relationships.

Psychometric data exist for depression and OCD patients: Cronbach's α measure of internal scale consistency ranged from 0.70 to 0.94; test—retest correlation was 0.73 (Mundt et al, 2002).

The recommended clinical cut-off is 10, above which a patient is said to be in the clinical range (Mundt et al, 2002).

For the MBT study, and since all the participants also met the criteria for depressive personality disorder, I relied on the psychometric data of the depression studies (Mundt et al, 2002). Reliable Change Indexes were calculated as 7.2 ($p < .2$) and 10.9 ($p < .05$).

Personal Questionnaire (PQ; Wagner and Elliott, 2001). The Simplified Personal Questionnaire is an individualized and idiographic change measure, usually consisting of 10 problems that a client would like to work on during his or her therapy. Its brevity makes it suitable as a weekly outcome measure; however, for the purpose of this study, it was only used monthly (see 'Adaptations to the original HSCED method').

Wagner and Elliott (2001) discuss the psychometric properties of the PQ and its various complexities but conclude that the measure has high internal reliability and is adequate to high test-retest reliability. A clinical cut-off of a mean PQ score of 3 and change of either 1.5 ($p < .05$) or 1 ($p < .2$) points are proposed for analyzing clinical significance and reliable change.

Change Interview (Elliott, Slatick and Urman, 2001). A 30-60 minute qualitative interview that can be administered at the end of therapy or every 8 - 10 sessions; it includes questions about what the patient sees as having changed over the course of therapy, what the patient attributes those changes to, and helpful and non-helpful aspects of therapy. The interview also includes the option of asking the patient to review and talk about his or her pre-treatment self-ratings or self-descriptions.

Global Assessment of Functioning Scale (GAF; DSM-IV-TR Axis V). The Global Assessment of Functioning Scale is a 100-point scale that measures a patient's overall level of psychological, social, and occupational functioning on a hypothetical continuum (0, least functional, to 100, most functional). The clinician decides on a score following a psychiatric consultation with the patient. The score does not include impairment in functioning due to physical (or environmental) limitations.

Numerous studies (e.g. Bodlung et al, 1994; Hall, 1995; Edson et al, 1997; Hintikka et al, 1999; Jones et al, 1995 as cited in APS, 1999) have provided empirical support for the GAF as a reliable and valid measure.

Checklist of mentalizing capacity (Bateman and Fonagy, 2006). This checklist was created to assist in the clinical assessment of mentalization. The clinician measures the mentalizing capacity of the patient in four different domains: in relation to other people's thoughts and feelings; perception of own mental functioning; self-representation; general values and attitudes. The overall score ranges from 0 (poor mentalizing) to 12 (very high mentalizing). This assessment and checklist was undertaken by the Consultant.

Treatment Outcome Profile (TOP; Marsden et al, 2008). The TOP is a 20 item measure that focuses on four important treatment domains as defined in the National Treatment Agency for Substance Misuse (NTA) care planning practice guide: substance use, injecting risk behaviour, crime, health and social functioning. For this study the TOP was only used to assess differences in substance use.

Working Alliance Inventory-Short Form (WAI-S; Tracey and Kokotovic, 1989). The WAI-S is a 12-item self-report measure designed to assess perceptions of the working alliance. It includes three subscales: goal (agreement on the goals of therapy); task (agreement on how these goals will be achieved), and bond (the bond between participant and therapist).

Participants were required to rate on a 7-point Likert scale from 1 (not at all true) to 7 (very true) the extent to which they believed each item was true of their relationship with their therapist. The final score ranges from 0 to 84; higher scores indicate a stronger working alliance.

Tracey and Kokotovic's (1989) factor analysis of the WAI yielded an alliance overall main factor and three other factors that accounted for the three alliance sub-scales. The WAI-S (short version) derived from this study and it yielded a Chronbach's alpha of .94. In the same study, the internal consistency reliabilities were .90, .84 and .88 for task, bond and goal scores, respectively (Tracey and Kokotovic, 1989).

Helpful Aspects of Therapy form (HAT; Llewelyn, 1988). A brief, open-ended, questionnaire usually completed by patients after each session in order to document the aspects of therapy that were especially meaningful to their therapeutic process. Patients are asked to describe in their own words the most helpful event in the session, and to rate how helpful it was. They are also asked about other helpful or hindering events in the session. This form was only used monthly (see 'Adaptations to the original HSCED method').

Therapist adherence to MBT checklist (Bateman and Fonagy, 2006). This is a self-rating form used by the therapist to monitor the implementation of mentalizing interventions. It measures six different domains: framework of treatment; mentalization; working in current mental states; bridging the gaps; affect storms; use of transference. The score ranges from 0% to 100% adherence.

Therapist and other clinical staff process notes and reports. The therapist and other clinical staff notes were analysed and compared with the outcome measures and patients' qualitative accounts. Particular attention was given to the therapist and consultant three monthly progress reports. These were only used to corroborate or disconfirm the researchers' claims.

Data from the test battery (see Table 2 under 'Procedures for Data Collection') started to be collected from service users once they were allocated to the MBT programme; this was aimed to be repeated at each review with the consultant (every 3 months). As in much naturalistic research it was not possible to stick to this plan and the first two reviews were delayed for about two months. This means that we ended up with data from three reviews only rather than the four initially planned.

Data gathered through qualitative interviews with service users started to be collected six months into treatment; interviews were repeated at twelve months. These deadlines were fulfilled with only minor variations. The overall organizational plan is to continue to collect data throughout the treatment and to repeat the qualitative interviews at the end of treatment (24 months) and six months after treatment (follow-up). However, for the purpose of this doctoral project, I am only using data concerning the first 12 months of treatment. The analysis at one year of treatment (one year before the end) had obvious pragmatic reasons to do with time constraints and deadlines for the completion of the doctorate. However, there were also other reasons that justify this decision:

- The reduction of the 'hello-goodbye effect': this is a difficult to attribute but feasible relational artefact described by Elliott (2002) where the patient enters therapy emphasizing distress to impress the clinical and research teams so that he is accepted in the programme. At the other end of therapy, however, the patient emphasizes improvement as a way to express gratitude to the staff or to justify the end of therapy. Some patients may protest against separation at the end of therapy; however, when they realize that therapy is going to end anyway, there is little to be gained by trying to look worse than one is! Since the present analysis is done way before the end of the therapy programme it is unlikely that the patients will simulate improvement.

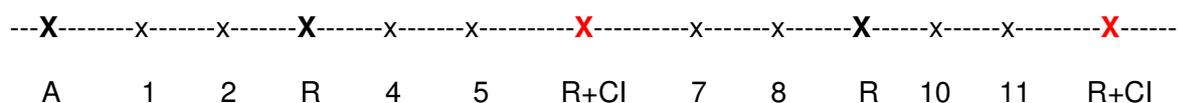
- The reduction of expectancy artefacts: 'cultural or personal expectations ('scripts') or wishful thinking may give rise to apparent patient change' (Elliott, 2002: p.12). For example, 'patients may convince themselves and others that because they have been through therapy they must, therefore, have changed' (Elliott, 2002: p.12). Post-therapy accounts are 'particularly vulnerable to this sort of retrospective expectancy bias' (Elliott, 2002: p.12). Elliott (2002) describes a method to distinguish between expectations and experience through the examination of the patients' use of language. Again, because the present analysis only includes data from the first year of treatment (in a two year programme), this effect is likely to be significantly reduced or even absent.
- Decisions regarding length of treatment are controversial and contradictory. In Bateman and Fonagy's study (2008: p.5) the figures presented suggest that improvement starts during the 18 month treatment period but increases even more in the 18 months following treatment. However, a study by the same authors (Bateman and Fonagy, 1999) show sustained improvement after only 4 to 6 months of treatment. Anecdotal evidence also suggests that, on many occasions, resolutions are made based on arbitrary decisions of clinicians or services without any ground in research.
- Bateman and Tyrer (2004) concluded on the need to have a long period of observation, preferably at least a year, before a treatment can be said to be properly evaluated.
- For these reasons, it seemed pertinent to investigate whether change could occur in the first year of treatment (doctoral study) and then compare with the effects of the second year of treatment and follow-up (post-doctoral).
- The continuation of the research following the completion of the doctorate could validate or disconfirm my conclusions. I was also interested in measuring what impact sharing

the results of the first year of treatment would have in the overall continuation of the programme. However, for ethical reasons concerning the possible negative impact on the participants and the therapist, only the quantitative results were shared. I concur with Stephen and Elliott's (2011) concerns regarding sharing some of the qualitative information, in particular the sceptical argument, as it can invalidate the client's and/or therapist experience. For the same reasons, the researchers' arguments were carefully audited for the use of invalidating language. We also used the disclaimer at the top stating: "the arguments presented here are made to facilitate the analysis of change in this case through the presentation of contrasting views; they are not necessarily the personal views of the author."

Procedures for Data Collection

The collection of the data was distributed in the following manner (see Table 2). Only the first year of treatment accounted for the purpose of this dissertation:

TABLE 2 – Timeline and Procedures for Data Collection (in months)



Notes:

A – Assessment with Consultant Psychiatrist in Psychotherapy

R – Review with Consultant Psychiatrist in Psychotherapy

R+CI – Review with Consultant + Change Interview with Principal Investigator

Numbers – Monthly collection of HAT and PQ by the group-therapist (MBT Adherence scale done at the same time)

Instruments used each time:

Initial Assessment and Reviews (Consultant Psychiatrist in Psychotherapy)	Monthly (During treatment – by the Therapist running the group)	At 6 and 12 months into treatment; end of treatment and 6-month follow-up (Principal Investigator)
<i>Clinical Outcomes in Routine Evaluation (CORE)</i>	<i>Helpful Aspects of Therapy form (HAT; Llewelyn, 1988)</i>	<i>Working Alliance Inventory-Short Form (WAI-S)</i>
<i>Work and Social Adjustment Scale (WSAS)</i>	<i>Personal Questionnaire (PQ)</i>	<i>Change Interview</i>
Construction of the <i>Personal Questionnaire (PQ)</i> with the participant - (only at assessment)	<i>MBT Adherence Checklist</i>	
<i>Risk Assessment Tool</i>		
<i>Checklist of mentalizing capacity</i>		
<i>Treatment Outcome Profile</i>		
<i>Global Assessment of Functioning Scale</i>		
<i>SCID-II – Structured Clinical Interview for DSM-IV Axis II Personality Disorders</i> (only at assessment)		

As the Principal Investigator I coordinated the above process acting as auditor and data analyst. All the outcome measures used have been widely tested regarding their validity and

reliability (see the original publications for psychometric data). The use of the adjudicative model and the opinion of independent *judges* (e.g. Bohart, 2000; Miller, 2004; Elliott et al, 2009) were also considered to assist in the trustworthiness of the qualitative elements (see under 'Procedures for data analysis')

Access

As a member of staff of this Mental Health Trust I was entitled to access patient's names and information. Information about the study was given by the consultant psychiatrist in psychotherapy once the potential participants were allocated to the MBT programme. Patients were given an information sheet at this stage to read and reflect on whether to take part in the study. The information sheet included information regarding participation in the interviews as well as audio recording procedures and confidentiality regulations. My contact details, as well as my supervisor's, were given at this point in case the patients wanted to discuss further details about their potential participation. Following their decision a meeting was set up with me and each participant individually to discuss the project further and to clarify any confusion or possible questions. A consent form was signed at this stage following the participant's decision to take part.

Patients were not pressured into taking part. The choice to opt out if they later changed their minds was clearly stated in the consent form (providing the study was not finalized). They were also reassured that treatment would not be affected if they decided to pull out at any stage.

Procedures for data analysis

The quantitative data examined included the Work and Social Adjustment Scale (WSAS), Clinical Outcomes in Routine Evaluation (CORE-OM), Checklist of Mentalizing Capacity, Global Assessment of Functioning (GAF) Scale, Treatment Outcome Profile for Substance Misuse (TOP), the Working Alliance Inventory (WAI-S) and a Risk Assessment Tool.

During assessment, the SCID-II for DSM-IV-TR Axis II was used to facilitate the establishment of a diagnosis; The Simplified Personal Questionnaire (PQ) was constructed with the patient during the assessment phase. The PQ was then used monthly as a measure of the patients' complaints. These measures were used to provide a quantitative account of the patients' change process over the course of therapy.

Three of these measures (PQ; CORE-OM and WSAS) were evaluated using clinical significance methods for determining whether the patients' shown clinically significant change between pre-therapy measures and after one year of treatment (Jacobson and Truax, 1991). Clinical Caseness levels (i.e. clinical cut-offs) and Reliable Change Indexes (RCI) - how much change was required for it to exceed measurement error - were calculated, taken from the original studies or discussed with the original authors when crucial information was missing.

The other measures (WAI-S; TOP; Mentalizing Capacity and GAF), were used to provide additional information only but no clinical significance methods were used.

The qualitative data included a Risk Assessment Tool, the Helpful Aspects of Therapy form (HAT), completed every month, and the Change Interview (CI) conducted six months into therapy and at one-year. The Change Interviews were transcribed and the relevant passages highlighted. A 'full' qualitative analysis procedure was not followed here. Instead, the main goal was to search for evidence in the transcript to fit a number of pre-determined themes. The following themes were thought to be the most relevant to the task we had at hand (Stephen, Elliott and MacLeod, 2011):

- Helpful therapy processes;
- Helpful factors in the participant's life situation;
- Participant's personal attributes/resources that may have helped make use of therapy;
- Difficult but potentially beneficial processes - in and out of therapy;
- Helpful aspects of taking part in the research; hindering therapy processes;

- Hindering factors in the participant's life situation / generic problems or symptoms that may have affected the therapy negatively;
- Participant's personal attributes that may have hindered them in therapy;
- Hindering aspects of taking part in the research; and missing aspects of therapy.

A particular coding procedure was then undertaken by me as the Principal Investigator, meaning a detailed analysis of the transcript interview to categorize phenomena that would fit under the several pre-determined themes. This process was influenced by my understanding of the data and certainly affected by my theoretical biases. Therefore the allocation of interview material to the themes was checked for agreement by the co-researcher as second rater. The full transcripts were also available to the judges.

Following the compilation of each case record (including the Change Interview coding) I entered into the 'critical reflection' stage with the sceptical researcher. I made the affirmative brief whilst the co-researcher prepared the sceptic brief.

For the preparation of the affirmative brief process-outcome correlations comparing descriptions of in-therapy processes with scores in outcome measures were analysed. These correlations were undertaken from different angles, according to the HSCED original method (Elliott, 2002): first, an attempt was made to link the content of the Helpful Aspects of Therapy form (HAT) with changes reported in the Change Interview (CI); second, Pearson's correlations were carried out to assess the association between the MBT adherence scale and the Personal Questionnaire (PQ), treating the scales as interval level data; finally, an attempt was made to link Helpful Events from the HAT Form with results on the PQ to establish the possibility of event-shift sequences. For a full description of these steps see Appendix E, F and G.

The therapist's three monthly reports as well as client notes written by the consultant, the therapist or the psychosocial nurse were used to back up or contradict the researchers' arguments.

The researchers followed Elliott's (2002) original method in their attempt to analyse five pieces of positive evidence: (change in stable problems, retrospective attribution, process-outcome mapping, within-therapy process-outcome correlation and event-shift sequences) and eight steps for the sceptic analysis of competing explanations for apparent client change (trivial or negative change, statistical artefacts, relational artefacts, expectancy artefacts, self-correction processes, extra-therapy events, psychobiological causes and reactive effects of research). The details for each of these steps can be found in Appendices E, F and G.

Both I and the co-researcher relied on the rich case records obtained by the several instruments to systematically evaluate the evidence engaging on a process of critical reflection (Elliott et al, 2009). In order to find out whether change had occurred and what brought about the change the two researchers gathered both positive and negative evidence, implicitly enacting both advocate and critic roles. This was based on the adjudicative model and the examples of Bohart (2000), Miller (2004) and Elliott et al (2009).

To determine whether our conclusions were *reasonable* I recruited nine independent experts (three for each case) to serve as a panel of judges and evaluate the evidence produced as well as the arguments of the two researchers (see standard of proof as 'clear and convincing evidence' – 80% probability - in Stephen and Elliott, 2011: p.238). I am using here the metaphor of 'case law', as used in the legal system (Elliott et al, 2009; Bohart and Boyd, 2000; Bohart et al, 2011). This differs from the social sciences' traditional search for certainty which relies on near-zero probability levels ($p < .05$ or $.01$). Bohart et al (2011) argue that psychotherapy research should be more flexible and shy away from linear causal explanations. The authors believe that psychotherapy does not mechanistically 'cause' individuals to get better, but rather provides an occasion for them to mobilize their own resources for change. Elliott (2002), on the same token, talks about a form of 'soft' or enabling causality.

Procedures for the Judges and Adjudication Phase

The judges recruited were not part of the research team. They were all senior psychotherapy practitioners with several years of research experience (see Table 1 under 'Individual contributions and members of research team' and also Appendix C). An attempt was made to choose judges from different theoretical orientations and cultural backgrounds so that a *fully mentalized* decision was possible. They were not allowed to know of each other's participation in the study to guarantee an independent judgement.

The judges' role was to familiarize themselves with the method and data and then to look at the arguments of both teams (affirmative and sceptic) and make a decision ('verdict') regarding:

- 1a - To what extent did the client change over the course of therapy?
- 1b - How certain are you? (On a scale of 0 to 100%)
- 2a - To what extent is this due to the therapy?
- 2b - How certain are you? (On a scale of 0 to 100%)

Each 'judge' decided on one case only. They were able to see the full case record, including results of the quantitative analysis, interview transcripts and coding. They were given four weeks to form a decision ('verdict') and reply to the researchers in the form of a short journal article review (2 to 3 pages maximum).

Following the data analysis and the adjudication phase I, in the quality of Principal Investigator, formed a final conclusion, showing clearly to the reader how this conclusion was reached. This type of analysis was utilized to examine the reliability and causes of client change over the course of MBT

Ethical Considerations

As with any research involving service users this study involved complex ethical considerations. Ethics were seen as *process* rather than a fragmented list of issues (Orlans,

2007); for that reason, a number of concerns were raised and dealt with throughout this dissertation rather than all presented in this section, in *isolation* from the context where they took place. Nevertheless, a number of generic guidelines were followed and are presented below:

Assurance of confidentiality was included in the information given to potential participants; information sheets clearly stated that no identifying information would be included in any verbal or written reports (see Appendix A – Ethical Approval).

Nevertheless, I would like to emphasise the fact that this research forms part of a doctoral project and will be, therefore, a public document. As a result, the risk of ‘exposing’ the individuals involved was carefully taken into consideration. On the other hand, the use of case studies with detailed information about the patients and their treatment further increases the likelihood of the participants being identifiable by someone who knows them well. Seeking informed consent was, therefore, essential.

The patients were informed that direct information about them will be made anonymous. However, they were also made aware that the name of the service and the NHS Trust may be used in any publications or verbal communications, including the doctoral dissertation.

As explained above in ‘Access’, participants were given information sheets and consent forms to sign. They had to actively and clearly opt in if they wished to take part in the study. They had the right to withdraw from the research at any point without affecting their treatment provision. In the same way, access to treatment was not dependent on participation in this research.

In spite of these reassurances, it is worth noting that the dual diagnosis MBT program was unique in the department. The patients had the right to engage in this program without participating in the research and this was clearly stated to them; however, there is a possibility that they would fear being refused in the MBT program and having to engage in ‘Treatment-as-Usual’, meaning a different form of therapy and stricter rules regarding the use of substances.

Confidentiality was also an ethical concern. Despite some of the risks highlighted previously, all the researchers and collaborators complied with the Data Protection Act regulation which entails:

- Storing all materials from the study in a locked filing cabinet and/or password protected computer files accessible only to the researchers.
- Destroying tapes as soon as they are transcribed or, at the latest, at the end of the study.
- Destroying transcripts, questionnaires, databases and other material at the end of the study or once the final report is printed.

When data had to be transported between sites a password protected memory stick was used. Any eventual e-mails exchanged between the researchers potentially containing data from the study were sent via a secure NHS system and also password protected so that only the recipients could access the material.

The study carried no serious risks to participants, but the sensitive nature of their experience of mental ill-health made it possible that some patients could become distressed, while others could be fatigued by an in-depth interview or by completing the test-battery. In these circumstances the interview or test-battery would be stopped and the participant consulted as to whether they wished to abandon the interview, take a break or resume at a later date. Permission would be sought from anyone who remained distressed to contact a clinician or carer of their choice. In the unlikely event that permission would be refused where acute distress was apparent, or where a participant would reveal information suggesting they could harm themselves or someone else, contact with a clinician would be made without permission. Clear information to this effect was included in the information provided for participants.

Fortunately, only one occasion occurred where the interview had to be stopped and re-arranged for a future date. The participant was very angry and becoming further distressed with the questions. He later calmed down without the need for a clinician's immediate intervention. He was then able to explore the incident further in his therapy.

ANALYSIS OF THE DATA AND RESULTS

In this section I will present a summary of each individual case study, including 1) the rich case record 2) the analysis of the data with the corresponding audit trail 3) the results obtained and 4) the conclusions from the two researchers and the HSCED judges. The full analysis of the data including the qualitative coding, the arguments of the researchers and the judges, parts of the interview transcripts and some additional tables are provided in appendices E, F and G.

In the conclusion section I will make inferences regarding common elements in the cases presented and any relevant differences.

Ms A

Rich Case Record

The Patient

Ms A was 56 years old when she entered this programme of therapy. She complained that she was suffering from mood swings from as early as she could remember. However, the first time she sought help was in 2009 following one of her numerous suicide attempts with an overdose. She had seen a psychiatrist once at 10 and had spent 8 weeks in a psychiatric hospital when she was 32, despite not remembering what led to this. She mentioned going through low phases and that sometimes this lasted for one year to a year and a half. During these phases she would often feel tearful, with poor motivation and concentration levels and also low self-confidence. She developed maladaptive strategies (e.g. drinking) to disconnect from her daily self-harming thoughts. She would frequently feel worthless and also complained of a great deal of guilt associated with her past. She reported a core feeling of emptiness and a

feeling of insecurity in relationships where the incidence of involvement would vary from being superficial to strong attachment or hatred in the other extreme.

She attempted suicide at least four times and others have reported that prior to those attempts she appears to be 'hyper'. During this phase she would be very social, going out at least three times a week and drinking 2 or 3 bottles of wine each time. She would often end the night having unprotected sex with strangers that she would randomly meet in a club. Frequently she would feel guilty the next day which would lead her to drink more and so the cycle would repeat itself.

Ms A said that she had a 'bad' childhood and that the home atmosphere was tense. She grew up in a home in which her father was always ill and she would often be called at school without warning to go and visit him in an acute hospital ward. She felt different from her peers and thought that school was dreadful. She was often bullied. Ms A lost her father in a somehow tragic manner when she was 18 years old. Her father was a paranoid schizophrenic who committed suicide; her mother died of cancer 11 years later. She has a young brother who had been missing in Malaysia for 11 years but with whom she regained contact (in March/April 2012), having had a first reunion in July 2012.

Ms A came to the department with an ICD-10 diagnosis of Emotionally Unstable Personality Disorder, Borderline Type with co-morbid moderate depression and behavioural problems associated with excessive alcohol use.

She lived on her own in a rented flat. She was on sick benefit and was several thousand pounds in debt. She was not in a relationship at the time of referral but soon after she reported beginning in a new relationship with a 'good man' that she wanted to keep. She is the mother of three sons and daughters who are 29, 31 and 32 and she also has grandchildren.

Ms A wanted to feel better and have a normal life. She received CBT before being referred to the psychotherapy department by her psychiatrist. Once in the psychotherapy department she attended once weekly group psychotherapy with a group-analyst before being recommended for the complex needs service and the MBT program.

Diagnosis and Medication

Ms A came to the department with an ICD-10 diagnosis of Emotionally Unstable Personality Disorder, Borderline Type with co-morbid moderate depression and behavioural problems associated with excessive alcohol use. She engaged in group psychotherapy for one year with a senior group analyst who later suggested she would benefit from engaging with the MBT program. She was taking 40mg of Citalopram once a day.

Following a series of consultations with both the MBT therapist and the Consultant Psychiatrist in Psychotherapy she was considered to meet the criteria for Avoidant Personality Disorder (main focus of clinical attention), Borderline Personality Disorder and Depressive Personality Disorder. The SCID-II for the DSM-IV-TR was used to facilitate the process of diagnosis (First et al, 1997). Ms A also met the DSM-IV-TR criteria for Moderate Alcohol Dependence, with some evidence of withdrawal symptoms. She was drinking 4 to 5 days per week, between 30-40 units of alcohol each time.

Outcome Data

Table A1 shows the results of three measures evaluated with clinical significance methods (Jacobson and Truax, 1991) over time. Contrary to the other two cases, Ms A's first point of measuring was after the therapy had started for one month. Despite some possible implications this score was used as the point of comparison (as if a pre-therapy measure) with other subsequent scores.

After one year of therapy, it is possible to observe positive change in the PQ ($p < .05$) and CORE-OM ($p < .05$) and no change in the WSAS comparing to the initial rating (Table A1).

TABLE A1 – Ms A Outcome Data (analysed with clinical significance methods)

Instruments	Cut-off	RCI Min (p<.2)	RCI Min (p<.05)	One Month ¹	5 Months	8 months	One Year
PQ	≥3	1.0 (↓)	1.5 (↓)	6.5	6	4.8 ** (+)	3.4 ** (+)
CORE-OM	≥1.25	0.43 (↓)	0.66 (↓)	2.91	2.85	1.5 ** (+)	1.56 ** (+)
WSAS	≥10	7.2 (↓)	10.9 (↓)	30	24	19 ** (+)	26 (=)

Notes. Values in bold fall within the clinical range; *p<.2; **p<.05; ↑ = increased score indicates positive change; ↓ = decreased score indicates positive change; (+) = reliable positive change in relation to first available score; (=) = no change in relation to first available score; (-) = reliable negative change in relation to first available score. ¹ This score was used as pre-therapy score or point of comparison

Table A2 illustrates the results gathered from additional measures. No clinical significance methods were used here. After one year of therapy it is possible to observe a substantial decrease in the use of alcohol (measured by the Treatment Outcome Profile – TOP), an increase in the mentalizing capacity, from moderate to good, and a reduction of symptoms in the Global Assessment of Functioning Scale (GAF).

TABLE A2 – Ms A Outcome Data (additional measures)

Instruments	Pre-therapy	One Month ¹	5 Months	8 months	One Year
WAI-S	N/A	N/A	M/D	M/D	68
TOP	M/D	105 units / week	160 units / week	30 units / week	21 units / week
Mentalizing Capacity	M/D	Moderate (4)	Good (6)	Good (7)	Good (9)
GAF	M/D	Serious Symptoms (41)	Serious Symptoms (50)	Moderate Symptoms (51)	Moderate Symptoms (51)

Notes. WAI-S scores range from 12 (very weak working alliance) to 84 (very strong working alliance);

TOP amounts are the average of a 28 day period; Mentalizing Capacity ranges from 0 (poor) to 12 (very high);

GAF scores range from 0 (persistent and very severe impairment) to 100 (superior functioning); N/A = Non Applicable;

M/D = Missing Data. ¹ This score was used as pre-therapy score or point of comparison.

Personal Questionnaire Data

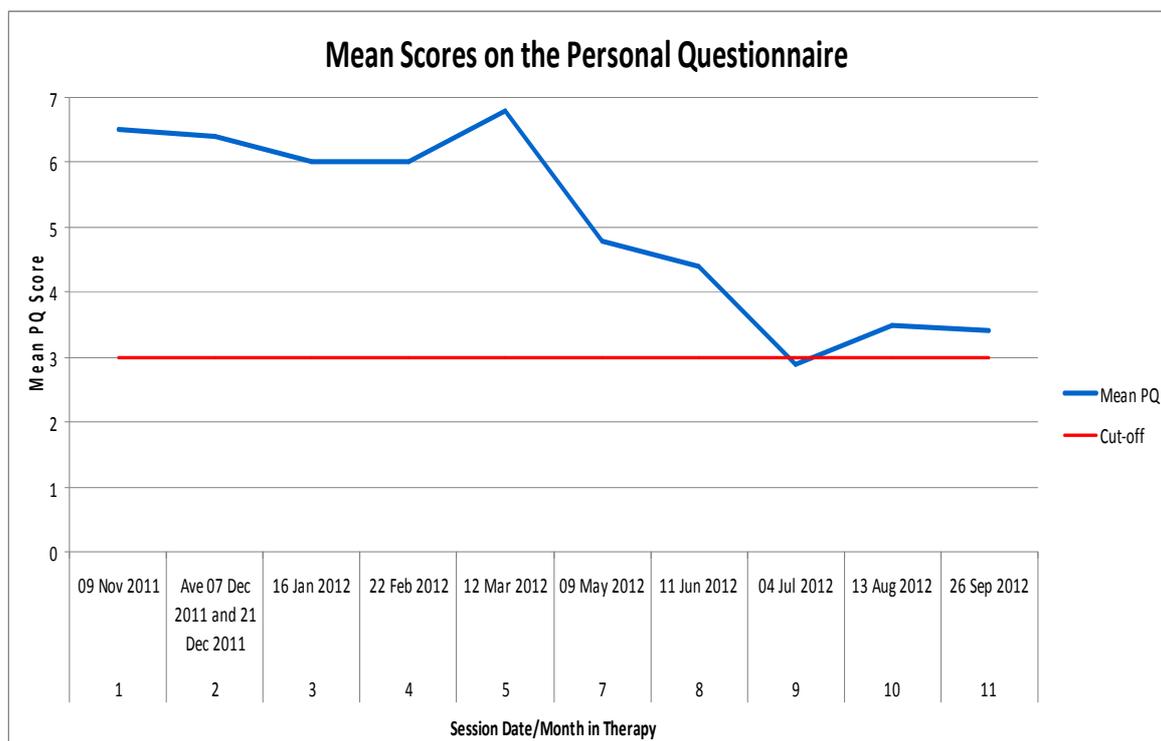
Once a month, after therapy, the patients were asked to rate each item on the extent to which it had troubled them over the last week. Items were rated on a 7-point scale, from 1 (not at all) to 7 (maximum possible). Table A3 indicates the duration of each item across Ms A's lifetime and summarises item ratings at one-month into therapy, eight months and one year into therapy. Figure A1 illustrates Ms A's mean PQ scores across therapy. A statistically significant reduction ($p < .05$) of 3.1 points can be observed, from Month 1 in therapy to 1 year.

TABLE A3 – Ms A PQ Ratings and Duration

Item	Duration of the Problem	One-Month	8 Months	One Year
1. Unreliable (due to drinking)	more than 10 years	7	4	3
2. Unstable and Impulsive	More than 10 years	7	4	2
3. Constant worry and anxiety about everything	More than 10 years	7	4	4
4. Lack of sleep (difficulties sleeping)	More than 10 years	6	6	6
5. Temper outbursts	More than 10 years	6	2	2
6. Low self-esteem	More than 10 years	7	7	3
7. Flat mood a lot of the time	More than 10 years	6	5	3
8. Difficulties engaging with people	More than 10 years	7	6	4
9. Social isolation	More than 10 years	6	5	4
10. Cry easily	More than 10 years	6	5	3

Notes. Instructions: Please complete before each session. Rate each of the following problems according to how much it has bothered you during the past seven days, including today. Anchors: Maximum possible (7), very considerably (6), considerably (5), moderately (4), little (3), very little (2), not at all (1).

FIGURE A1 – Ms A Mean PQ Scores Across Therapy



Note. The red line indicates the cut-off point between the clinical and non-clinical range on this measure (3.0).

Qualitative Data

Client's View of Helpful Aspects of Therapy

The Helpful Aspects of Therapy form (HAT) was completed once a month together with the Personal Questionnaire (PQ), both referring to the same session. Patients were asked to note the most helpful aspect or aspects of that session and to apply a helpfulness rating to that aspect on a 9-point scale from 9 (extremely helpful) to 1 (extremely hindering).

Ms A completed ten out of twelve HAT forms; one was incomplete and without ratings (Table B1).

TABLE B1 – Ms A view of Helpful Aspects of Therapy

Month	Helpful Aspect / What made it helpful	Rating
07 December 2011	I was really worried about my actions on Saturday after a row with my partner. I discussed it with the group and they made me see things in a different way / I went back and had a long talk with my partner and sorted my feelings out	8.5
07 December 2011	Speaking with the group	7
21 December 2011	Talking about parents / off loading guilt about the lack of help when my mother was dying	7
16 January 2012	To talk about isolation / Talking about it	7
22 February 2012	Nothing	---
12 March 2012	I think [Group Member A] and I have solved some problems / Feel more relaxed about coming	8
09 May 2012	Group noticed I had fluff in my hair and removed it / I felt like they cared / Toward the end / ---	9
04 July 2012	The group was happy for me that my brother was here from Malaysia, I felt great support / It made me feel I had people that cared about me	8.5
13 August 2012	[Group Member A] saying she is going to work a day and a half a week, gave me a lot of hope for myself / I feel maybe I could achieve going back to work	8
26 September 2012	[Therapist Name] was pleased that I was trying to start making children bracelets to sell on a craft stall / It helped because I felt pleased about it and [Therapist Name] seemed so pleased that it gave me a boost	8

Note. 9 = extremely helpful, 8 = greatly helpful, 7 = moderately helpful

The Helpful Aspects of therapy form also asked the patients to note any aspect of the session which they experienced as hindering or unhelpful. They were asked to apply a

hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering. Five Hindering Aspects were reported by Ms A (Table B2).

TABLE B2 – Ms A view of Hindering Aspects of Therapy Sessions

Month	Hindering Aspect	Rating
07 December 2011	Talking about someone else's problems with rape	2
21 December 2011	I thought [Group Member A] one of the group held (?) against me a dispute we had in an earlier session	3
22 February 2012	People in the group playing illness one-upmanship	2
11 June 2012	I said I believe I was born with this illness, [Group Member B] said if I was born with it I can just say nothing is my fault, I told him I feel everything is my fault and I got very upset	3
04 July 2012	[Group Member A] asked [Therapist Name] how many suicides she had under her belt, I didn't like it and I don't want to know	2

Note. Ms A was asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering.

Change Interview Data

Each patient engaged in two Change Interviews (Elliott, Slatick and Urman, 2001); one six months into therapy and one after a year. At each Change Interview they were asked to identify key changes that had taken place, and to make attributions regarding these changes (see Tables C1 and C2). Relevant passages taken from the full interview transcript can be seen on tables C3 to C12 on Appendix E.

TABLE C1 – Ms A's Change Interview Record At 6 Months

Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. My confidence is better	Somewhat surprised by it	Very unlikely	Extremely important
2. I am calmer	Very much surprised by it	Very unlikely	Extremely important
3. Motivation to deal with me	Very much surprised by it	Very unlikely	Extremely important
4. Drinking is more under control	Somewhat expected it	Very unlikely	Extremely important
5. Mood is not so flat	Somewhat surprised by it	Very unlikely	Extremely important

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

TABLE C2 – Ms A's Change Interview Record At 1 Year

Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. I have got a lot more confidence and improved self-esteem	Very much surprised by it	Very unlikely	Extremely important
2. I can walk around and not feel that everyone is staring at me / I don't get the panicky feeling I used to /	Very much surprised by it	Very unlikely	Extremely important

less paranoid / engaging more with people			
3. Not letting people crossing over me (hardly at all)	Very much surprised by it	Very unlikely	Extremely important
4. My head is not crammed with bad thoughts anymore	Somewhat expected it	Very unlikely	Extremely important
5. More on top of my housework	Somewhat expected it	Very unlikely	Extremely important
6. More organized in general	Somewhat surprised by it	Very unlikely	Extremely important
7. I look forward for my grandchildren do come / not panicking that I will mess up	Very much surprised by it	Very unlikely	Extremely important
8. Drinking has reduced / it is a lot better	Somewhat expected it	Very unlikely	Extremely important
9. Less impulsive and unstable	Very much surprised by it	Very unlikely	Extremely important
10. Less temper outburst	Very much surprised by it	Very unlikely	Extremely important
11. Less isolated socially	Very much surprised by it	Very unlikely	Extremely important

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

No Changes for the worst were reported by Ms A.

Summary of Key Descriptions in Change Interview at 1-Year

A summary of key descriptions in Ms A's change interviews, organized under different themes is shown in Appendix E, Tables C3 – C12.

Dialectical Procedure / Critical Reflection

A summary of the affirmative and sceptic briefs and rebuttals is presented below, the full version can be found in Appendix E.

Affirmative Brief

The job of Researcher 1 (Principal Investigator) was to find corroborated, positive evidence pointing to therapy as a major cause of patient change. The search for this evidence was divided into five different sections. To make a reasonable case for the causal role of therapy in patient change, HSCED requires that at least two different kinds of evidence support the therapy-change link (Elliott, 2002; Elliott et al, 2009).

The affirmative brief suggested that there was strong evidence to support the following claims:

- Significant changes have occurred in Ms A's stable and chronic problems
- Ms A clearly attributes these changes to the influence of therapy

The first claim was supported mainly by the quantitative elements of the study, but also through the subjective judgement of the consultant and the quality of the working alliance with the therapist (Tables A1 and A2).

The second claim was grounded in Ms A's 'likelihood without therapy' ratings; the importance attributed to the changes; and the degree of surprise shown. It is also argued that

the specificity and idiosyncrasy of her accounts give greater weight and credibility to the retrospective attribution argument (Bohart, 2008).

The affirmative brief then proclaims that there is evidence, although not sufficiently clear, to infer that:

- The process of therapy in general is linked to the positive outcomes
- Significant therapy 'events' have helped to reduce the severity of the patient's problems

Evidence for the first claim was presented in two ways: first, an attempt was made to connect therapeutic events reported in the Helpful Aspects of Therapy (HAT) forms to the outcomes reported in the Change Interview (CI) – see Table E1 in Appendix E; second, selected quotes from Ms A's Change Interview (CI) were connected to theoretical principles and quotes from her therapist, which were then linked with final outcome – See Table E2 in Appendix E.

For the second claim, two therapeutic events were matched with reliable gains, of at least one point ($p < .2$), in the Personal Questionnaire.

The affirmative brief found limited and indirect evidence to:

- Support the link between specific MBT processes or techniques and positive outcome.

The Spearman r correlation test was run and no correlation was found between the MBT specific interventions in the adherence scale and the therapy outcome in the Personal Questionnaire (PQ). Despite this fact, the affirmative brief points to the consistently high self-ratings of the therapist regarding 'working with current mental states', 'bridging the gaps' and 'use of transference', which seem to go accordingly with her three-monthly progress reports and the importance she attributed to working relationally in the here-and-now for the positive outcome of therapy.

Sceptic Brief

The sceptic brief presented competing explanations for apparent client change. The main arguments of the sceptic brief were (see 'Appendix E' for the full argument):

1. That Ms A's apparent changes were trivial or negative and that substantial therapeutic change could not be established.

This argument was grounded in a number of issues such as: Ms A's quantitative scores remaining within the clinical range after one year of treatment (Table A1); lack of change observed in the 'additional measures' from 7 months to one year (Table A2); some individual items in the PQ remaining unchanged (Table A3); and inconsistencies between quantitative and qualitative data.

2. The possibility of statistical error could not be excluded.

The sceptic brief argued that the negative change between seven months and one year reported on the Work and Social Adjustment Scale (WSAS) could be viewed as casting doubt on the other statistical measures since any reliable change in those dimensions has not been comprehensively replicated across all indicators.

3. Ms A was a 'people pleaser' and this self-presentational strategy, plus interpersonal dynamics between Ms A and the researcher, accounted for the reported changes.

The sceptic brief raises a number of problems such as the possibility of the 'hello-goodbye' effect (Elliot, 2002) and the lack of 'differentiation' observed (Bohart and Boyd, 1997 as cited in Elliot, 2002: p.11), stating that Ms A's descriptions do not contain a mixture of positive, negative and neutral claims. The sceptic brief also suggested that Ms A was

encouraged by the researcher/interviewer to provide a positive account of therapy (quotes from the Change Interview can be found in Appendix E).

4. Ms A's evidence was influenced by her own expectation-driven narrative of getting better.

The sceptic brief attempted to show how the client's personal expectations of change accounted for the progress she reported. According to the sceptic team, Ms A's narrative was scripted in such a way as to conform with her inner desire to change, her drive to please others and her avoidance of any information that could disconfirm these attributes.

5. Ms A was determined to help herself and this accounted for any change observed.

The idea that Ms A was someone who 'tried very hard' to make use of self-help techniques was presented by the sceptic brief as a self-correction process and, therefore, a competing explanation for change.

6. Significant extra-therapy events occurred in Ms A's life during the MBT program, providing a satisfactory explanation of change.

Arguments are put forward regarding the contribution of educational courses that she started prior to engaging in the MBT program; starting a new relationship with a 'good man' soon after the start of MBT; and regaining contact with her brother who had been missing in Malaysia for 11 years. The sceptic brief argued that "given this contextual information it appears that the client's description of every change having been 'very unlikely' without therapy does not

show that she has realistically considered the impact that these very significant extra-therapy events may have had on her life”.

7. An alteration in Ms A’s medication caused any changes recorded.

It is argued that the medication change undertaken three months after the start of the MBT accounts for any change observed (see ‘Diagnosis and Medication’).

8. Ms A’s participation in the research cannot be causally separated from her participation in the MBT program.

The sceptic brief concluded that the MBT treatment may or may not have been helpful on its own but that it was impossible to separate whether any changes in the client were due to therapy, research, or a combination of therapy and the research (a conjunction that was described by the researcher/interviewer as a ‘package’ of treatment during the One Year Change Interview, p.127).

Affirmative Rebuttal of the Sceptic Case

The purpose of this rebuttal was to challenge the arguments put forward in the sceptic brief that Ms A changed little during therapy and that evidence existed to support alternative explanations for Ms A’s changes. A refutation was presented for all eight arguments made by the sceptic researcher, in the same order (the full affirmative rebuttal can be found in Appendix E):

1. Ms A’s quantitative data unequivocally points to reliable and substantial change, surpassing even the minimum criteria suggested by Elliott (2002).

In summary, the affirmative rebuttal argued that '1) more than the minimum requirements in the outcome measures were reached suggesting very confidently that change has occurred; 2) the patient and therapist agree that there was a change and 3) the subjective evaluation of the Consultant (through the GAF and Mentalizing Capacity scales for example) also points to significant change. The triangulation of such a strong body of evidence does not leave room to accept the sceptic arguments as valid.'

2. Ms A's attributions are realistic and backed up by the therapist reports and the results of the consultant reviews;

3. Ms A's relational tendencies to please do not influence the results as she also reports difficult processes and aspects that have not changed. Furthermore, the 'reverted' items in Ms A's outcome measures (usually used to detect lies or inconsistencies) matched with the other 'normal' items.

The affirmative rebuttal also makes use of a number of therapist quotes denoting that change had indeed occurred, regardless of Ms A's relational tendencies. Furthermore, the therapist commented, in her five-month report, that her tendency to please had lessened and become part of her conscious process.

4. The warm responses of the therapist and researcher do not encourage the patient to simulate change but are, instead, a fundamental therapeutic process for this patient. This is reflected on the WAI-S high score (Table A2).

The affirmative rebuttal uses interview quotes to show that, despite the warmth, the same attention was given to negative or disappointing aspects of therapy.

5. It is not possible to isolate the influence of extra-therapy events and its cumulative, snowballing effect with the therapy programme.

In addition, it is argued that Ms A's problems were chronic and with over 10 years duration, making it highly unlikely that self-correction processes or extra-therapy events alone could explain the patient changes (see Appendix E for a detailed discussion of these processes).

6. The medication by itself cannot explain such a range of internal and external changes.

The affirmative rebuttal remarked that the therapist and the consultant, in their reports and patient notes, state many changes that seem independent of the medication. The patient herself reported that she was not satisfied with her medication and wanted to make changes.

7. The research, whilst not hindering, does not seem to be a fundamental helpful factor and did not, therefore, cause the changes.

Ms A, when asked about what had caused the changes, made no mention to the research. Also, even admitting that the research provided an 'extra reflective space', when asked about helpful aspects of the research she did not spontaneously refer to this fact.

Sceptic Rebuttal of the Affirmative Brief

This sceptic rebuttal challenged the validity of the affirmative brief's conclusions arguing that:

1. There was no substantial change in Ms A's stable problems

The sceptic rebuttal reminded that: Ms A remains on the clinical range on each measure of the outcome data - Table A1; the observed changes were not replicated across all quantitative indicators (see WSAS, Table A1); there has not been a global drop in the client's PQ ratings (see Item 4, Table A3).

Quotes from the therapist and patient were also used suggesting that Ms A is someone who is *changing* rather than someone who has already *changed substantially*.

2. The case for retrospective attribution advanced by the affirmative argument is unreliable and evidence shows that Ms A did not attribute any changes in functioning to aspects of the therapy that were specific to MBT.

The sceptic brief points to the potential unreliability of the Change Interview (CI) and the inflated replies of Ms A, which seem imbedded in a relational tendency to please.

Using interview quotes, the sceptic rebuttal suggests that the client did not retrospectively attribute any changes in her functioning to features of the treatment that were specific to MBT; instead, it is proposed that Ms A found being in a generally supportive group with other individuals experiencing substance misuse problems to be the key helpful factor in the therapy.

3. The process-outcome mapping posited by the affirmative brief cannot account for the majority of the qualitative outcomes; instead, it has been shown that MBT adherence and HAT do not co-vary positively.

Of the eleven qualitative outcomes reported by Ms A at the One Year Change Interview (Table C2), the sceptic brief suggests that the affirmative brief was unable to link 88% of those with specific processes of the MBT programme. All the more, the 12% that were linked were considered insubstantial, requiring a 'leap of faith' to be believed.

4. No within-therapy process outcome correlations have been established.

The Pearson's r correlation matrix between the levels of MBT adherence and the PQ results did not reveal significant associations.

5. Therapy events cannot be shown to have led to a stable shift in client patterns.

The sceptic brief wonders about the reliability of the research procedures, in particular the concurrent measurement of the Helpful Aspects of Therapy form (HAT) and the Personal Questionnaire (PQ).

The full version of these refutations is presented in Appendix E.

Adjudication

The three judges working on Ms A's case were blind to each other's participation guarantying, in this way, an independent judgement.

Their individual conclusions are shown in Table D1 below which includes the mean and median of their scores.

Following Stephen, Elliott and Macleod's (2011) suggestion, greater weight was given to the median scores which were taken as the best representation of the judges' decision.

In this way, taken together, the overall opinion of the three judges was:

- That Ms A changed considerably over the course of therapy (60 % certain)
- That these changes were due to the therapy to a considerable extent (60 % certain)

TABLE D1 - Adjudication Decisions for Ms A / Mean and Median Scores

	Judge A	Judge B	Judge C	Mean	Median
1a. To what extent did Ms A change over the course of therapy?	40 %	60 %	60 %	53 %	60 %
1b. How certain are you?	80 %	60 %	60 %	67 %	60 %
2a. To what extent is this due to the therapy?	40 %	80 %	60 %	60 %	60 %
2b. How certain are you?	60 %	80 %	60 %	67 %	60 %

Notes. Anchors for questions 1a and 2a: no change (0%), slightly (20%), moderately (40%), considerably (60%), substantially (80%), completely (100%).

Summary of judges' opinions (see Appendix E for the full version)

Judge A has put greater weight on the affirmative and sceptic briefs as the basis for his argument. He felt that there was a good, but not an overwhelming case, for improvement in symptomatology and distress at a moderate level. In his view, the question as to whether this could be fully maintained, and further built on, remained open. He shared some of the sceptic brief's concerns regarding the wish to please the team and the alcohol binges as casting doubt on the efficacy hypothesis. Also, greater assurance would be achieved if the outcome measures had moved below clinical cut-offs. Despite these problems the judge agrees with the affirmative position regarding the improvement of mentalizing capacity and the reliability of Ms A's self-claims of improvement. He believes that the in-group experiences described are evidence of some positive change interpersonally and that some of this will prove translatable to outside therapy settings in a durable way.

In terms of what caused the changes Judge A was cautious in accepting the process-outcome links proposed by the affirmative brief. He believed out-of-therapy events and other in-therapy elements, such as psychosocial nursing, to be also accountable factors.

Finally, Judge A argued that Ms A's ability to form a sustained therapeutic alliance had been demonstrated, which was probably the most crucial fact.

Judge B gave greater weight to the interview transcript to form the basis of her argument. She did not think that Ms A had changed substantially but thought she was starting to construct a new self-narrative and to make considerable changes, despite not sustainable yet. Judge B reported important changes regarding being less paranoid, more confident facing others (e.g. episode with other member of the group) and strangers (e.g. situation at the supermarket). Ms A used to run away when feeling exposed and shamed and was now facing it, not hiding from others. Despite considerable change being noted, Judge B still referred to some problems that Ms A would have to work on.

Judge B believed that the changes achieved were due to therapy to a substantial degree. She stated that Ms A had learned to face her shameful aspects, to accept herself through the acceptance of the other group members and the acceptance and support of her therapist and consultant. A good working alliance was also mentioned as a crucial factor. Her motivation and determination were stated as moderator factors and some extra-therapy events (e.g. new relationship and reconnection with brother) were deemed as playing a part in the snowball of change.

Judge C starts with a reminder of the complex diagnosis we are dealing with stating that it would be unrealistic to expect clear, linear, positive gains for an individual with such a presentation. Her arguments are mostly based on the information coming from the client (i.e. quantitative and qualitative data) and, at all times, relative to the nature of the client's presentation. Judge C questioned the sceptic brief doubts regarding the credibility of Ms A's judgement of her own progress giving a number of relevant examples that show we can trust Ms A's claims. The judge described group therapy processes that she considered as vital therapeutic work. She also rejected the sceptic argument that the influence of therapy was minimal, explaining that week-on-week changes are normal in this kind of presentation and that the cumulative effects of therapy should be given more emphasis.

The consistency and reliability of the therapeutic setting, as well as the greater understanding of her avoidance strategies were considered to be mediator factors. Extra-therapy events were considered as having a moderate effect.

Mr Z

Rich Case Record

The Patient

Mr Z is an only child; at the time of referral he was 46 years old; he looked like a meek and mild man but described himself as having a terrible temper that he loses when provoked or sometimes with an unknown trigger. He was smoking cannabis, using it as a crutch, 11-12 joints per day. He also used cocaine, speed and LSD in the past as a form of escapism but not anymore.

His parents were both retired. They split up when he was 23. He described his mother as outgoing and a 'normal' person and his dad as short-tempered with isolation tendencies.

Mr Z described difficulties at school. He felt depressed since his early teens and stated that his depression has crippled his existence, especially regarding jobs in his adult life. He described his emotions as running high since he was a teenager and was told that it was always in his head. Mr Z also complained of having nightmares and intrusive thoughts since childhood. He described mood swings and emotional outbursts. Mr Z feels that his problems have created instability in his relationships and problems with employment and in keeping hobbies.

Before the therapy started he had a spurt of unsuccessful attempts at work where he has left abruptly because of losing his temper. He describes himself getting so angry that he would lose control.

He described feeling suicidal since the age of 13 but having only acted on those feelings once in the year 2001. He had been self-harming from this age.

He was taking Paroxetine and Quetiapine prescribed by his GP and he felt that it had started taking effect. He remained reliant on cannabis to calm his nerves but had made a slight reduction in his use since the medication was taking effect.

The generic psychiatrists from CMHT have made different and provisional diagnoses during the year 2011: cyclothymia, bipolar affective disorder and borderline personality disorder. These were hypothesis to be investigated by the psychotherapy department.

Music was the only thing he described has giving him satisfaction.

He was unemployed and was living with another man. The therapist had some reservations regarding his commitment to therapy but he ended up being accepted for the program following his meeting with the Consultant Psychiatrist in Psychotherapy and the application of the SCID-II. The diagnosis of borderline personality disorder was confirmed; he also met the criteria for depressive personality disorder and for substance abuse and dependency according to the DSM-IV-TR.

Mr Z wanted to gain more understanding about his mental problems in order to bring about change. He was hoping to get back into work.

Psychopharmacological Medication Record (incl. herbal remedies)

<u>Medication Name</u>	<u>For What Symptoms</u>	<u>Dose / Frequency</u>	<u>How Long</u>	<u>Last Adjustment</u>
Paroxetine (Antidepressant – SSRI)	Depression	20 mg / Day	Since February 2010	February 2010
Quetiapine (Anti-psychotic)	'To help me sleep and calm me down'	50 mg / Day	Since March 2011	March 2011

Pre MBT Program

- February 2011 – Referred to the psychotherapy department / personality disorder service by the CMHT psychiatrist
- Consultation with group therapist on April 2011
- Second consultation with group therapist on May 2011
- Consultation with the Consultant Psychiatrist in Psychotherapy to discuss the MBT program and to apply the SCID-II

Results of SCID-II and Diagnostic Hypothesis

- DSM-IV-TR Axis I: Previous provisional hypothesis of bipolar affective disorder and cyclothymia
- DSM-IV-TR Axis II / SCID-II Results: Mr Z met the diagnostic criteria for Borderline Personality Disorder (main focus of clinical attention) and Depressive Personality Disorder. He also scored high in a number of different personality traits but not enough to establish a diagnosis.
- Substance Abuse Disorder: Mr Z met the DSM-IV-TR diagnostic criteria for Cannabis dependency and abuse. He has used cocaine, amphetamine and LSD in the past. There was no evidence of problematic use of alcohol.

Outcome Data

Table A1 shows the results of three measures evaluated with clinical significance methods over time.

After one year of therapy, it is possible to observe positive change in the PQ ($p < .05$) and WSAS ($p < .2$) and negative change in the CORE-OM ($p < 0.5$), comparing with the pre-therapy rating (Table A1).

TABLE A1 – Mr Z Outcome Data (analysed with clinical significance methods)

Instruments	Cut-off	RC min (p<.2)	RC min (p<.05)	Pre- therapy	5 Months	8 Months	One Year
PQ	≥3	1.0 (↓)	1.5 (↓)	6.9	4.1 ** (+)	4.8 ** (+)	4.0 ** (+)
CORE-OM	≥1.25	0.43 (↓)	0.66 (↓)	0.82	1.56 ** (-)	2.26 ** (-)	2.65 ** (-)
WSAS	≥10	7.2 (↓)	10.9 (↓)	34	24 * (+)	25 * (+)	26 * (+)

Notes. Value in bold fall within the clinical range; *p<.2; **p<.05; ↓= decreased score indicates positive change; (+) = reliable positive change in relation to first available score; (-) = reliable negative change in relation to first available score;

Table A2 illustrates the results gathered from additional measures. No clinical significance methods were used here. After one year of therapy it is possible to observe a slight reduction on the use of cannabis (TOP), an increase on mentalizing capacity from poor to moderate, and a slight decrease of symptomatology on the Global Assessment of Functioning scale (GAF), despite not moving up from 'serious symptoms'. The alliance with the therapist, as measured by the Working Alliance Inventory (WAI-S) has improved from 8 months (1st measurement) to a year.

TABLE A2 – Mr Z Outcome Data (additional measures)

Instruments	Pre-therapy	5 Months	8 Months	One Year
WAI-S	N/A	M/D	41	56
TOP	1g cannabis / day	½ g Cannabis / Day	1g Cannabis / Day	0.6-0.7g Cannabis / Day
Mentalizing Capacity	1 (poor)	5 (moderate)	4 (moderate)	4 (moderate)
GAF	Serious Symptoms (41)	Moderate Symptoms (51)	Serious Symptoms (41)	Serious Symptoms (45)

Notes. WAI-S scores range from 12 (very weak working alliance) to 84 (very strong working alliance); TOP amounts are the average of a 28 day period; Mentalizing Capacity ranges from 0 (poor) to 12 (very high); GAF scores range from 0 (persistent and very severe impairment) to 100 (superior functioning); N/A = Non Applicable; M/D = Missing Data.

Personal Questionnaire Data

Once a month Mr Z was asked to rate each item on the extent to which it had troubled him over the last week. Items were rated on a 7-point scale, from 1 (not at all) to 7 (maximum possible). Table A3 indicates the duration of each item across Mr Z's lifetime, and summarises item ratings at the pre-therapy, 6-months and one-year stages of therapy. Figure A1 illustrates Mr Z's mean PQ scores across therapy. A statistically significant drop ($p < .05$) of 2.9 points can be observed from pre-therapy to 1-year.

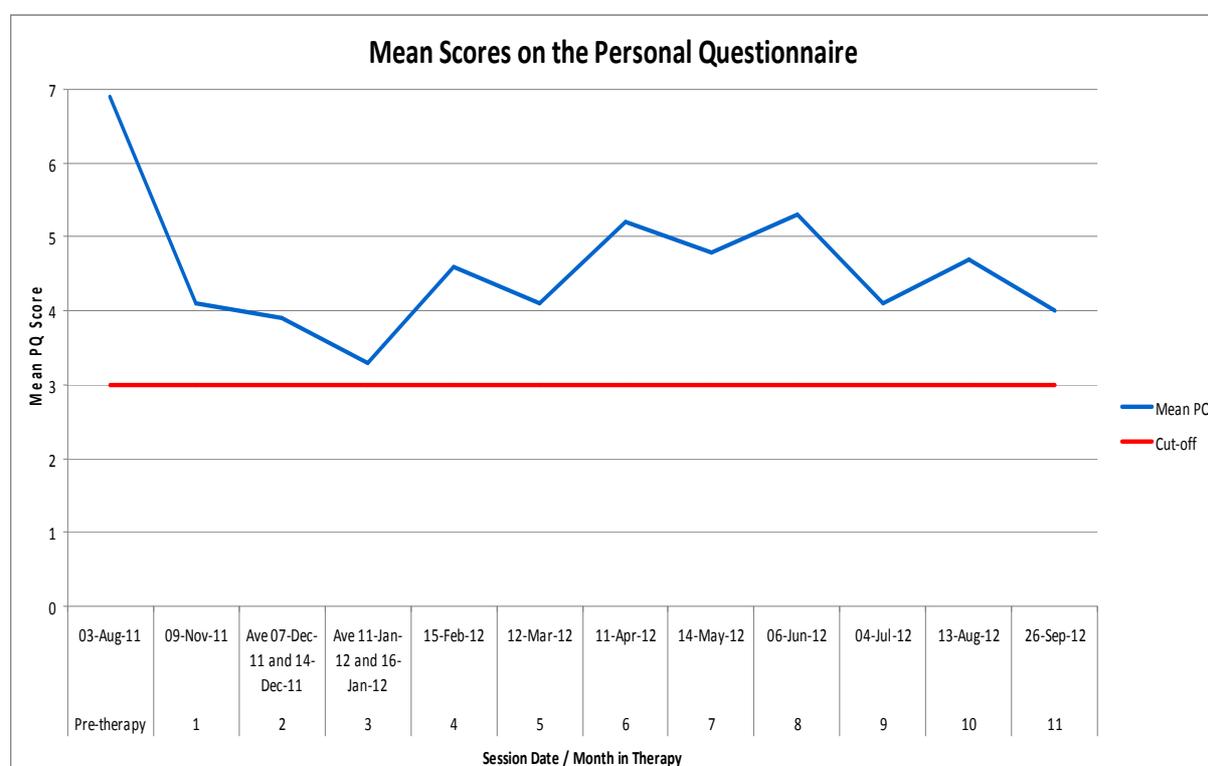
TABLE A3 – Mr Z's PQ Ratings and Duration

Item	Duration of the Problem	Pre-therapy	At 5-Months	At One-Year
1. Not believing in myself	more than 10 years	7	2	6
2. Not knowing when to stop	more than 10 years	7	5	5
3. Depressive spirals	more than 10 years	7	2	3
4. Disorganized thinking	more than 10 years	7	7	4
5. Taking things too far in relationships	more than 10 years	7	3	1
6. Self-loathing and negativity	more than 10 years	7	4	5
7. Poor sleep	more than 10 years	7	5	5
8. Dark disturbing thoughts	more than 10 years	7	4	6
9. Not knowing how to manage	more than 10 years	7	2	3

myself in any relationship	years			
10. Financial problem	more than 10 years	6	7	2

Notes. Instructions: Please complete before each session. Rate each of the following problems according to how much it has bothered you during the past seven days, including today. Anchors: Maximum possible (7), very considerably (6), considerably (5), moderately (4), little (3), very little (2), not at all (1).

FIGURE A1 – Mr Z's Mean PQ Scores Across Therapy



Note. The red line indicates the cut-off point between the clinical and non-clinical range on this measure (3.0).

Qualitative Data

Client's View of Helpful Aspects of Therapy

The HAT form was completed together with the Personal Questionnaire (PQ) and referred to the same session. Mr Z was asked to note the most helpful aspect or aspects of that

session and to apply a helpfulness rating to that aspect on a 9-point scale from 9 (extremely helpful) to 1 (extremely hindering). The patient completed nine out of eleven HAT forms. Three were incomplete. The HAT also gives the opportunity to report more than one helpful event: Mr Z described and rated five of these 'secondary' helpful events; however, two of these were only partially completed (Table B1).

TABLE B1 – Mr Z's view of Helpful Aspects of Therapy

Month	Helpful Aspect / What made it helpful / Where in the session / How long did the event last	Helpfulness Rating
09 November 2011	Something someone else said about slowly losing control of temper over the course of a time scale and as (exploding temper) ...	8,5
December 2011	-----	---
January 2012	-----	---
15 February 2012	Mentions of compulsive lying / I have had this problem / Beginning / All session	7
12 March 2012	Nothing	---
11 April 2012	All of it, talking about self hatred / Been thinking like that lately	8
11 April 2012	-----	7
14 May 2012	[Group Member B] spoke up and what he had to say seemed very useful + insightful; unfortunately his negativity got in the way he didn't find his thought / he was touching upon something that had relevance to me	8
14 May 2012	I was able to clarify what I think I am and what I want to get out of this session	7
06 June 2012	Whole session was helpful; all was able to open up somewhat	8

	including myself. Also everybody turned up!! / Not entirely sure yet	
04 July 2012	Not sure yet / NA	---
04 July 2012	Light heartedness	---
13 August 2012	Realizing that cannabis is my mask not just part of it / I hadn't looked at it that way before	8
13 August 2012	Something about the past – present; how can we leave the past behind and move forward / Just a new way of looking at things	8
13 August 2012	[Group Member A] talking about her past and her problems	8
26 September 2012	Not sure	---

Note. 9 = extremely helpful, 8 = greatly helpful, 7 = moderately helpful

The Helpful Aspects of Therapy form (HAT) also asked the patients to note any aspect of the session which they experienced as hindering or unhelpful. They were asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering. Mr Z reported four hindering events; some of his replies are comments about himself or the process of therapy and research and do not specifically relate to therapy events; in addition, two of these events were left unrated (Table B2).

TABLE B2 – Mr Z's view of Hindering Aspects of Therapy Sessions

Month	Hindering Aspect	How Hindering
12 March 2012	Not in my field; alcohol related problems	-----
14 May 2012	[Group Member B] did not finish in what he was saying or at least left no time to discuss it properly	4
06 June 2012	The things I mentioned; not sure how relevant it was	-----

26 Sept 2012	Been finding it hard not to take everything negatively	3
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Note. KW was asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering.

Change Interview Data

Each patient engaged in two Change Interviews (Elliott, Slatick and Urman, 2001); one six months into therapy and one after a year. At each Change Interview (CI) they were asked to identify key changes that had taken place, and to make attributions regarding these changes (see Tables C1 and C2). Relevant passages taken from the full interview transcript can be seen on tables C3 to C12 on Appendix F.

TABLE C1 – Summary of Mr Z's Changes – At 6 Months

Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. I have more understanding and can focus more	Very much expected	Very unlikely	Extremely important
2. Things are changing	Neither expected nor surprised	Very unlikely	Extremely important
3. More hopeful	Somewhat surprised by it	Very unlikely	Extremely important
4. Not acting-out so much; checking with others first	Very much surprised by it	Very unlikely	Extremely important
5. More able to control impulses	Very much surprised by it	Very unlikely	Extremely important

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

TABLE C2 – Summary of Mr Z's Changes – At 1 Year

Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. Control a little bit more my aggression (able to put a lid on it)	somewhat surprising	very unlikely	extremely important
2. Gained more control over emotions in general	somewhat expected	very unlikely	extremely important
3. Stopped taking things too far in relationships	somewhat expected	Neither likely or unlikely	extremely important
4. Managing myself better in relationships	somewhat expected	somewhat likely	extremely important

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

Summary of Key Descriptions in Change Interview at 1-Year

A summary of key descriptions in Mr Z's change interviews, organized under different themes is shown in Appendix F, Tables C3 – C12.

Dialectical Procedure / Critical Reflection

A summary of the affirmative and sceptic briefs and rebuttals is presented below (the complete arguments can be found in Appendix F).

Affirmative Brief

As previously explained the affirmative brief's job was to find corroborated, positive evidence pointing to therapy as a major cause of patient change. The steps and procedures were the same used for Ms A (see above).

The affirmative brief provided evidence to support the following statements:

- Substantial changes have occurred in Mr Z's stable and chronic problems
- Mr Z clearly attributes these changes to the influence of therapy

The first argument is based mainly on the quantitative indicators, suggesting a significant and reliable change in problems of over 10 years duration (Tables A1 and A3 and Figure A1). The subjective judgement of the Consultant Psychiatrist in Psychotherapy, and the use she made of additional measures (Table A2), is also used to back up the claim.

The second statement is backed up with direct evidence from the patient, particularly the 'likelihood without therapy' ratings and the importance attributed to the changes during the **C**hange **I**nterview (Tables C1 and C2). A number of quotes from the Change Interview (CI) are used, highlighting the specificity and idiosyncrasy of Mr Z's statements which increases its credibility (Bohart, 2008). An example from the one-year CI is:

Interviewer: OK. What else do you think was responsible for the changes?

Participant: Group therapy

Interviewer: The therapy, the group, yeah

Participant: Oh yeah the group has been 99% and you know the fact that I've got a bit of understanding outside of group helps

The affirmative brief then argues that some evidence exists, although of less weight and clarity, to support the following statements:

- The process of therapy in general is linked to the positive outcomes

- The 'framework of treatment' was linked to positive outcomes ($r = .722$ at $p < .05$; Table F2, Appendix F) but no link was found between the use of specific MBT elements or techniques and therapeutic outcome
- Significant therapy 'events' have helped to reduce the severity of the patient's problems

For the first point two avenues were taken: first a link was proposed between psychotherapy processes highlighted in the Helpful Aspects of Therapy form (HAT) and the changes Mr Z reported in the Change Interviews (CI) – see Table E1 in Appendix F; second, a number of quotes from the patient's Change Interview (CI) are linked with theoretical principles and the views of the therapist and consultant and then later associated with outcome (see Table E2 in Appendix F).

The second point was backed up with evidence from a correlation matrix using a computer program and the Spearman r test (see Table F2 in Appendix F).

Finally, in the last point, four significant shifts in the Personal Questionnaire were identified (Figure A1) and linked with both processes from the same session and processes from previous sessions, as observed in the Helpful Aspects of Therapy form (HAT).

Despite different levels of clarity and weight, five different types of evidence were, in one way or another, discovered, which is above the minimum requirements suggested by Elliott (2002) of two different types of evidence. The affirmative brief has, therefore, supported the therapy efficacy hypothesis.

Sceptic Brief

As for Ms A, the sceptic brief presented competing explanations for Mr Z's apparent changes. The main arguments of the sceptic brief were:

1. Mr Z's apparent changes were at best trivial and many were negative; therefore substantial therapeutic change cannot be established

The basis for this argument rests in the permanence of the quantitative measures within the clinical range (Table A1 and Figure A1); the negative change shown in the CORE-OM (Table A1); and the minimal changes in the use of cannabis (Table A2 and CI). Individual items of the Personal Questionnaire (PQ) were also analysed showing that some items have remained the same or, indeed, got worse (Table A3). The sceptic brief also used quotes from Mr Z's Change Interview (CI) to demonstrate that minimal change had occurred (e.g. 'It just seems to be the same barrage that I've always had').

2. The positive change identified in the Personal Questionnaire (PQ) between five months and one year of therapy was the only positive statistical change to occur during the therapeutic period. This is likely to represent a statistical anomaly that can be explained by factors such as expectancy effects or relational artefacts.
3. Relational artefacts such as self-presentational strategies, the 'hello-goodbye' effect, and the interview style adopted confound any positive changes recorded in the data.

Quotes from the Change Interview (CI) and notes from the Psychosocial Nurse were used to highlight self-presentation strategies, for example 'wearing a mask', putting up an 'act' and the problem of compulsive lying (HAT form, 15th February 2012 – Table B1).

The 'hello-goodbye effect' (Elliott, 2002: p.11) is also proposed as being in operation, suggesting that Mr Z is acting according to what is expected of him and, therefore, showing that he is changing. The sceptic brief also highlights a number of excerpts from the Change Interview, suggesting that the interviewer influenced the research situation through the use of leading questions biased mainly towards positive changes (see Appendix F for further details).

4. Mr Z's personal accounts were influenced by his expectation-driven narrative of changing as opposed to resulting from a valid experiential process.

This statement was supported by evidence that Mr Z provided 'scripted' accounts of the process of treatment as opposed to producing idiosyncratic and experiential narratives (Elliott, 2002: p.12). This reliance on cultural schemas when describing therapy – e.g. 'understanding', 'non-judgemental', the 'little things said' – was thought to reduce the credibility of Mr Z's accounts.

5. The patient had an active desire to bring about change and was equipped with the resolve to do so, minimising possible therapeutic attributions.

The sceptic brief - through an analysis of the 'likelihood without therapy' ratings and 'how surprising/expected' the changes were (Tables C1 and C2) - suggested that Mr Z has attributed a large proportion of his changes to factors other than the MBT program.

6. Extra-therapy events impacted upon Mr Z and were more decisive than the therapy, specifically his initial diagnosis prior to commencing the MBT program and the understanding he received from others.
7. Psychobiological causes may be minimally in operation in terms of Mr Z's reduction of cannabis.

It is argued that the reduction in cannabis intake, undertaken at certain periods during the MBT program (Table A2 and C1), accounted for any changes observed.

8. Mr Z participated in the research in a self-conscious way and this undertaking cannot be causally separated from his involvement in the MBT program.

The sceptic brief highlights the influence that the research may have had in providing an additional space for reflection. A quote from Mr Z is also used where he poses the responsibility of change in the whole 'package':

Interviewer: The research?

Mr Z: Yes, yeah, the whole, the whole team has helped

Affirmative Rebuttal of the Sceptic Brief

The purpose of this rebuttal was to challenge the arguments put forward in the sceptic brief that Mr Z changed little during therapy and that evidence existed to support alternative explanations for Mr Z's changes. A refutation was presented for all eight arguments made by the sceptic team, in the same order:

1. Different sources of evidence suggest that Mr Z changed substantially. The quantitative data strongly points in the direction of positive change surpassing even the minimum criteria suggested by Elliott (2002).

The affirmative rebuttal challenged the sceptic position stating that: the complexity of Mr Z's problems and his diagnosis were not taken into consideration; the statistical indicators surpassed the Reliable Change Index (Jacobson and Truax, 1991) in two out of three instruments, which is above the minimum criteria to assume that change has occurred (Elliott, 2002); the CORE-OM at pre-therapy was likely to be unreliable.

The affirmative rebuttal also highlighted errors in the sceptic brief judgement: the suggestion of a negative change in the Work and Social Adjustment Scale (WSAS) and

Personal Questionnaire (PQ); the claim that the cannabis use has not changed; the suggestion of non-improvement in Mentalizing Capacity; and the reading of the PQ scores (see Appendix F for the full argument).

2. The great majority of the quantitative measures used point in the direction of positive change which leaves no room for suspicion that statistical errors were in place.

Looking at the results globally, the affirmative rebuttal made a different interpretation from the one made by the septic brief, considered here to be biased and inaccurate. The alternative interpretation presented was that Mr Z achieved substantial and reliable positive change from pre-therapy to 5-months; and that this change was then sustained until the one-year mark with no further improvement or deterioration (see, for example, Tables A1 and A2 and Figure A1).

3. There is credible evidence that Mr Z's responses were genuine and that no 'hello-goodbye' effect was in place, mostly because therapy was only half-way through. The avoidant personality traits of Mr Z may have affected the Change Interview but not to the extent of manipulating the data.

A number of quotes from the Change Interview (CI) were used to disconfirm the sceptic argument that Mr Z was trying to please the team. Examples showing *differentiation* (Bohart and Boyd, 1997 as cited in Elliott, 2002: p.11), meaning the use of neutral or negative comments by Mr Z, were given (see Tables C3 to C12 and the full affirmative rebuttal in Appendix F for more examples):

Interviewer: (...) are you acting in any different way or any behaviour that has changed?

Participant: I don't think so, no

The affirmative rebuttal also rejects the role of self-presentational artefacts for Mr Z's therapy attributions, since there are a number of *elaborated* (Bohart and Boyd, 1997 as cited in Elliott, 2002: p.11) accounts of the therapy's influence in his narrative, containing specific details about what has changed and how the change came about.

The affirmative rebuttal accepted the argument made that the Interviewer has guided Mr Z on occasions. However, this strategy was justified as necessary to surpass the 'avoidant' traits of the patient. Furthermore, the 'guidance' provided was not channelled towards a particular direction and the same attention was paid to positive and negative evidence.

4. Enough evidence exists to suggest that many of Mr Z's accounts were self-reflective and credible as opposed to mainly expectation-driven. Mr Z was indeed surprised with many of his changes.

The sceptic argument was only partially refutable since Mr Z has shown a great variety of responses in the 'how expected/surprised' question (see Tables C1 and C2). A convincing and consistent conclusion could not, therefore, be reached. However, an excerpt from the Change Interview showing detailed, careful and self-reflective descriptions was used as evidence that, at least some of Mr Z's accounts were grounded in his immediate experience, which increases the credibility of his narrative.

5. All of Mr Z's problems were of more than 10 years duration whilst the majority of his reported changes were considered to be 'very unlikely' without the therapy. Both these facts cast serious doubt as to the possibility that self-corrections processes alone would cause any of the reported changes.

6. There is no evidence that the 'extra-therapy events' reported can fully explain the changes. At best, there is a bidirectional influence between these events and the therapy program itself.

Despite the likely influence of such events as receiving a diagnosis and the understanding of his family, the affirmative rebuttal gives examples showing that the therapy programme played the greatest influence. For example, during the 6-months interview, Mr Z attributes 99% of influence to the therapy programme, leaving the diagnosis and the understanding to second stage:

Interviewer: OK. What else do you think was responsible for the changes (inaudible)?

Participant: Group therapy

Interviewer: The therapy, the group, yeah

Participant: Oh yeah the group has been 99% and you know the fact that I've got a bit of understanding outside of group helps

7. No changes in medication were made during the MBT program and therefore it is not possible to make a link between the use of medication and psychosocial change. In addition, there is sufficient evidence that the reduction in cannabis was linked with the therapy program and could not by itself explain all the changes reported.
8. Mr Z seemed to take the research as more of an inconvenience than a benefit or, at best, he was neutral about his participation making it very unlikely that the research was solely responsible for the changes observed.

Sceptic Rebuttal of the Affirmative Case

The sceptic rebuttal challenged the validity of the affirmative brief's conclusions arguing that:

- There was no substantial change in Mr Z's stable and chronic problems

The sceptic team adverted to the various fluctuations in the outcome measures and to the fact that Mr Z had remained on the clinical range in all the instruments used (Table A1 and A2). Quotes from the therapist and consultant were used to support the argument that no substantial change had occurred. For example, the therapist's 12 month Progress Report, one year into therapy, describes the patient as feeling 'he is so ugly he cannot imagine that anyone would see him differently' (see Appendix F for more examples).

- It is not clear that Mr Z reliably attributed any changes he experienced to the therapy

Despite the apparently strong evidence provided in the affirmative brief regarding Mr Z's retrospective attribution, the sceptic team believed the evidence was biased, questioning the validity of Mr Z's attributions.

- The process-outcome mapping asserted by the affirmative brief does not accurately account for the majority of the changes reported by Mr Z.

The sceptic brief described the mapping process undertaken by the affirmative team (see Tables E1 and E2 in Appendix F) as extremely tentative, requiring a 'leap of faith' to be believed. The time gap between process and outcome, at times almost a year, was also questioned. In addition, the sceptic brief argued that the mapping suggested did not reflect the Personal Questionnaire (PQ) scores in certain individual items (see Appendix F for a detailed discussion).

- No link was established between MBT techniques and therapy outcome.

The sceptic brief suggested that the category 'framework of treatment' did not specifically relate to MBT techniques. In this way, the correlation established with the PQ results ($p < .05$) should be seen, according to the sceptic position, as negative evidence for the effectiveness of the MBT program.

- Therapy events cannot be shown to have led to a stable shift in client problems.

The sceptic rebuttal argues that the links made by the affirmative brief between the Personal Questionnaire (PQ) scores and the Helpful Aspects of Therapy forms (HAT) are questionable and can be explained by other factors (see Appendix F). It is also argued that the pre-therapy measurements are unreliable since they were undertaken more than two months before the start of the program.

Adjudication

The three judges working on Mr Z's case were blind to each other's participation guarantying, in this way, an independent judgement.

Their individual conclusions are shown in Table E1 below which includes the mean and median of their scores.

Following Stephen, Elliott and Macleod's (2011) suggestion, greater weight was given to the median scores which were taken as the best representation of the judges' decision.

In this way, taken together, the overall opinion of the three judges was that:

- Mr Z changed considerably (60%) over one-year of MBT (with 80% certainty)
- The change was substantially (80%) due to the effects of MBT (with 80% certainty)

TABLE D1 – Adjudication Decisions for Mr Z / Mean and Median Judge’s responses

	Judge D	Judge E	Judge F	Mean	Median
1a. To what extent did Mr Z change over the course of therapy?	60 %	60 %	20 %	47 %	60 %
1b. How certain are you?	80 %	60 %	100 %	80 %	80 %
2a. To what extent is this due to the therapy?	80 %	80 %	80 %	80 %	80 %
2b. How certain are you?	80 %	60 %	100 %	80 %	80 %

Note. The anchor given to judges was: 0% (nothing); 20% (slightly); 40% (moderately); 60% (considerably); 80% (substantially) and 100% (completely)

Summary of Judges Opinions

Judge D gave greater weight to the quantitative information and background data, as well as the sceptic and affirmative briefs. He believed there was evidence that the client had changed; however, that change seemed to fluctuate. Considering the severity and duration of Mr Z’s problems, Judge D thought that the changes were ‘considerable’ (60%). Mr Z reported learning to live with his problems in a different kind of way, which was why Judge D did not choose ‘completely’ (100%).

The judge believed that the influence of therapy was substantial stating that sufficient occasions occurred where the client confirmed this. He has shown a substantial level of certainty in his decision, saying that the interviews gave the client enough opportunity to say that the therapy had not been helpful.

The judge identified a number of processes that mediated change: sharing experiences with other people in the group; experiencing acceptance; experiencing self-disclosure; becoming more reflective; noticing when things were not as bad as he had imagined; feeling supported (cared for?) when ‘a plan’ was put together to help him reduce his cannabis intake. He also noted that the client seemed able to ‘hang on in there’ despite the difficulties he

experienced, considering this to be an important personal attribute that served as a moderator factor.

Judge E decided with 60% certainty that the client changed considerably. She based her decision on both the quantitative and qualitative data, including the judgement of the consultant and the client. The 40% of doubt rested mainly on the negative change observed in the CORE scores. The judge used an excerpt from the 6-month transcript that suggested the patient's understanding of himself had changed considerably but that his symptoms had not. This could explain the inconsistencies indicated by outcome measures.

Judge E decided also with 60% certainty that the changes were substantially due to the therapy. This argument was based on the client's own attributions of change in the Change Interview. The 40% of doubt rested on the possible effects of his medication and the increased understanding shown by his dad. The judge suspects that the patient may have underestimated these aspects during the various quantitative and qualitative evaluations.

A number of therapy processes were considered helpful to the client: being aware of others' similar experience; non-judgemental aspects of therapy; reflective stance of the therapy; difficult interactions in the group provided helpful learning.

Judge E also listed a number of client characteristics that could have helped him make use of therapy: client's own self-awareness; awareness of his anger; awareness of his passive aggression; keeping a lid on his anger may have helped; being more open in the group.

Judge F thought, with 100% certainty, that the client changed only slightly (20%). The main basis for her argument was the client's background information, the quantitative outcome data and the material from the Change Interview.

For judge F the nature of the client's problems and diagnosis would predict a slow and progressive recovery, making it difficult to achieve substantial changes in only one year of therapy. Regarding the outcome measures, the judge believed that the pre-therapy results for

the CORE-OM, situating the client in the non-clinical range, should be disregarded considering them unreliable in contrast with all the other indicators (Table A1). She considered the outcome measures to show significant change during the first 5 months of therapy and that the changes were then maintained until the one-year mark.

The judge commented that Patient Generated Measures, such as the PQ, are usually more sensitive to change than generalized measures, such as the WSAS and CORE-OM (Ashworth et al, 2007). This, together with the fact that the PQ was administered by the therapist - potentially driving the patient to exaggerate the changes - could explain why the improvement shown in the PQ is higher than the one shown in the WSAS (Table A1).

The triangulation with the qualitative information has confirmed to the judge that there were small changes in the patient but no recovery.

Judge F decided that the slight changes observed were substantially (80%) due to the therapy. She was certain (100%) of this decision. The main argument in favour of this verdict was the observation of 'changes in stable and chronic problems' soon after the therapy had started. The judge also gave weight to the 'retrospective attribution' argument as well as the evidence presented in both the affirmative brief and affirmative rebuttals to this purpose. The fact that Mr Z was also able to criticise the program gave greater credibility to his attributions.

The judge attributed the other 20% of justification to extra-therapy events, such as the support from his father and friends. She trusted that therapeutic and extra-therapeutic events interacted with each other in stimulating the changes.

In summary, Judge F considered the following therapy processes to be helpful for the client: the hope to improve; identification with other stories told by the group members; the experience of new relational patterns in the group that were then translated into his 'real' life, giving him further confidence in himself; greater insight; good therapeutic alliance with the group psychotherapist; the working alliance established with the psychosocial nurse and the possibility of having one-to-one sessions with her.

On the other hand, for Judge F, the increased mentalizing capacity of the patient could be an indicator that this variable had played a part in the process of change. However, to infer over the mediating effect of mentalization would require the contrast with other cases where the variable 'mentalization' could be linked with outcome or, alternatively, to contrast 'mentalization' with other mediating variables such as 'insight'. With the available data we can observe that the patient improves alongside his mentalizing capacity. However, we cannot determine cause and effect...

In Judge F's opinion, the personal resources of the client that helped him make use of therapy were: motivation; capacity for insight; the help from his father and the quality of their relationship; and the support from his friends.

Mr X

Rich Case Record

The Patient

Mr X was referred by IAPT in May 2011 and he was 33 years old at the time of referral. He suffered from anxiety, panic attacks, mood swings and depression. He has been feeling low for 20 years and has relied on alcohol for most of this period, with evidence of physical dependence and withdrawal symptoms. He managed to stop drinking 6 months prior to his referral to the psychotherapy/complex needs department and, when the MBT program started, he was alcohol free for 10 months. He has been smoking cannabis since his teens, then stopped between the ages of 24 – 28 and has been smoking daily for the last four years, 10-15 joints per day, buying 19 grams every week. He described issues from his childhood that were still affecting him. He can be very tearful and sometimes is taken over by his accumulated anger; he mainly hits out at the wall. He talked about putting up a false front and that he has

always hidden his feelings of humiliation. He said that when his anxiety hits him hard he just has to go home, regardless of where he is.

He took an overdose at 14 as he felt hopeless at school but again it was not taken seriously. He mentioned that he had suicidal thoughts on a daily basis.

Mr X had a son when he was 16; he has brought him up on his own with difficulty. At the time of referral his son was having trouble in school, with the police and had recently been released from prison for stealing. It appears that this period in prison has changed his son and since then he has engaged in college.

Mr X had terrible debts and had recently heard that he has been made redundant following 14 weeks off work. He feels he has fallen down a hole. He complained about difficulties in relationships and his inability to trust others.

He spoke about his mother leaving him when he was 16, just at the time his son was born. There is a real overall sense of abandonment and, despite not remembering anything specifically happening to him when he was younger, he felt misunderstood in his pain and anxiety which he accumulated over the years.

The MBT programme started on the 9th of October 2011; in the opening sessions he agreed to focus on issues from his childhood and how these have negatively impacted on his life. He reacts badly to issues of rejection, isolation and anger. He wanted to understand his aggression, paranoia, over analysing and his difficulties with relationships.

Psychopharmacological Medication Record (April 2012 – 6 months into MBT programme)

<u>Medication</u> Name	<u>For What</u> Symptoms	<u>Dose / Frequency</u>	<u>How Long / Since</u> When	<u>Last Adjustment</u>
Acamprosate	alcohol anti-craving	333mg	Unknown	Reduction from 666 mg on April 2011
Paroxetine	Depression	40 mg	1 Year	From 30mg to

				40mg (Unknown date, prior to Dec 2011)
Risperidone	Anti-psychotic ('to help me give up smoking weed')	2 mg	Started in Dec 2011 with 0.5 mg and then adjusted to 1mg in Jan 2012	March 2012 – up to 2 mg
Zopiclone	Sleep deprivation	7.5 mg on prn basis at night	Start date unknown but over 6 months ago	Date unknown

Mr X decided to stop all medication apart from Paroxetine on June 2012 and went back to smoking cannabis daily. During the 1 Year Change Interview (CI) he stated that he was now ready to stop the cannabis and go back to the medication.

Psychopharmacological Medication Record (September 2012 – 12 months into MBT programme)

<u>Medication Name</u>	<u>For What Symptoms</u>	<u>Dose/Frequency</u>	<u>How Long / Since When</u>	<u>Last Adjustment</u>
Paroxetine	Depression	40 mg once daily	18 months	Date unknown
Aripiprazole	Anti-psychotic	10 mg once daily	Started on 23 rd May 2012	23 rd May 2012 (to replace Risperidone)
Zopiclone	Sleep Deprivation	7.5 mg on prn basis at night	Start date unknown but longer than 1 year ago	Date unknown but over a year ago

NOTE. Mr X decided to stop all the above medication (apart from Paroxetine) in June 2012 and went back to smoke cannabis.

Pre-Therapy

- Initial consultation with MBT therapist in May 2011; name was forwarded to complex needs service
- 3 appointments with MBT Consultant for the application of the SCID-II and other questionnaires
- Second consultation with MBT therapist in August 2011
- Consultation with MBT therapist in September 2011 and with Principal Investigator for consent form

Results of SCID-II and DSM-IV-TR Diagnostic Hypothesis

Mr X met the diagnostic criteria for several simultaneous personality disorder types: borderline, depressive, paranoid and antisocial. He also demonstrated traits of several other disorders but not enough for a diagnosis.

- Diagnosis: Borderline Personality Disorder (main focus of clinical attention); Depressive Personality Disorder; Paranoid Personality Disorder; Antisocial Personality Disorder.
- Traits: Avoidant; Passive-Aggressive; Schizotypal; Narcissistic; Histrionic

Substance Abuse Disorder

Mr X met the DSM-IV-TR diagnostic criteria for Cannabis dependency and abuse; during a brief period (February to May 2012) he also met the DSM-IV-TR criteria for cocaine and ecstasy abuse.

In addition, Mr X met the criteria for Moderate Alcohol Dependence, with some evidence of withdrawal symptoms. This disorder was in total remission (maintained).

DSM-IV-TR Multi-axial Diagnosis (at pre-therapy)

Axis I	304.30	Cannabis Dependence
	305.60	Cocaine and Ecstasy Abuse
	303.90	Moderate Alcohol Dependency, with some evidence of withdrawal symptoms - In total remission (maintained).
Axis II	301.83	Borderline Personality Disorder (main focus of clinical attention)
	301.9	Depressive Personality Disorder
	301.0	Paranoid Personality Disorder
	301.7	Antisocial Personality Disorder
Axis III		None
Axis IV		Inadequate finances; Difficulties disciplining his son
Axis V	GAF = 45 (current)	

Outcome Data

Table A1 shows the results of three measures evaluated with clinical significance methods over time. After one year of therapy, in comparison with the pre-therapy scores, it is possible to observe positive change in all the three measures: the PQ ($p < .05$), CORE-OM ($p < .05$) and WSAS ($p < .2$).

TABLE A1 – Mr X Outcome Data (analysed with clinical significance methods)

Instruments	Cut-off	RCI Min ($p < .2$)	RCI Min ($p < .05$)	Pre- therapy	5 Months	8 Months	1 Year
Personal Questionnaire	≥ 3	1.0 (↓)	1.5 (↓)	6.8	5.4 * (+)	3.8 ** (+)	3.9 ** (+)
CORE-OM	≥ 1.25	0.43 (↓)	0.66 (↓)	2.45	2.18 (=)	2.39 (=)	1.62 ** (+)
WSAS	≥ 10	7.2 (↓)	10.9 (↓)	28	18 * (+)	28 (=)	20 * (+)

Notes. Pre-therapy measures were taken 1 month before the start of MBT. Values in bold fall within the clinical range; * $p < .2$; ** $p < .05$; ↓ = decreased score indicates positive change; (+) = reliable positive change in relation to first available score; (=) = no change in relation to first available score; (-) = reliable negative change in relation to first available score.

Table A2 illustrates the results gathered from additional measures. No clinical significance methods were used here. After one year of therapy it is possible to observe an improvement in mentalizing capacity from poor to moderate. His cannabis use remains the same (TOP) and his Global Assessment of Functioning (GAF) denotes a slight improvement, despite not moving up from 'serious symptoms'. The Working Alliance Inventory (WAI-S) showed a gradual improvement in the alliance with the therapist from 5 months (1st measurement) to a year (Table A2).

TABLE A2 – Mr X Outcome Data (additional measures)

Instruments	Pre-therapy	5 Months	8 Months	1 Year
Working Alliance Inventory (WAI-S)	N/A	52	56	63
TOP	10-15 spliffs cannabis per day (19g per week)	2g cocaine 1x or 2x per week	Ecstasy once Cannabis once	10-15 spliffs cannabis per day (19g per week)
Mentalizing Capacity	0 (poor)	3 (moderate)	4(moderate)	5 (moderate)
GAF	45 (serious symptoms)	41 (serious symptoms)	51 (moderate symptoms)	50 (serious symptoms)

Notes. WAI-S scores range from 12 (very weak working alliance) to 84 (very strong working alliance); TOP amounts are the average of a 28 day period; Mentalizing Capacity ranges from 0 (poor) to 12 (very high); GAF scores range from 0 (persistent and very severe impairment) to 100 (superior functioning); N/A = Non Applicable.

Personal Questionnaire Data

Once a month Mr X was asked to rate each item on the extent to which it had troubled him over the last week. Items were rated on a 7-point scale, from 1 (not at all) to 7 (maximum possible). Table A3 indicates the duration of each item across Mr X's lifetime, and summarises item ratings at the pre-therapy, 6-months and one-year stages of therapy. Figure A1 illustrates

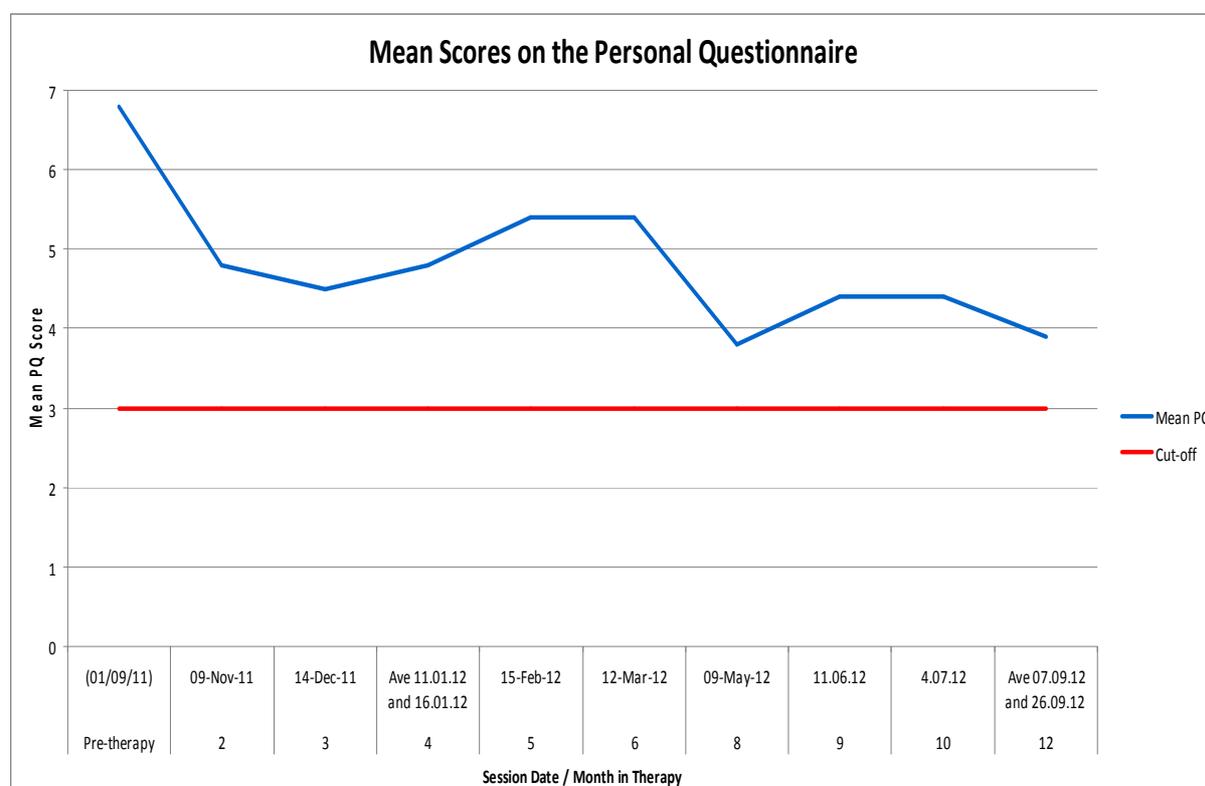
Mr X's mean PQ scores across therapy. After one year of therapy, a statistically significant ($p < .05$) drop of 2.9 points can be observed in the mean PQ score (Figure A1).

TABLE A3 – Mr X PQ Ratings and Duration

Item	Duration of the Problem	Pre-therapy (Sep 2011)	6 Months (March 12)	One-Year (Ave 07.09.12 and 26.09.12)
1. Angry and aggressive	more than 10 years	7	7	4.5
2. Paranoid and worry all the time	more than 10 years	7	6	4.5
3. Over analysing and complicating	more than 10 years	7	6	4.5
4. Feel people are always lying to me	more than 10 years	7	5	5
5. I have no support	more than 10 years	6	5	3
6. Not managing relationships	more than 10 years	7	4	3.5
7. Violent, erratic, mood swings	more than 10 years	7	7	5
8. Having a life	more than 10 years	6	7	4
9. Impulsive (testing)	more than 10 years	7	1	3
10. Always frustrated	more than 10 years	7	6	2.5

Notes. Instructions: Please rate each of the following problems according to how much it has bothered you during the past seven days, including today. Anchors: Maximum possible (7), very considerably (6), considerably (5), moderately (4), little (3), very little (2), not at all (1).

FIGURE A1 – Mr X's Mean PQ Scores across Therapy



Qualitative Data

Client's View of Helpful Aspects of Therapy

The Helpful Aspects of Therapy (HAT) form was completed together with the PQ, both referring to the same session. Patients were asked to note the most helpful aspect or aspects of that session and to apply a helpfulness rating to that aspect on a 9-point scale from 9 (extremely helpful) to 1 (extremely hindering). Mr X completed nine out of twelve HAT forms; three were left unrated or completed inaccurately. The HAT form also gives the opportunity to report a second Helpful Event; Mr X did so on two occasions.

TABLE B1 – Mr X's view of Helpful Aspects of Therapy

Month	Helpful Aspect / What made it helpful	Helpfulness Rating (min 1 – max 9)
09 th November 2011	I came in the group feeling like my best friend had crossed the line with owing me money / When I discussed it with the group and they shared their opinions with me I realized that I hadn't listened to my friend properly and overreacted	8
14 th December 2011	I take a lot out of the group but can't think of just anything this time	
11 th January 2012	On Monday I was saying now that I've given up smoking weed I was gonna give up fags and [Group Member A] said why do it all over night and she was right	
16 th January 2012	I was going to give up fags but had already given up weed and the group said to me why would I want to put that much pressure on myself / They made me realize that I would possibly relapse and when I went home I know they were right as I wasn't thinking straight	9
16 th January 2012	[therapist] had a chat about my concerns and that the support is there	8
12 th March 2012	(rated a helpful event with 8 but left the form blank)	8
09 th May 2012	The fact that the group understand I'm in a bad place doing ecstasy and ended up smoking a joint and how it's affected me / the fact they do things and use them as crutches	8
11 th June 2012	Nothing / Nothing	2
07 September 2012	Being truthful all the time / because it will help me get better	9
26 September 2012	Talking to [therapist] as I really aint feeling well but come in as I always worry that [therapist] would think I was lying and think I was working or couldn't be bothered to attend group therapy / it was helpful and important as [therapist] reassured me that she knows I'm not lying and she believed me	9
26 September 2012	I told [therapist] I know now I need to start reducing my weed ready for me to quit	8

Note. 9 = extremely helpful, 8 = greatly helpful, 7 = moderately helpful

The Helpful Aspects of Therapy (HAT) form also asked the patients to note any aspect of the session which they experienced as hindering or unhelpful. They were asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering. Mr X only recorded one hindering aspect during the first year of MBT.

TABLE B2 – Mr X's view of Hindering Aspects of Therapy Sessions

Month	Hindering Aspect	How Hindering
11 June 2012	Just don't know who to trust up there and haven't felt so low about it as do now	2

Note. Mr X was asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering.

Change Interview Data

Each patient engaged in two Change Interviews (Elliott, Slatick and Urman, 2001); one six months into therapy and one after a year. At each Change Interview they were asked to identify key changes that had taken place, and to make attributions regarding these changes (see Tables C1 and C2). Relevant passages taken from the full interview transcript can be seen on tables C3 to C12 on Appendix G.

TABLE C1 – Summary of Mr X's Changes – At 6 Months

Positive Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. Stopped impulsive texts	Somewhat surprised by it	Very unlikely	Extremely important
2. Calmed down (since stopping the	Very much expected it	Very unlikely	Extremely important

weed)			
3. I can listen more in the group and outside	Very much expected it	Very unlikely	Extremely important
4. I have more money (since stopping the weed)	Very much expected it	Very unlikely	Extremely important

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

Negative Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
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1. More lethargic than at the beginning	Somewhat expected it	Neither likely nor unlikely	Not at all important
2. Impulsiveness for other drugs	Very much surprised by it	Very unlikely	Not at all important

Notes:

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

TABLE C2 – Summary of Mr X's Changes – At 1 Year

Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. Back at work (part-time)	somewhat surprising	somewhat unlikely	very important
2. Texting got a lot	very much expected	somewhat unlikely	very important

better			
3. Thinking differently, more positive thinking	somewhat expected	Somewhat unlikely	very important
4. Greater awareness of what's is happening to me	very much expected	very unlikely	extremely important
5. Less angry and aggressive	somewhat expected	somewhat unlikely	extremely important
6. Not paranoid and worried all the time	somewhat surprising	Somewhat unlikely	extremely important
7. Not always frustrated	very much surprising	very much unlikely	extremely important

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

Summary of Key Descriptions in Change Interview at 1-Year

A summary of key descriptions in Mr X's Change Interviews, organized under different themes is shown in Appendix G (Tables C3 – C12).

Dialectical Procedure / Critical Reflection

A summary of the affirmative and sceptic briefs and rebuttals is presented below (the full version can be found on Appendix G)

Affirmative Brief

The affirmative brief provided evidence to support the following statements (the steps and procedures were the same used for Ms A and Mr Z):

- Substantial changes have occurred in Mr X stable and chronic problems

This statement was strongly supported by the quantitative indicators (Tables A1, A2, A3 and Figure A1). Significant change was observed in all the measures evaluated with clinical significance methods (Table A1). The judgement of the Consultant, when using the additional measures (Table A2), was also considered favourable. In addition, and consistent with other research findings (Horvath and Symonds, 1991), the working alliance seemed to improve gradually along the year correlating positively with outcome.

- Mr X clearly attributes these changes to the influence of therapy

Evidence for this conclusion was found on the 'likelihood without therapy' ratings at the Change Interview (CI) and the level of importance attributed to each change (Tables C1 and C2). Excerpts from the Change Interview (CI), as exemplified below, provided additional evidence of retrospective attribution:

Participant: (...) my thinking's definitely started to change since I've been in group therapy

More examples of Helpful Aspects attributed by Mr X are shown in Table B1 and in Table C3 (Appendix G). Further details and analysis is also provided in Appendix G.

The affirmative brief also suggested, although with less certainty, that:

- The process of therapy in general is linked to the positive outcomes

An attempt was made to connect the content of Helpful Aspects of Therapy forms (HAT) to the changes reported in the Change Interview (see Table E1 in Appendix G). A number of

helpful core themes were suggested 1) the understanding and supportive attitude of the therapist and group members 2) listening to different perspectives 3) observing similar maladaptive patterns in other group members 4) and being able to talk in confidence to the therapist. A second analysis then suggested a number of 'mentalizing' interventions made by the therapist as well as 'corrective emotional experiences' to be linked with the final outcomes (see Table E2 in Appendix G).

- Significant therapy 'events' have helped to reduce the severity of the patient's problems

A number of 'helpful events' were suggested as having a logic and direct link with drops observed on the PQ scores. Examples of helpful processes highlighted were: discussing issues with the group and the group sharing their opinions with Mr X; the group's understanding that he is in a bad place and the realization that other members also have their 'crutches' (see Appendix G for the full analysis).

- No evidence was found for point number 4 (within-therapy process-outcome correlation).

Despite this fact, it is suggested that 'working with current mental states', a mentalizing intervention, may have played a role in the final results.

The affirmative brief concluded that more than the minimum requirements suggested by Elliott (2002) to support the therapy efficacy hypothesis were met.

Sceptic Brief

As with the previous cases, the sceptic brief presented competing explanations for Mr X's apparent changes. The main arguments of the sceptic brief were:

1. Mr X did not change substantially during the first year of the MBT programme and any changes observed are trivial or negative in nature

This conclusion was based on a number of aspects: the permanence of the outcome measures in the clinical range (Table A1); fluctuations between the different measuring points (Tables A1 and A2); the GAF form still showing 'serious' symptoms after one year of MBT (Table A2) and Mr X's relapse into daily cannabis use (Table A2 and CI). The sceptic team also raised problems with the interpretation of the PQ results (Table A3).

2. The possibility of statistical artefacts limits the ability to infer positive changes from this data.

The argument above was grounded on the following concerns: two missing forms on the Personal Questionnaire (Figure A1 above and additional tables in Appendix G); 'regression to the mean by outliers' (Elliott, 2002: p.10) through the possibility of the pre-treatment score being artificially high; the suggestion that experiment-wise statistical errors were present, reflecting apparent reliable differences having occurred by chance alone; and inconsistencies between the qualitative and quantitative data.

3. The self-presentational tendencies of Mr X and the interpersonal dynamics between the patient and the research team confound the data

It is argued that Mr X's accounts at the One Year Change Interview lack *differentiation* (Elliott, 2002) and may also have been influenced by his use of cannabis the night before. Mr X's relational tendencies are also put into question, particularly the fact that he is described as someone who hides his emotions and puts up a 'false front'.

4. The patient's expectation-driven narrative of change accounts for any progress he reported

The sceptic brief gives examples of some of Mr X's 'scripted' accounts, suggesting that these are distant from the client's actual experiences. The fact that Mr X was only surprised or very surprised by four out of eleven reported changes also suggested, according to the sceptic team, that expectancy artefacts were operating in his accounts of therapy at least some of the time.

5. Mr X engaged in self-correction processes both prior to and during therapy; this reduces the likelihood of the MBT programme being responsible for any changes recorded.

The duration of Mr X's problems of more than 10 years (Table A3) makes self-correction an unlikely explanation for any changes observed. However, the sceptic team described a number of situations where Mr X has shown a degree of personal resolve and motivation, believing that this could have influenced the results.

6. Important extra-therapy events occurred in Mr X's life during the treatment period which have been shown to have influenced the patient significantly

Two events were described by the sceptic team as significant for the final outcome: the fact that Mr X had found a job during the MBT programme and his close relationship with a female friend.

7. Psychobiological causes cannot be eliminated as an explanation for patient change

The changes in medication observed during the first year of therapy, plus the several changes Mr X has made in the use of illicit drugs were thought to have a considerable impact on the outcomes of therapy.

8. The reactive effects of taking part in the research process may be contributing to any possible improvements observed

The research was thought to have had an impact on outcome, particularly because Mr X participated in 'an extremely self-conscious way, at times deploring it and on other occasions seemingly deferring to it' (cited in sceptic brief, Appendix G).

Affirmative Rebuttal of the Sceptic Case

The purpose of this rebuttal was to challenge the arguments put forward in the sceptic brief that Mr X changed little during therapy and that evidence existed to support alternative explanations for Mr X's changes. A refutation was presented for all eight arguments made by the sceptic team, in the same order:

1. Different sources of evidence suggest that Mr X changed substantially. The quantitative data strongly points in the direction of positive change surpassing even the minimum criteria suggested by Elliott (2002).

The affirmative rebuttal highlighted a number of mistakes and important omissions in the sceptic positions: the severity and chronic nature of Mr X's problems was not taken into consideration; mistakes on the interpretation of Reliable Change Indexes (Jacobson and Truax, 1991) and how Global Change is inferred (Table A1); not focusing on pre-therapy values as a baseline for comparison (Tables A1 and A2); and biased reading of Tables A2 and A3.

2. The great majority of the quantitative measures used point in the direction of positive change which leaves no room for suspicion that statistical errors, such as 'regression to the mean by outliers' or 'experiment-wise error', were in place.

The affirmative rebuttal made a number of suggestions to overcome the problem raised of 'regression to the mean by outliers' using, to that purpose, a conflation of two or more scores to be used as baseline. Significant improvement was still observed following these modifications (see Appendix G for details). In addition, the chronic nature of the client's problems provided additional evidence that 'regression to the mean by outliers' was not in operation (Elliott, 2002).

The sceptic brief also raised the possibility of experiment-wise error, but rapidly dropped that claim after concluding that the minimum criteria to avoid this error had been met (for example, the requirement for change on two out of three quantitative measures or on one measure at the $p < .05$ level of significance, leading to 'global reliable change').

3. There is enough evidence to assume that Mr X's attributions are plausible and that his responses were not performative utterances to please the researcher or the MBT team.

The affirmative rebuttal presents evidence to show that Mr X is not concerned with pleasing the team. For example: the hindering event presented in Table B1; the negative changes described on the 6-Month Change Interview (Table C1) and the missing aspects of therapy reported during the one-year Change Interview (Table C11 in Appendix G). A refutation on the influence that cannabis may have had on his performance at the Change Interview is also presented (see Appendix G for further details)

4. Mr X was surprised by some (but not all) of his changes which may indicate some expectancy artefacts. However, enough evidence exists to suggest that many of Mr X's accounts were self-reflective and credible as opposed to mainly expectation-driven.

An excerpt of the CI was used showing self-reflection and awareness of his own difficulties:

I feel that I can do it and I know that it'll be for the best of my interest whereas before I think I done it thinking that it was gonna be a... (pause) hundred percent cure (R: Right) Um, you know, I'll come of the cannabis oh I'm going to be a better and it's not going to be as easy as that. Um... (Coughs) it's still going to be a lot of work that I've got to put in um, but I know that.

5. All of Mr X's problems were of more than 10 years duration whilst all of his reported changes were considered to be unlikely without the therapy. Both these facts, together with both the therapist and his own statements regarding the direct influence of therapy, cast serious doubt as to the possibility that self-correction processes alone would cause any of the reported changes (see Appendix G for further details).

6. There is no evidence that the 'extra-therapy events' reported can fully explain the changes. At best, there is a bidirectional influence between these events and the therapy programme itself.

For example, when asked what brought about the changes Mr X did not spontaneously refer to the work situation, one of the extra-therapy events mentioned in the sceptic brief.

On the other hand, the relationship with his female friend was occurring for many years which, by itself, did not affect the severity of his presentation and the results of his assessment.

Finally, an analysis of the 'likelihood without therapy' ratings has shown that all of the changes were considered unlikely (at different degrees) without the therapy.

7. It seems unlikely that the medication would have caused, unidirectionally, the positive changes observed. The unreliable way in which Mr X used the medication would, at best, cause more instability rather than improvement.

8. There is enough evidence pointing to Mr X's resistance to the research process for at least the first 6-7 months of the programme. Even if he was starting to understand the purpose of it all towards the one-year mark there are too many contradictions and it is not possible to affirm that client outcome was affected mostly as a function of being in research

Sceptic Rebuttal of the Affirmative Case

The sceptic rebuttal challenged the validity of the affirmative brief's conclusions arguing that:

1. The affirmative argument cannot sustain the case for substantial or clear change in Mr X's long standing problems.

The sceptic rebuttal disputes the affirmative argument on four grounds: first Mr X's baseline measures were considered to be artificially inflated; second, there were problems with the quantitative data, especially the presentation of the Personal Questionnaire (PQ) results; third, towards the end of the year Mr X appeared to be experiencing a worsening of symptoms; and fourth, at the end of the first year of therapy Mr X still remained in the clinical range in all of the indicators (see Tables A1, A2, A3 and Figure A1; the full argument is presented in Appendix G).

2. The case for retrospective attribution advanced by the affirmative brief is unreliable

The fact that Mr X rated seven of his reported changes as very much or somewhat expected was presented as evidence that expectancy effects were operating. The sceptic

rebuttal also considered that Mr X was not a reliable witness to his own change due to a number of problems: smoking cannabis the night prior to the Change Interview; not having slept well; and the fact that he puts on a 'false front' and had difficulties revealing his true feelings.

Other issues were reported as confounding Mr X's retrospective attributions, such as finding a job and the relationship with his female friend.

3. There are no obvious connections between patient outcome and events that occurred during the MBT programme.

The sceptic rebuttal raised a number of problems such as: the difficulties experienced by Mr X in completing the HAT forms which renders doubts in reliability; the fact that the affirmative brief was only able to map four out of thirteen reported changes; and the possibility that some of the changes reported during the six months Change Interview were not sustained through to the one year mark.

An analysis of PQ individual items was also made and further challenges arose, such as the time gap between the reported 'process' and the corresponding outcome.

4. No correlations between therapist MBT adherence and PQ ratings have been established (see Table D1 in Appendix G)
5. Therapeutic events cannot be convincingly shown to have led to a stable shift in client patterns.

The sceptic rebuttal made two main arguments, in summary: 1) that there were no clear links between Helpful Aspects of Therapy (HAT) events and PQ scores for the same session and that any connections forwarded by the affirmative brief had alternative explanations 2) **in** terms of the link between the HAT events and PQ ratings over the following months, the sceptic

rebuttal claimed that the affirmative brief has only managed to link two HAT events to such changes: Mr X discussing his friend owing him money on 9th November 2011 and the group understanding his drug use and identifying with it on 9th May 2012. Furthermore, it was raised that ten HAT events (Table B1) had not been linked to PQ ratings for the following months, highlighting only a very tenuous connection at best.

Adjudication

The three judges working on Mr X's case were blind to each other's participation guarantying, in this way, an independent judgement.

Their individual conclusions are shown in Table E1 below which includes the mean and median of their scores.

Following Stephen, Elliott and Macleod's (2011) suggestion, greater weight was given to the median scores which were taken as the best representation of the judges' decision.

In this way, taken together, the overall opinion of the three judges was:

- That Mr X changed moderately (40%) over the course of therapy (80% certainty)
- That the changes were substantially (80%) due to the effects of therapy (80% certainty)

TABLE D1 – Adjudication Decisions for Mr X / Judges Mean and Median Scores

	Judge G	Judge H	Judge I	Mean	Median
1a. To what extent did Mr X change over the course of therapy?	40 %	40%	80 %	53 %	40 %
1b. How certain are you?	80 %	80 %	80 %	80 %	80 %
2a. To what extent is this due to the therapy?	60 %	80 %	80 %	73 %	80 %
2b. How certain are you?	100 %	60 %	80 %	80 %	80 %

Note. The anchor given to judges was: 0% (nothing); 20% (slightly); 40% (moderately); 60% (considerably); 80% (substantially) and 100% (completely)

Summary of Judges' Opinion (for the full version see Appendix G)

Judge G considered, with a substantial degree of certainty (80 %), that Mr X changed only moderately (40%). She based her judgement on the scores of the quantitative measures (particularly in Table A1), and the fact that Mr X's problems were of over 10 years duration. She was not 100% sure due to some potential statistical issues. Change was rated as only moderate (40%) as there were some aspects that appeared to not have changed for the client, or that had reverted to a similar position as they were at baseline, for instance, his cannabis use, although the judge agrees that his understanding of the problem and self-awareness has altered serving as an important pre-requisite for behavioural change.

Judge G decided, with 100% certainty, that the changes achieved by Mr X were considerably (60%) due to the therapy. The judge based her argument mainly on the data coming directly from the client, i.e. the Change Interview. The client's attributions of change were considered to be valuable and credible data, in particular as they were idiosyncratic and specific to Mr X's situation – for example, being heard by the group, gaining increased understanding about his relationship with his best friend.

The judge discredited the sceptic argument for expectancy artefacts, stating that it was not sufficient to justify the strong statements the client made as to how he perceived the changes. The high ratings on the Helpful Aspects of Therapy form (HAT), as well as the processes described (e.g. support from the group and trust in the therapist) were also important for the judge's decision. Furthermore, the judge commented that these ratings seemed to correlate with particular event-shifts on the PQ ratings.

Judge G understood the difficulties in finding process-outcome correlations in the context of research literature, pointing to the lack of a dose-response relationship in terms of improvement. In this way, importance is given to the 'entire therapeutic encounter' rather than to singular therapy events.

In summary, judge G considered the following therapy processes to be important: the support provided by the group; the experience of hearing other people's views about his

difficulties; increased resilience and compassion for himself resulting from the empathy and understanding of the group; the therapist's and the group's commitment to showing Mr X that he is trusted. The judge noted, in relation to the above processes, that Mr X's most improved scores on the PQ related to the items 'having no support' and 'not managing relationships'.

Judge G also commented on a number of characteristics and/or personal resources of the client serving as moderator factors, in summary: Mr X's readiness to change; personal strength and self-directedness as catalysts of the therapy process; and perseverance.

Judge H considered, with 80% certainty, that Mr X changed only moderately (40%). She believed that the change was not global and that the client was not psychologically ready to change more than he did. The judge seemed to be unsure whether Mr X learned to neglect his issues or, instead, if he felt less distressed and ready to give up cannabis.

Judge H decided, with 60% certainty, that the client changes were substantially (80%) due to the therapy. The judge did not think the changes were due to the medication, as the client's history suggests. She believed that Mr X tried to control therapy as if it was his life, making him feel less clinically distressed.

For judge H, the feedback from other group members were perceived by Mr X as 'being cared for' which was a fundamental therapeutic process.

The ability of Mr X to hear others, in spite of his paranoid traits, was considered an important personal resource and, therefore, a moderator factor.

Judge I considered, with 80% certainty, that the patient changed substantially (80%). The judge put weight in all the available data but more on Mr X's background information.

The judge thought that the patient made several changes – the more obvious two being that he returned to work, after struggling to maintain a job because of his anxiety whenever he was out of the house. He also previously struggled with forming and maintaining relationships

and reported being paranoid, yet he managed to establish a strong working alliance, use the group as a support system (both of which require trust) and start a romantic relationship.

From Judge I's perspective, the patient also made 'psychological' changes – he has increased awareness and reflexivity into his own process.

Judge I decided, with 80% certainty, that the patient's changes were substantially (80%) due to the therapy. The judge commented on the difficulties and impossibility in finding single 'causal links'. However, it seemed clear for the judge that the long term difficulties of Mr X (over 20 years) could not improve in one year without the influence of therapy. She also reiterated that the patient himself attributed the changes to the therapy.

Judge I noted that many of Mr X's changes were in the realm of relationships, stressing that therapy may have served as a safe environment from which he could learn and apply this to new settings.

The judge felt that a number of therapy processes were helpful for the client, in summary: building trust; the structure of therapy and its routines, helping him to get out of the house and face the 'panic'; receiving feedback; and the opportunity to reflect.

Finally, the judge considered Mr X to be honest, perseverant and willing to change. These personal resources were classified as moderator factors, facilitating the change.

MEAN AND MEDIAN RESULTS FOR THE THREE CASES

Although with some variation (see Table F1), the median response of the nine HSCED Judges regarding the three patients was that the patients changed considerably (median 60%) and that the change was substantially due to the effects of therapy (median 80%). The reason presented by the majority of the Judges not to decide on *substantial* change (80%), the standard proposed by Elliott (2002), had to do with the chronic nature of the patients' problems as well as their level of severity.

The judges experienced a high degree of certainty over their decision (median 80%).

TABLE E1 – Mean and Median Responses for the 9 Judges

	Ms A Mean for Judges A, B and C	Ms A Median for Judges A, B and C	Mr Z Mean for Judges D, E and F	Mr Z Median for Judges D, E and F	Mr X Mean for Judges G, H and I	Mr X Median for Judges G, H and I	Mean For the 9 Judges	Median for the 9 Judges
1a. To what extent did the patient change over the course of therapy?	53 %	60%	47 %	60 %	53 %	40 %	51 %	60 %
1b. How certain are you?	67 %	60 %	80 %	80 %	80 %	80 %	76 %	80 %
2a. To what extent is this due to the therapy?	60 %	60 %	80 %	80 %	73 %	80 %	71 %	80 %
2b. How certain are you?	67 %	60 %	80 %	80 %	80 %	80 %	76 %	80 %

Note. The anchor given to judges was: 0% (nothing); 20% (slightly); 40% (moderately); 60% (considerably); 80% (substantially) and 100% (completely)

DISCUSSION

Discussion of the Findings

Methods and Outcome of the Research

The evidence produced through various sources, namely the outcome measures, the interpretation of the affirmative and sceptic teams and the decision of three judges per case, give a clear indication of *considerable* positive change in all the three patients, assumed to have been caused, to a *substantial* degree, by the therapy programme.

The high level of certainty experienced by the Judges over their decisions (median 80% for the two questions in Table F1) indicates that the rich case record and the researchers' arguments were sufficiently clear. However, there is considerable variance in the decisions about change, ranging from mildly (20%) to substantially (80%). This was somehow expected, due to the complexity of the cases. Nevertheless, it could also highlight a number of methodological issues, at different levels. A number of problems/questions are first raised and then possible answers are suggested for each point:

1. Quality of the Instruments Used

- Clinical significance methods and Reliable Change Indexes (Jacobson and Truax, 1991) were only used in three out of six outcome measures. Out of these three, only one (CORE-OM) has been widely used in secondary care settings appearing to be suitable and reliable for complex cases with severe psychopathology (Barkham et al, 2005).
- The overall preference for generic measures of distress over measures for specific problems or symptoms - for example, depression, interpersonal relationships, self-harming behaviour, impulsiveness and use of psychiatric services – see Bateman and Tyrer (2004).

2. Data Collection

- The data loss and possible distortion of meaning arising from the monthly collection of outcome measures that were tailored for weekly use (HAT and PQ)
- The pressure and influence generated by the group therapist in requesting the completion of the forms every month (even if these were put in a sealed envelope only for the researchers to see)

3. Data Analysis

- Inadequately completed forms, due to the complexity of the cases, leading to important gaps in information and difficulties linking process and outcome
- Repetitive patterns in the affirmative and sceptical arguments, with the affirmative emphasising the value of subjective data from patients while the sceptic doubting this.

4. Adjudication

- Was the reading of the anchors in the rating system homogeneously understood by the Judges?
- Did the Judges differ in their own definition of *substantial* change?
- Were the questions too open, leaving excessive margin for subjective opinion?
- Did the Judges want to please or help the researcher – were they biased in favour of positive outcome?

Despite the fact that many of these issues have been predicted and discussed in previous chapters, its impact may have still been relevant and further discussion is justified.

1) Instruments. The Work and Social Adjustment Scale (WSAS) was chosen for a number of reasons: quick and easy to use (only five questions of multiple-choice); easy to understand and relevant to the patients' problems. Adding to these, the WSAS was already

being used in routine evaluation which could help create minimum disruption in the running of the service. However, there was one significant problem: the measure did not have psychometric data available in cases of personality disorder and addiction. Since all the patients were diagnosed with Depressive Personality Disorder, a decision was made to use the data from the depression studies (Mundt et al, 2002). This left us, however, with a significant problem, since no comparison to other studies is possible.

It is known that social functioning is the area with greater resistance to change in patients diagnosed with personality disorder, in particular when combined with complex addiction problems. Judge A, for example, emphasizes this point. Using a specific behavioural scale to measure self-harm, suicidality or number of hospital admissions could have changed the perception of change, making the Judges opinions more uniform.

2) Data Collection. The decision for monthly collection was mainly of a practical nature due the very high number of sessions and patients (these problems were discussed at length in 'Data Collection'). Measuring every session for each of the three cases, would generate over 500 forms to analyse! However, the choice for monthly ratings may not have resulted as well as expected, as important fluctuations were lost. One solution for future studies could be to use the PQ every week but to abandon the use of the HAT, relying only on the information from the Change Interview (CI). However, the recommended frequency for using the CI, particularly if no other source of data on helpful aspects of therapy is available, is every eight sessions (i.e. one month in twice weekly therapy), which would mean an average of ten interviews to transcribe and analyse for each patient. This may also prove impractical, so other solutions are needed when using multiple case studies for researching complex treatment programs such as this.

The pressure generated by the therapist's request for monthly completion of the HAT and PQ is another problem for which no easy solution was found. Different options were discussed and tried unsuccessfully: taking the questionnaires home led to some not being returned; completion after the session in the waiting room led to the same result; and having someone else, another therapist or researcher, coming to the therapy room to request the forms

seemed too disruptive of the therapy process. The best solution, despite some clear disadvantages, was for the therapist to request them at the end of the session. Again, the choice was to only do this once per month to avoid disrupting the treatment.

On the other hand, the involvement of the therapist in this process may have created a greater sense of *integration* between research and clinical practice, where the research instruments become *part* of the treatment being often a theme of discussion and reflection. This 'extra element' could have generated a process of 'appropriate responsiveness' (Stiles, 2009) which, in itself, can optimize the findings and confound the effects of treatment with the research, even if an effort was made to conceal the questionnaires from the therapist and to ask questions to the participants about the possible influence of research (undertaken during the Change Interview).

3) Data Analysis. This was particularly true with the Helpful Aspects of Therapy (HAT) form which patients described as difficult to understand and hard to complete in the 'heat of the moment'. Educational sessions prior to the start of the research programme could be a solution or, alternatively, as suggested above, abandon this form altogether and gather this information from regular interviews.

The repetitive pattern observed in the 'affirmative' and 'sceptic' briefs could have been avoided by swapping the roles for different cases. However, the HSCED method follows specific steps which could, by itself, cause this sense of repetition when analysing multiple cases.

4) Adjudication. This problem, discussed recently in Stephen, Elliott and MacLeod (2011), is complex and is still without answer. Introducing a stringent definition of change could affect the richness of the process, taking the value of *hermeneutics* away. For example, Judge I added a category on one of the adjudication tables (see Appendix G) saying that her arguments were influenced to a great degree by her own definition of patient change.

On the other hand, leaving it too open to interpretation can create difficulties in producing a consistent body of evidence. One solution, used in this research, is to use Judges of different theoretical orientations, and then see if they reach similar conclusions. When the

conclusions are too disparate as, for example, with Mr Z and Mr X, a fourth Judge should be consulted.

Arguably, the openness for dialogue, discussion and reflexivity is a strong feature of the HSCED methodology. However, I also wonder if leaving it too open could dilute the results. Perhaps greater systematization is needed, without jeopardizing the value of 'interpretation' and 'hermeneutics'.

The fact that different judges have been persuaded by different arguments (affirmative or sceptical) can also demonstrate that these were not particularly biased.

There is also the possibility that some of the Judges, particularly the less experienced ones, may have wanted to please the Principal Investigator as a way of returning the 'consideration' that he showed in choosing them for the study. They may have thought that a negative opinion would be less appreciated by the researcher. Despite all the effort dedicated to an independent and unbiased opinion this possibility is still worth considering in any future research (see 'Procedures for the Judges and Adjudication Phase').

Notwithstanding many of the problems above, the overall tendency of the Judges was to give more importance to the data coming directly from the patient (e.g. the Change Interview), showing that the HSCED method is robust enough to allow for conclusions to be made, even if part of the data is inconclusive (e.g. quantitative instruments). Judge C, for example, states that 'it is naïve to expect evidence of linear and neat change-sequences when the presentation is of this complex nature. (...) therapy can go on for months and even years with ups and downs that do not always reflect the quality of the work directly week-on-week. It is the cumulative effects of therapy, rather than week-to-week processes that count, in my experience, when working at the end of the spectrum of presentation.'

Most psychotherapy programs for this client group, including the one in analysis here, are of 18 to 24 months duration. However, the positive results observed in this study are

evidenced after only one-year of treatment, a result that is aligned with other studies that showed a reduction of symptoms starting as early as four months after the start of treatment (Bateman and Fonagy, 1999; Chiesa et al, 2004).

On the basis of the positive results observed half-way through the MBT programme (One-Year), it seems reasonable to suggest that, by the end of the programme (2-Years), the patients will experience further and more substantial change. It seems likely that the potential of the patients' therapeutic process was not fully realized yet. This raises the question of whether the changes observed at One-Year can be sustained, and potentially increased, towards the end of therapy mark (2-Years) and also at follow up. We will be able to answer these questions at the second stage of this project, where measurements are predicted at the end of therapy and at 6-months follow up.

The fact that the clients were selected according to common characteristics- mixed diagnosis of borderline and depressive personality disorders; difficulties with psychotropic substances; chronic problems with over ten years duration - can help in making assumptions for future treatment.

Process

The study has also revealed a number of common client characteristics operating as moderator factors, which could help further in making generalisations: motivation for change, determination, and perseverance. In all the three cases there were also positive changes occurring in the external environment, which could be related to the therapy although it is not possible to infer that categorically in all cases.

The moderator factors discovered are aligned with Orlinsky, Rønnestad, and Willutzki's (2004) studies on the working alliance showing that some of the key predictors of positive outcome are the client's level of active participation, willingness to work collaboratively and cooperatively with their therapist, and openness to the process.

The motivation and determination shown in all the three cases is arguably co-created via the preparation stage of the programme, the commitment and skill of the team members, the extra concern given for being in a research program, and the pre-existing willingness of the patients, rather than coming solely from them.

This research has also shown a number of common therapeutic processes that seemed to have been helpful for the three cases. Aspects related to the group stood out as the most important and common to all three patients, being often translated into 'real life' out-there: the support, empathy and understanding from the group as well as the identification with other people's stories; the experience of new interpersonal relational patterns; the experience of receiving feedback and hearing other people's views; and the commitment of the group to show trust for each other. These processes could have been decisive for the affective internal transformation observed; overall, the patients felt more trusted, cared for, confident, and with increased resilience and compassion for themselves. In fact, similar therapeutic factors for group psychotherapy had previously been identified by Bloch and Crouch (1985), who were themselves building on the work of Yalom (1985).

Other processes reported as helpful for all the cases were: the quality of the working alliance with the therapist, her level of commitment and the consistency and reliability shown throughout the year 'never missing a session apart from once when she was having serious personal problems'; the reflective stance of the therapy programme, providing several opportunities for 'thinking'; the structure of the therapy and its routines; the extra help provided by the psychosocial nurse and the opportunity for one-to-one time with her.

In addition, the overall sense taken from the patients, the practitioners, the researchers and the HSCED judges was of the MBT programme as a 'secure base' where patients felt held and contained, allowing them to mentalize and improve emotional regulation.

Many of these processes appeared to also help the patients integrate and accept parts of themselves previously perceived as 'shameful', 'ugly' or 'blameworthy'.

Most of the findings from this research, either taken individually for each case or taken together for the three patients, seem to be consistent with the research literature and the 'Dodo-bird Hypothesis', showing that common elements, rather than specific techniques, have the greatest influence in change (Bateman and Tyrer, 2004; Wampold, 2001; Imel and Wampold, 2008). The quality of the working alliance has probably been the most consistent common element in research studies (Orlinsky, Rønnestad and Willutzki's, 2004) and was once more established as important. However, certain elements found to be essential in this study have not been given enough attention in the literature, such as the warmth and dedication of the therapist and the therapy team, as well as their ability to be consistent and reliable throughout the programme. The capacity to maintain such a stance, whilst also keeping strong and clear boundaries appears to be of fundamental importance; however, this is difficult to capture in large research studies that do not look at the minutia of the work.

Mentalizing Capacity and Symptom Improvement

As mentioned above, common elements to most psychotherapies, rather than specific techniques (e.g. mentalization strategies) have shown to have the greatest impact on outcome. However, it is curious to note that the mentalizing capacity of the patients seems to have improved alongside the reduction of symptoms (see Table A2 for each patient). This leaves one of our earlier questions unanswered: whether the reduction of symptoms and the increased capacity to regulate emotions is caused by the improved mentalizing ability, maximized by the therapy situation or, instead, if mentalizing more effectively is in itself an outcome, resulting from the overall improvement in functioning. This problem is the theme of larger discussions in the field; for example, Bateman and Fonagy (2006) see emotional regulation or dysregulation as secondary to a mentalizing problem whilst other authors, like Schore (1994) or Siegel (1999) see it as the primary problem. A greater contribution towards this discussion could have been achieved by using a more robust MBT adherence scale such as the 17 item Mentalization-Based Treatment Adherence and Competence Scale (MBT-ACS; Karterud et al, 2012). At the

time the instruments for this project were selected this measure had not been widely tested; nonetheless it is still a limitation that could be easily avoided in future research.

Treatment of Substance Misuse

The present findings put into question the commonly used exclusion criteria for patients with addiction problems in Counselling Psychology and Psychotherapy services. This barring of addictions has been practiced along the years in the UK and elsewhere, being in treatment or in research programmes. Our study is one of the few that accepted patients with addictions in a psychotherapy programme. Other exceptions are Philips, Kahn and Bateman (2012) in Stockholm and Bales et al (2012) in the Netherlands. The potential for service development is clear, since most psychology and psychotherapy services still refuse to work with this type of co-morbidity.

Other Findings

A number of questions can also be raised regarding the slightly lower rate of change observed in Mr X, comparing to the other two cases. Mr X was only considered to have changed moderately (median 40%) by the three Judges allocated to his case, comparing to 60% (median) for the other two participants. This can be due to his additional diagnosis of anti-social personality disorder, known in the literature for being treatment resistant (NICE-77, 2010), although it is not possible to infer this based on one case alone. It is also possible that this additional diagnosis may have biased the Judges' opinions. More research is needed to assess whether the slower rate of change observed in cases similar to Mr X is due to the anti-social characteristics of his personality or due to other factors. This may also highlight the importance of a developmentally based dimensional system for the classification of Mental Disorders that could help group the patients by aetiology and 'personal characteristics' rather than just a 'category' or 'diagnosis' based on symptoms alone. There were proposals for the new DSM V to

move in this direction whilst also creating a number of new 'categories' that may prove very unhelpful (Kraemer, 2007).

Critical Evaluation of the HSCED Method

This study gave us the opportunity to test the use of HSCED in new territory, due to the nature of the patients (complex cases) and the type of therapy under study (a structured programme, with various components, using group psychotherapy as its basis). I decided to introduce a new development, by asking the therapist to provide three-monthly reports answering the same research questions as the two researchers. This proved very useful in backing up or disconfirming the researchers' conclusions.

Since many of the processes resulting from the Change Interview and Helpful Aspects of Therapy (HAT) forms relate to aspects concerning the group, I conclude that it is a limitation not to have analysed the group process directly using, for example, a measure of group cohesion to explore possible links with outcome. I recommend that any future research of this type uses a measure that can capture these processes.

The HSCED method, consistent with my own ideas of 'truth' and 'reality', can be seen as being post-positivist, aligned with such philosophies of science as critical realism (Bhaskar, 1978) and dialectical constructivism (Greenberg and Pascual-Leone, 2001 as cited in Elliott et al, 2009). These philosophies encourage conflict and the opposition of different views as a way of generating more useful assumptions about the problem under scrutiny. Several assurances were put in place to increase the validity of our findings, such as the adjudication made by a team of expert judges and the use of two different researchers for the production of the affirmative and sceptical positions. However, in research of this type, with such complex group dynamics under inspection, a number of important methodological questions come to light: is it possible to answer the HSCED research questions (made with an objective tone and predicting a 'yes' 'no' type of answer) using a hermeneutic and very subjective method that tries to reach only 'reasonable assurance' or an answer that is 'beyond a reasonable doubt' (Elliott et al, 2009;

Polkinghorne, 1983)? Is it possible to reduce such a complex data set compiled through the 'rich case record' to a simple single answer (McLeod, 2010)? With so many variables in operation it is questionable whether the lowered degree of certainty proposed by Elliott et al (2009), from the traditional $p < .05$ or $p < .01$ used in social sciences to the considered more realistic and useful standard of $p < .2$, is still too high. However, if the degree of uncertainty considered tolerable is increased further, would the meaning and validity of the research be compromised?

The use of such an intense method of data collection and analysis, and the use of dialectical debates over vast amounts of information, raises more questions than answers. We seem to have reached 'plausible' conclusions based on dialectical debates and the adjudication of a judging team. There was a clear 'search for the 'truth'', concomitant with the acceptance that this truth is only relative. However, the more information we accumulated and the more we debated, the more questions were raised that we had no way to answer. For example, what was the impact of the quality of relationships between the researchers and the psychotherapy team in the collection and interpretation of the data? The fact that I, as the Principal Investigator, have previously been an Honorary Psychotherapist within the team cannot be ignored and may have influenced the findings. For example, I was strongly involved in the creation of this psychotherapy programme for dual diagnosis and it was my conviction and desire that this would work. The use of a 'sceptic researcher' may have helped in counterbalancing the possibility of bias.

Another pertinent question relates to the quality of relationship between the two researchers, also previous colleagues in the psychotherapy team, and the possible influence this created on the enthusiasm of their arguments and rebuttals. Also, how can we measure the impact of power structures in the organization and the influence it had on practitioners and researchers? For example, the fact that I, as the Principal Investigator, had previously been under clinical supervision with the Consultant Psychiatrist in Psychotherapy and Head of Department, who later became part of my research team, under my instruction, is an important variable to consider. The attempts of the consultant to still 'guide' and 'direct' me were

inevitable, although a culture of 'enquiry' and acceptance of whatever findings appeared to have been gradually established. It is questionable whether the researchers could be less 'influenced' if they were independent from the service. Nevertheless, they would also lose sight of a number of important 'nuances' that are only observable by 'being there'.

Furthermore, and despite the clear potential for biases, I operate under the belief that researcher and researched are an indivisible unit that can never be separated, but rather become *figure* or *ground* at different times and under different pressures (Orlans and Van Scoyoc, 2009). Despite the strict control of the variables in RCTs, for example, it is curious to note that many of their findings are usually in the direction that the researcher desires (effect known as 'researcher allegiance'), showing that it is impossible not to influence the results (Elliott and Freire, 2008). What distinguishes this type of research from RCT's, who strictly control the variables, is the conscious acknowledgment of this impossibility of separating figure from ground which, in itself, creates a research environment that encourages reflexivity and the attempt to name the complex dynamics in operation. This kind of attitude also brings the research closer to the reality of services, since they do not normally operate under laboratory, controlled conditions. This raises the question, common in the literature, whether RCT's are correctly placed as the 'gold standard' of research since the control of variables creates a situation that is unlike clinical reality (Seligman, 1995).

Correlations

The statistical analysis carried out comparing outcome rating scales (Personal Questionnaire - PQ) with adherence has its limitations. It is compromised by the non-independence of observations involved, which can create spurious results. It would have been more appropriate to carry out this type of analysis with a larger sample using independent observations rather than attempting it within the current small scale case study approach.

The Issue of Generalizability

According to Chambless et al (1998), case study evidence requires at least nine cases (with control) so that the status of 'well established treatment' can be attributed. According to the same study, three cases would be enough for the designation of 'probably efficacious' treatment. However, it would require the comparison with a control case where no treatment had been administered. This means that, however useful the HSCED method may be for practice and practitioners, it is just a minor part of the complex process of evidence building.

CONCLUSIONS

Based on the rich case records presented and the corresponding analysis, it is plausible to assume that patients with mixed personality disorders - in particular of the borderline and depressive types – presenting also with co-morbid substance addiction can achieve identifiable change with a structured programme of mentalization-based psychotherapy already after the first year of a two year treatment programme. A reduction of symptoms seems to occur very rapidly, in some cases during the first month of treatment, being then sustained until the One-Year mark. Further measurements and interviews will be undertaken at the end of the programme (2-Years) and at 6 months follow-up, helping to consolidate or disconfirm the present conclusions. Despite some variations, the median conclusion of the nine HSCED judges was that, after One-Year of MBT, the patients have changed *considerably* (60%). They concluded, with 80% certainty (median), that the changes were *substantially* (80%) due to the effects of the therapy programme.

This study allowed also for specific insight into the processes that led to the changes, showing that common elements in all psychotherapies, rather than specific mentalization techniques, had the greatest impact on these preliminary outcomes, a conclusion that supports the meta-analytic studies on common factors (e.g. Imel and Wampold, 2008).

The use of the HSCED method in this setting and with this level of disturbance was unmapped territory. It has shown the potential to answer important questions whilst integrating multiple variables and viewpoints. Despite the clear potential for use in non-randomized samples and naturalistic settings, a number of questions were raised regarding the scientific validity of having such a high degree of uncertainty resulting from such varied and relative viewpoints. This indicates that more work is needed in developing and systematizing the method and its applicability for multiple cases in complex settings.

Replication of this study is required so that a body of 'case law' can be developed to allow for stronger conclusions and generalizations regarding the efficacy of MBT in mixed

personality disorder and addiction as well the specific processes that facilitate the change. Other research methods may also be required to complement the evidence gathered through HSCED.

Contribution and Implications for Future Research

This research project has been particularly relevant at a local level. Our findings are of significant importance for the future delivery of MBT within the Personality Disorder Service at this Mental Health Trust as they can serve as base for service improvement and development. This effect is already visible with great learning achieved by all involved.

The knowledge acquired was also of considerable value to the three Drug and Alcohol Services within the region as it helped shape their service provision for this challenging client group. A mentalizing attitude, meaning more reflection and less impulsivity, was gradually introduced within team meetings through clinical discussions and presentations. It was also disseminated to other services through local drug and alcohol events and conferences (e.g. Pereira, 2011).

The links with the Specialist Personality Disorder service were also improved. Further changes have been implemented with the training partnership developed between me and the Head of Psychotherapy Services where we set up a number of seminars and workshops currently being delivered at Universities and National Conferences (Pereira and Heydari, 2012; 2013; 2013a). This follows on from a period of great interest from various organizations that still remains, leading me to present the project at various conferences and to deliver seminars and lectures, both nationally and internationally (Pereira, 2010a; 2010b; 2011; 2011a; 2012; 2012a; 2013; 2013a).

Providing funding becomes available, I expect that more change will come in the form of formal recruitment of MBT trained staff to work in the Drug and Alcohol Service in close liaison with the Psychotherapy Department. The possibility of recruiting a Counselling Psychologist to the CDAS team was already mentioned by the senior management.

A major contribution, currently in discussion between managers of the NHS Trust and commissioners, is the complete redesign of personality disorder and complex needs services in the region, with plans to establish Day Units with multidisciplinary teams using structured programs of MBT. A recent presentation I made at the Psychiatry Training Scheme of this Trust has contributed significantly to the confidence of commissioners.

The relevance of this study in the current economic climate is clear, since the effectiveness of an intervention will save money in the medium to long term. It has shown to be of particular importance to the development of the Specialist Personality Disorder service at this Trust and to the Drug and Alcohol Services. In the medium to long term, with the continuation of the MBT programme and its repercussions, it can also provide indirect benefits to CMHT's and A&E departments by reducing caseloads and hospital admissions. This runs accordingly with the NIMH(E) (2003) recommendations for research within the specialist personality disorder teams established in the UK.

The use of the HSCED method in new territory will be invaluable for other researchers, practitioners and service managers wishing to evaluate particular interventions.

This research will be of particular weight to the field of Counselling Psychology and I trust it will initiate a process of bridging the gap between Counselling Psychology, MBT and the group-analytic tradition.

Finally, this project will appeal to practitioners working with personality disorders and substance abuse since it provides detailed accounts of therapist's interventions and how they were perceived and/or taken by the patients.

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APPENDICES

APPENDIX A

Ethical Approval and Sponsorship

governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Protocol	Version 2.0	15 February 2011
Response to Request for Further Information		
REC application	62385/17302 5/1/273	06 January 2011
Questionnaire: Helpful Aspects of Therapy Form (H.A.T.)		
Questionnaire: Simplified Personal Questionnaire		
Questionnaire: Treatment Outcomes Profile		
Questionnaire: Working Alliance Inventory (WAI)		
Letter from employer, Ales Dezman		29 September 2010
CV for academic supervisor, Maja O'Brien		04 January 2011
Psychotherapy Consultation Appointment	Version 2.0	15 February 2011
Participant Information Sheet	Version 2.0	15 February 2011
Interview Schedules/Topic Guides	Client Change Interview Protocol	
Questionnaire: Global Assessment of Functioning (GAF) Scale		
Investigator CV	Joao Pereira	17 December 2010
Participant Consent Form	Version 2.0	15 February 2011
Summary/Synopsis	Version 2.0	
Letter from Sponsor	South Essex Partnership University NHS Foundation Trust (Dr H Heydari)	30 November 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

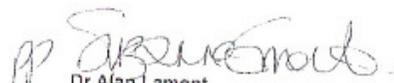
The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/H0301/4	Please quote this number on all correspondence
------------	--

With the Committee's best wishes for the success of this project

Yours sincerely


Dr Alan Lamont
Chair

Email: suzanne.emerton@eoe.nhs.uk

Enclosures: "After ethical review – guidance for researchers" [SL-AR1 for CTIMPs, SL- AR2 for other studies]

Copy to: Ms Sarah Thurlow
South Essex Partnership University NHS Foundation Trust
Pride House
Christy Close
Southfields Industrial Estate
Laindon
Essex
SS15 6EA



What Works in Mentalization Based Treatment: systematic case studies

REC Name: Essex 1 Research Ethics Committee

REC reference: 11/H0301/4

Title: What Works in Mentalization Based Treatment: systematic case studies

Research summary

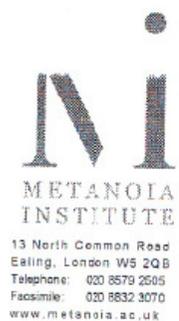
Research Summary not yet available

Opinion: Favourable Opinion

Date of REC opinion: 28/02/2011

Date published: 02/03/2011

[Back](#)



João Pereira
3 Ormanton Road
Sydenham
London, SE26 6RB

7th March 2011

Dear João,

RE: *What Works in Mentalization Based Therapy: systematic case studies in personality disorder and addiction.*

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as Chair of the Research Ethics Committee.

Yours sincerely,

Dr Patricia Moran
Chair of Metanoia Research Ethics Committee
Integrative Department

Providing Partnership Services in Bedfordshire,
Essex and Luton



27 January 2011

Directorate of Clinical Governance & Quality

Pride House
8 Christy Close
Southfields Industrial Estate
Laindon
Essex SS15 6EA

Joao Pereira
South Essex Partnership NHS Foundation Trust,
CDAS - Community Drug and Alcohol Service
Grays Hall,
Orsett Road
Grays, Essex

Tel: 01268 407811

Fax: 01268 407810

E-mail: andrea.bedford@sept.nhs.uk

Chair: Lorraine Cabel
Chief Executive: Dr Patrick Geoghegan OBE

Dear Joao

Research Study: What works in mentalisation based treatment: systematic case studies

On behalf of the Research Governance Steering Committee I can confirm that your application was reviewed at the meeting that took place on the 27 January 2011. The Committee considered your project to be very worthwhile and have approved your application subject to a favourable opinion from the Research Ethics Committee.

If the Ethics Committee require amendments to any of your documentation please provide me with copies of the revised documents by email care of Andrea Bedford (andrea.bedford@sept.nhs.uk) or by post to the above address so that I can review any amendments on behalf of RGSC. I will write to you again confirming final approval once a favourable ethics opinion is received.

A signed copy of this letter will be posted to you within the next week.

With kind regards.

Yours sincerely

Jenny Secker
Professor of Mental Health
On behalf of the Research Governance Steering Committee

www.sept.nhs.uk



South Essex Partnership University 
NHS Foundation Trust

may only delegate such responsibilities in their area if agreed in writing by both Parties.

For and on behalf of

The Metanoia Institute

Name: K. FROHANT

Title: HEAD OF CENTRAL SERVICES

Signature: 

Date: 11/4/11

For and on behalf of

**The South Essex Partnership University
NHS Foundation Trust**

Name: Peta Birch

Title: Associate Director Clinical
Governance & Quality

Signature

Date: 24.03.11

Schedule 1

Assignment of Sponsor duties between parties

Sponsor Duty	Assigned to
The research proposal is worthwhile and of a scientific quality that is appropriate for a student postgraduate project	The University
Ongoing management/supervision of the project	The University
Intellectual property rights and their management are appropriately addressed	The Trust
Arrangements proposed for the work are consistent with the Department of Health Research Governance Framework	The Trust
Ongoing monitoring of the project	The Trust
The research project reflects the dignity, rights, safety and well-being of participants and the relationship with care professionals	The University and The Trust
Indemnity arrangements are in place in relation to negligent and non-negligent harm occurring during the research project.	The Trust
The research proposal has been approved by an appropriate research ethics committee and the Trust's Research Governance Steering Committee	The Trust
All scientific judgements made by the sponsor in relation to responsibilities set out here are based on independent and expert advice	The University (review panel)

Arrangements are proposed for disseminating the findings	The University and The Trust
--	------------------------------

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
7. I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature:



Print Name:

SARAH THURLOW

Post:

RESEARCH MANAGER.

Organisation:

SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS
FOUNDATION TRUST

Date:

14/12/2010 (dd/mm/yyyy)

APPENDIX B

Authorizations and Copyright



Mr. Joao Pereira
 Metanoia Institute and Middlesex University / South Essex Partnership NHS
 Psychotherapy
 128 Napier Road
 London London
 E11 3JZ
 United Kingdom

August 31, 2010

LIMITED COPYRIGHT LICENSE (ELECTRONIC) # 2010318.54

Dear Mr. Pereira

You have permission to use the Working Alliance Inventory (WAI) for the investigation:

"What Works in Menatalization-Based Treatment: systematic case studies of dual diagnosis patients undergoing group psychotherapy"

This limited copyright release extends to all forms of the WAI for which I hold copyright privileges, but limited to use of the inventory for not-for-profit research, and does not include the right to publish or distribute the instrument(s) in any form.

I would appreciate if you shared the results of your research with me when your work is completed so I may share this information with other researchers who might wish to use the WAI. If I can be of further help, do not hesitate to contact me.

Dr. Adam O. Horvath
 Professor
 Faculty of Education and
 Department of Psychology

Ph# (778) 782-3624
 Fax: (778) 782-3203
 e-mail: horvath@sfu.ca
 Internet: <http://www.educ.sfu.ca/alliance/allianceA>

From: isaac.marks@kcl.ac.uk
 To: jmundt@centerforpsychconsulting.com, joao_pgpereira@hotmail.co.uk
 Date: Wed, 6 Jul 2011 11:13:57 +0100
 Subject: WSAS

July 11 Dear João Pereira, It's fine for you to use the WSA for your research without charge. best,
 Isaac

From: Jim Mundt [mundt@centerforpsychconsulting.com] 5 July 2011 Dear Joao, Below is an excerpt
 from an email Dr. Marks sent to another researcher. If you are going to administer the WSAS in a visual
 format, the anchor points would be beneficial:

Further to Dr Mundt's letter below, you have my permission to translate and use the WSAS without
 charge in your research. I can quote you a charge for its use in everyday practice.

Regarding the anchor points, these are: 0=not at all; 2=slightly; 4=definitely; 8=markedly; 8=very
 severely

Good luck with your work. Isaac Marks

From: João Pereira [mailto:joao_pgpereira@hotmail.co.uk] July 04, 2011 7 To: Jim Mundt Dear Dr.
 Mundt:

I have been trying to contact Dr. Marks regarding the article below but I have been unable to find his
 correct contact details.

I am doing research on mentalization treatment for personality disorders for my Ph.D at an NHS
 psychotherapy department in England. I intend to use the WSAS as one of the measures. I was wondering
 whether you would give me permission to use the WSAS for research purposes. I was also wondering
 whether there is a manual for this scale and where I can find it.

Many thanks for your time. João Pereira BSc, PGDip, MSc, Psychologist
www.eastlondonpsychotherapy.com

British Journal of Psychiatry 2002; 180: 461-464 JAMES C. MUNDT, ISAAC M. MARKS, M. KATHERINE
 SHEAR and JOHN M. GREIST The Work and Social Adjustment Scales: a simple measure of impairment in
 functioning

The information transmitted is intended only for the person or entity to which it is addressed and may contain
 confidential and/or privileged material. Statements and opinions expressed in this e-mail may not represent
 those of the Royal College of Psychiatrists. Any review, retransmission, dissemination or other use of, or
 taking of any action in reliance upon, this information by persons or entities other than the intended recipient
 is prohibited. If you received this in error, please contact the sender immediately and delete the material from
 any computer. The Royal College of Psychiatrists is a charity registered in England and Wales (128838) and
 in Scotland (SC038369)

From: Cecilia Stoute [mailto:CStoute@psych.org]
Sent: 09 May 2011 21:51
To: Pereira Joao (RWN) SE Partnership
Subject: RE: Request for permission to reprint Text from APA/APPI books and journals including all editions of the DSM

Dear Mr. Pereira,

Permission is granted as outlined on the request below for inclusion in your dissertation/thesis/research only. Permission is granted under the following conditions:

- Permission is nonexclusive and limited to this one time use
- Use is limited to English language only; print only as necessary for dissertation/thesis/research
- Permission must be requested for additional uses (including subsequent editions, revisions and any electronic use)
- Permission fee is gratis for this one time use
- No commercial use is granted
- This permission is not valid for commercial or funded research endeavors

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Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (Copyright © 2000). American Psychiatric Association.

Sincerely,

Cecilia Stoute

Licensing and Permissions Manager

American Psychiatric Association

1000 Wilson Blvd, Suite 1825

Arlington, VA 22209

E-mail: cstoute@psych.org

<http://www.appi.org/CustomerService/Pages/Permissions.aspx>

Date: Tue, 3 May 2011 12:27:45 -0400
 From: cabades@pi.cpmc.columbia.edu
 To: joao_pgpereira@hotmail.co.uk
 Subject: Re: Permission to use the SCID-II for research purposes

Dear João Pereira,

Here is a link with information on how to reference the SCID-II in your work:
<http://cumc.columbia.edu/dept/scid/info/refscid.html>

With respect to obtaining the instrument, visit:
http://cumc.columbia.edu/dept/scid/faq/scid_2.html

Kind regards

Desiree Caban, M.A., Clinical Psychology
 Columbia University
 Department of Psychiatry
 1051 Riverside Drive, Unit 60
 New York, NY 10032
 212.543.5524 Phone / 212.543.5525 Fax

>>> João Pereira<joao_pgpereira@hotmail.co.uk> 4/29/2011 9:44 AM >>>

Dear colleagues

I am a forensic psychologist and doctoral student in psychotherapy.

I have been developing a project for the evaluation of a newly implemented Mentalization Based Treatment programme at South Essex NHS Trust, together with the Consultant Psychiatrist in Psychotherapy, Dr. Hamideh Heydari.

This is a mixed methods study (mainly qualitative) and has received favorable ethical opinion by Essex Research Ethics Committee and Metanoia Institute / Middlesex University in London. I receive academic supervision from Professor Maja O'Brien.

As part of the assessment procedures we are aiming to use the SCID-II to assess the presence of personality disorder.

I was just wondering if I need your permission to use this tool for research purposes? I will be referencing all the materials and, of course, would be willing to share the results with you.

Many thanks for your time

Best wishes

Joao Pereira

João Pereira BA, MSc, PhD
www.essexhampdenpsychotherapy.com

Date: Wed, 4 May 2011 11:21:09 +0100
Subject: RE: core use for research

Dear Joao,

Thank you for your email.

CORE IMS paper tools are free of charge to use and you are very welcome to use them for your project.

You can download all of our forms for free by visiting our website here
http://www.coreims.co.uk/forms_malar.php

The only time a cost will be incurred is if you were to purchase our software systems to input the data collected.

Please let me know if you would like any further details.

Best Wishes

Leanne

Leanne Robotham, Customer Liaison Lead
tel: 01788 546019
fax: 01788 331407
email: leanne.robatham@coreims.co.uk

Please note my days of working are Tuesday to Thursday 9-5pm.

CORE News Issue 1 – The future of psychological therapy

Please visit <http://www.coreims-online.co.uk/newsletterissue1.pdf>

CORE News Issue 2 - Lessons from America

Please visit http://www.coreims-online.co.uk/documents/CORE_News_March2009.pdf

CORE: a decade of development

Please visit <http://www.coreims.co.uk/CORE-A-Decade-of-Development.pdf>

From: Joao Pereira [mailto:joao_ppereira@hotmail.co.uk]
Sent: 29 April 2011 15:38
To: Admin
Subject: core use for research

Dear colleagues

I would like to know if I can use CORE tools for the purpose of a research doctoral project without charge. Do I need permission to do this?

Many thanks for your time

Best wishes

Joao Pereira

APPENDIX C

Details of the Nine HSCED Judges

DETAILS OF THE NINE HSCED JUDGES

Judges for Ms A

- Judge A

Dr Phil Crockett, MbChb MRCPsych MInstGA. Consultant Psychiatrist in Psychotherapy, Director of NHS Psychotherapy Services in the North of England. Special interest in personality disorder, psychodynamic psychotherapy, eating disorders and Mentalization Based Treatments

- Judge B

Dr Inês Mendes, PhD. Visiting Lecturer at Instituto Superior da Maia, Portugal. Main Approach: Emotion Focused Therapy. Inês Mendes is an Assistant Professor at the Department of Psychology at ISMAI (Instituto Superior da Maia, Maia, Portugal). Her main publications concern narrative change on psychotherapy, namely emotion-focused and client-centred therapies. She is also a researcher at the project Decentring and change in psychotherapy headed by João Salgado (ISMAI/CINNEIC - FCT Grant PTDC/PSI PCL/103432/2008, 2010-2013). Her current research interests are theoretically focused in narrative novelties development and their application to change processes in psychotherapy.

- Judge C

Dr Rachel MacLeod, BSc (Hons), PG Dip, DPsych. Chartered Counselling Psychologist in the NHS. Rachel MacLeod had several years of clinical and research experience and defined her main approaches as Cognitive-Behavioural and Person Centred.

Judges for Mr Z

- Judge D

Graham Westwell. Senior Lecturer in Counselling and Psychotherapy at Edge Hill University Preston, United Kingdom. His research interests were linked with person-centred and experiential psychotherapies.

- Judge E

Susan Price (Formerly Wiggins), BSc, MSc, MBACP (Accred), PhD. Chartered psychologist and University lecturer. Susan defined her main approaches as integrative and person-centred.

- Judge F

Dr Celia Sales, PhD. Psychologist and Family Therapist. Professor of Family Therapy, Statistics and Research Methods in Psychology. Director of the Post-Graduation Course on Family and Community Therapy, Universidade Autónoma de Lisboa (UAL).

Professor of Psychology at Évora University. Vice-President of the Portuguese Association of Family and Community Therapy.

Current research projects: Individualized patient progress systems, qualitative-quantitative integration methods, multicultural families and healing systems.

Judges for Mr X

- Judge G

Meghan Craig, DPsych. Research consultant in the NHS and Visiting Lecturer at Regents College, London. Her main approach was phenomenological-existential.

- Judge H

Lara Caeiro, PhD. Group Analyst, Portuguese Group Analytic Society. Lara is a Researcher in Neuroscience at Faculdade de Medicina, Universidade de Lisboa. Her main approach was psychoanalytic.

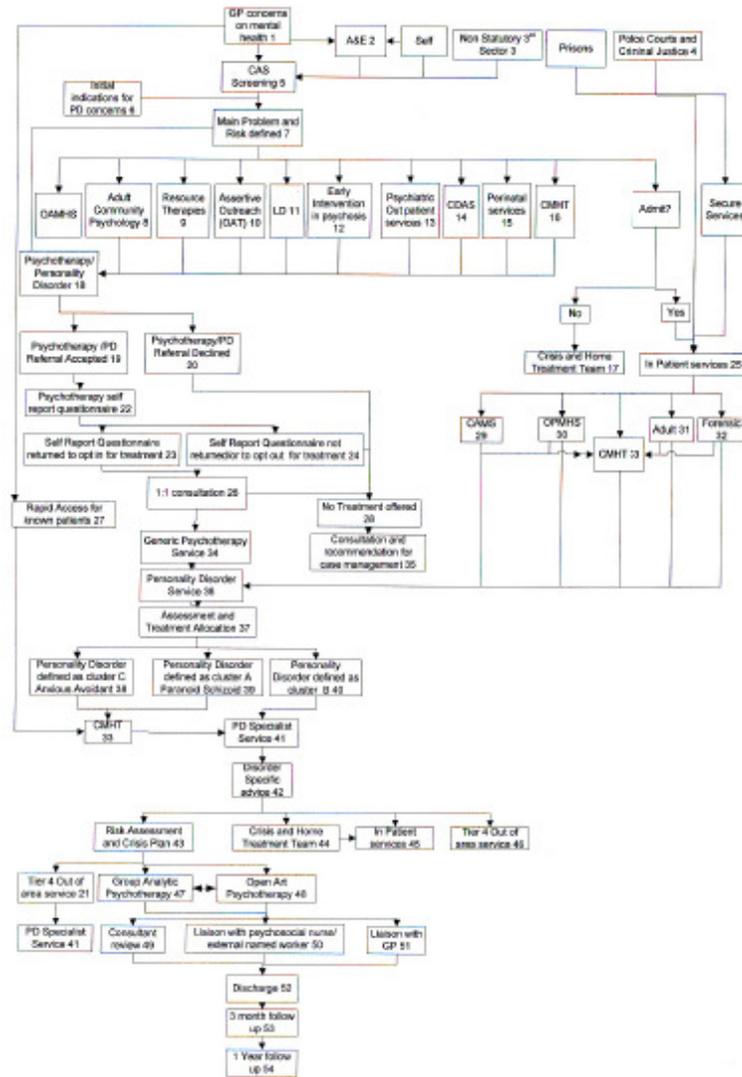
- Judge I

Maria Ali, MSc, Dip CBT, DCPsych (Candidate). Maria Ali has a Masters in Health Sciences (Sexual Health) (Sydney), a Diploma in Cognitive Behavioural Skills (Derby) and is currently reading for a Doctorate in Counselling Psychology and Psychotherapy from the

Metanoia Institute. She is working as a Counsellor with the Dorset HealthCare University NHS Foundation Trust and defined her approach as Integrative.

APPENDIX D

Map of Medicine



Appendix E

Full Analysis of Ms A

‘What Works in Mentalization Based Treatment: systematic case studies in personality disorder and addiction’

Hermeneutic Single Case Efficacy Design for the case of ‘Ms A’

Sub-Appendices

Appendix A: Rich Case Record

Appendix B: Affirmative Brief

Appendix C: Sceptic Brief

Appendix D: Affirmative Rebuttal of the Sceptic Brief

Appendix E: Sceptic Rebuttal of the Affirmative Brief

Appendix F: Affirmative Brief Summary

Appendix G: Sceptic Brief Summary

Appendix H: Interview Transcripts

Appendix I: Additional Tables

Appendix J: Adjudication

APPENDIX A

RICH CASE RECORD

The Patient

Ms A was 55 years old when she entered this programme of therapy. She complained that she was suffering from mood swings from as early as she could remember. However, the first time she sought help was in 2009 following one of her numerous suicide attempts with an overdose. She had seen a psychiatrist once at 11 and had spent 7 weeks in a psychiatric hospital when she was 33, despite not remembering what led to this. She mentioned going through low phases and that sometimes this lasted for one year to a year and a half. During these phases she would often feel tearful, with poor motivation and concentration levels and also low self-confidence. She developed maladaptive strategies (e.g. drinking) to disconnect from her daily self-harming thoughts. She would frequently feel worthless and also complained of a great deal of guilt associated with her past. She reported a core feeling of emptiness and a feeling of insecurity in relationships where the incidence of involvement would vary from being superficial to strong attachment or hatred in the other extreme.

She attempted suicide at least four times and others have reported that prior to those attempts she appears to be 'hyper'. During this phase she would be very social, going out at least three times a week and drinking 2 or 3 bottles of wine each time. She would often end the

night having unprotected sex with strangers that she would randomly meet in a club. Frequently she would feel guilty the next day which would lead her to drink more and so the cycle would repeat itself.

Ms A said that she had a 'bad' childhood and that the home atmosphere was tense. She grew up in a home in which her father was always ill and she would often be called at school without warning to go and visit him in an acute hospital ward. She felt different from her peers and thought that school was dreadful. She was often bullied. Ms A lost her father in a somehow tragic manner when she was 19 years old. Her father was a paranoid schizophrenic who committed suicide; her mother died of cancer 12 years later. She has a young brother who had been missing in Malaysia for 11 years but with whom she regained contact (in March/April 2012), having had a first reunion in July 2012.

Ms A came to the department with an ICD-10 diagnosis of Emotionally Unstable Personality Disorder, Borderline Type with co-morbid moderate depression and behavioural problems associated with excessive alcohol use.

She lived on her own in a rented flat. She was on sick benefit and was several thousand pounds in debt. She was not in a relationship at the time of referral but soon after she reported beginning a new relationship with a 'good man' that she wanted to keep. She is the mother of three sons and daughters who are 33, 33 and 31 and she also has grandchildren.

Ms A wanted to feel better and have a normal life. She received CBT before being referred to the psychotherapy department by her psychiatrist. Once in the psychotherapy department she attended once weekly group psychotherapy with a group-analyst before being recommended for the complex needs service and the MBT programme.

Psychopharmacological Medication Record (incl. herbal remedies)

<u>Medication Name</u>	<u>For What Symptoms</u>	<u>Dose/Frequency</u>	<u>How Long</u>	<u>Last Adjustment</u>

Citalopram	Anxiety / Depression	40 mg / once a day	9 Months	28.12.11
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Pre MBT Program

- Ms A attended once-weekly group psychotherapy in the department for one year (led by a senior group-analyst)
- Initial consultation with MBT psychotherapist in May 2011; name was put to the complex needs service / MBT program
- Three appointments with the Consultant Psychiatrist in Psychotherapy for the application of the SCID-II and other questionnaires.
The research was explained to Ms A at this stage
- Second consultation with MBT therapist in August 2011
- Consultation with MBT therapist in September 2011 and with the Principal Investigator to ask for consent and explain further details about the research
- MBT program started in October 2011

Results of SCID-II and Diagnostic Hypothesis (DSM-IV-TR, 2000)

DSM IV Axis I

There was mention of co-morbid depression in some of her psychiatric reports but no formal diagnosis or DSM / ICD codes were given.

DSM IV Axis II / SCID II Results

Ms A met the diagnostic criteria for multiple personality disorder: avoidant, borderline and depressive types. She also demonstrated traits of several other disorders but not enough to establish a diagnosis.

Diagnosis:

- Avoidant Personality Disorder (main focus of clinical attention); Borderline Personality Disorder; Depressive Personality Disorder.

Traits:

- Dependent (scored high); Passive-Aggressive; Paranoid; Schizotypal; Schizoid; Histrionic.

Substance Abuse

Ms A met the DSM IV criteria for Moderate Alcohol Dependence, with some evidence of withdrawal symptoms. She was drinking 4 to 5 days per week, between 30-40 units of alcohol each time.

References

DSM-IV-TR, 2000. Washington DC: American Psychiatric Association.

Outcome Data

The research protocol called for patients to complete a battery of quantitative outcome measures at assessment, during each three-monthly review with the consultant and at the end of therapy. This battery comprised the Work and Social Adjustment Scale (WSAS), CORE-OM, Checklist of Mentalizing Capacity, Global Assessment of Functioning (GAF) Scale, Treatment Outcome Profile for Substance Misuse (TOP) and a Risk Assessment Tool. During assessment the SCID-II for DSM-IV Axis II was used; The Simplified Personal Questionnaire (PQ) (Wagner and Elliott, 2001) was constructed with the patient during the assessment phase. The PQ was then used monthly as a measure of Ms A's complaints. These measures are used to provide a quantitative account of Ms A's change process over the course of therapy.

Three of these measures (PQ; CORE-OM and WSAS) were evaluated using clinical significance methods for determining whether Ms A shows clinically significant change between pre-therapy measures and after one year of therapy (Jacobson and Truax, 1991). The other measures (WAI-S; TOP; Mentalizing Capacity and GAF) are used to provide additional information only but no clinical significance methods were used.

Cut-off measures represent the point beyond which the client can be considered to be in the clinical range on each outcome measure. Values that fall within the clinical range are highlighted in bold.

TABLE A1 – Ms A Outcome Data (analysed with clinical significance methods)

Instruments	Cut-off	RCI Min (p<.2)	RCI Min (p<.05)	One Month	5 Months	8 months	One Year
PQ	≥3	1.0 (↓)	1.5 (↓)	6.5	6	4.8 ** (+)	3.4 ** (+)
CORE-OM	≥1.25	0.43 (↓)	0.66 (↓)	2.91	2.85	1.5 ** (+)	1.56 ** (+)
WSAS	≥10	7.2 (↓)	10.9 (↓)	30	24	19 ** (+)	26

Notes. Value in bold fall within the clinical range; *p<.2; **p<.05; ↑ = increased score indicates positive change; ↓ = decreased score indicates positive change;

(+) = reliable positive change in relation to first available score; (=) = no change in relation to first available score; (-) = reliable negative change in relation to first available score.

TABLE A2 – Ms A Outcome Data (additional measures)

Instruments	Cut-off	RCI Min (p<.2)	RCI Min (p<.05)	One Month	5 Months	8 months	One Year
WAI-S	N/A	N/A	N/A	M/D	M/D	M/D	68
TOP	N/A	N/A	N/A	105 units / week	160 units / week	30 units / week	21 units / week
Mentalizing Capacity	N/A	N/A	N/A	Moderate (4)	Good (6)	Good (7)	Good (9)
GAF	N/A	N/A	N/A	Serious Symptoms (41)	Serious Symptoms (50)	Moderate Symptoms (51)	Moderate Symptoms (51)

Notes. WAI-S scores range from 12 (very weak working alliance) to 84 (very strong working alliance; TOP amounts are the average of a 28 day period; Mentalizing Capacity ranges from 0 (poor) to 12 (very high); GAF scores range from 0 (persistent and very severe impairment) to 100 (superior functioning); N/A = Non Applicable; M/D = Missing Data.

Personal Questionnaire Data

A simplified Personal Questionnaire (Wagner and Elliott, 2001) was used during screening to identify the key difficulties that each patient wished to address in therapy and to provide a rating of the extent to which they remained troubled by each difficulty as therapy

progressed. The patients were also asked to state the duration of each item across their lifetime. Once a month, after therapy, the patients were asked to rate each item on the extent to which it had troubled them over the last week. Items were rated on a 7-point scale, from 1 (not at all) to 7 (maximum possible). Table A3 indicates the duration of each item across Ms A's lifetime and summarises item ratings at one-month into therapy, eight months and one year into therapy. Figure A1 illustrates Ms A's mean PQ scores across therapy.

TABLE A3 – Ms A PQ Ratings and Duration

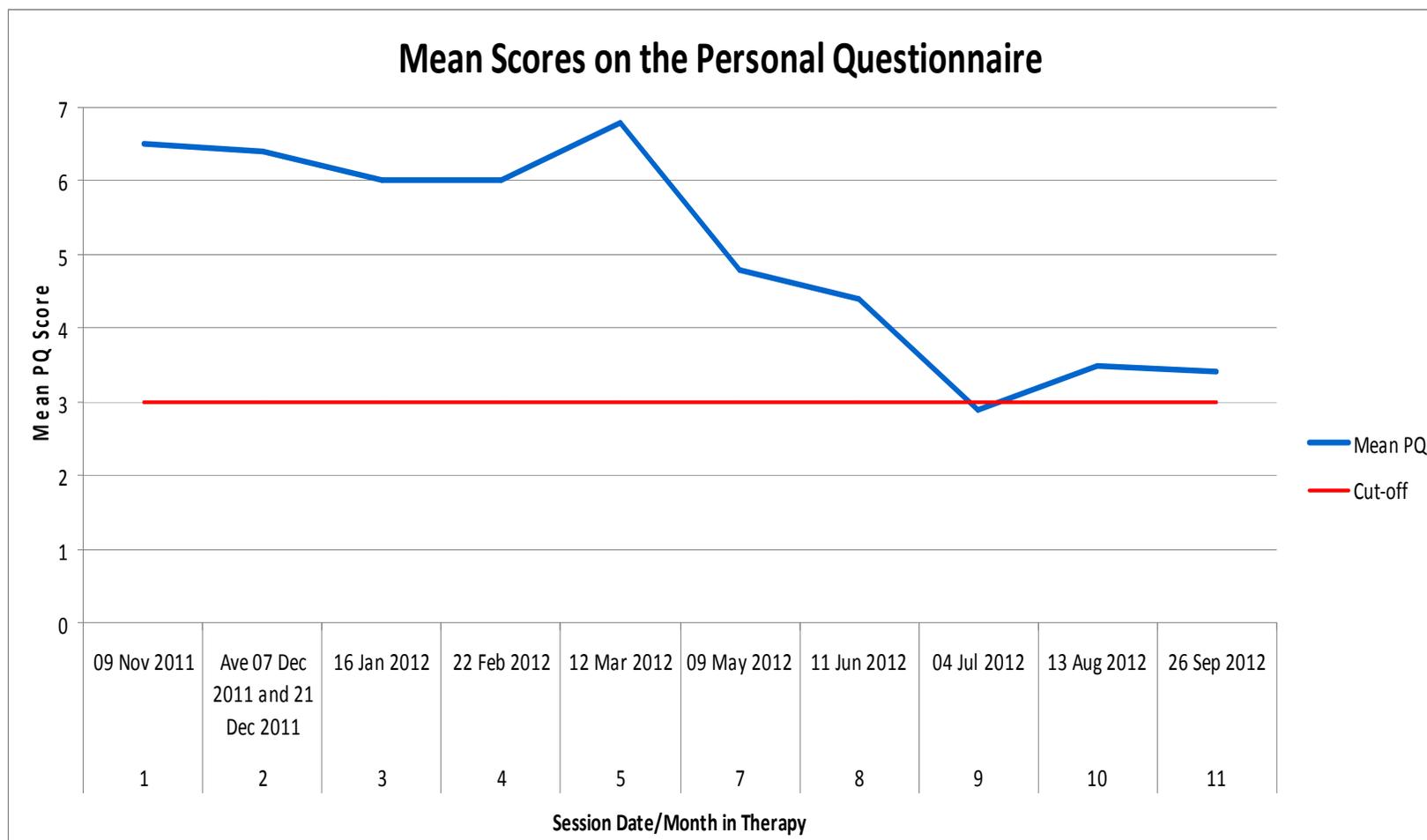
Item	Duration of the Problem	One-Month	8 Months	One Year
1. Unreliable (due to drinking)	more than 10 years	7	4	3
2. Unstable and Impulsive	more than 10 years	7	4	2
3. Constant worry and anxiety about everything	more than 10 years	7	4	4
4. Lack of sleep (difficulties sleeping)	more than 10 years	6	6	6
5. Temper outbursts	more than 10 years	6	2	2
6. Low self-esteem	more than 10 years	7	7	3

7. Flat mood a lot of the time	more than 10 years	6	5	3
8. Difficulties engaging with people	More than 10 years	7	6	4
9. Social isolation	more than 10 years	6	5	4
10. Cry easily	more than 10 years	6	5	3

Notes. Instructions: Please complete before each session. Rate each of the following problems according to how much it has bothered you during the past seven days, including today. Anchors:

Maximum possible (7), very considerably (6), considerably (5), moderately (4), little (3), very little (2), not at all (1).

FIGURE A1 – Ms A Mean PQ Scores Across Therapy



Note. The red line indicates the cut-off point between the clinical and non-clinical range on this measure (3.0).

Qualitative Data

Client's View of Helpful Aspects of Therapy

The Helpful Aspects of Therapy (HAT) measure (Llewelyn, 1988) was completed by each patient once a month in order to document the aspects of therapy that were especially meaningful to their therapeutic process. The HAT was completed together with the PQ and referring to the same session. Patients were asked to note the most helpful aspect or aspects of that session and to apply a helpfulness rating to that aspect on a 9-point scale from 9 (extremely helpful) to 1 (extremely hindering).

TABLE B1 – Ms A view of Helpful Aspects of Therapy

Month	Helpful Aspect / What made it helpful	Rating
07	December	I was really worried about my actions on Saturday after a row with my partner. I discussed
2011	it with the group and they made me see things in a different way / I went back and had a long talk with my partner and sorted my feelings out	8.5

07 December 2011	Speaking with the group	7
21 December 2011	Talking about parents / Off loading guilt about the lack of help when my mother was dying	7
16 January 2012	To talk about isolation / Talking about it	7
22 February 2012	Nothing	---
12 March 2012	I think [Group Member A] and I have solved some problems / Feel more relaxed about coming	8
09 May 2012	Group noticed I had fluff in my hair and removed it / I felt like they cared / Toward the end / ---	9
04 July 2012	The group was happy for me that my brother was here from Malaysia, I felt great support / It made me feel I had people that cared about me	8.5

-
- 13 August 2012 [Group Member A] saying she is going to work a day and a half a week, gave me a lot of hope for myself / I feel maybe I could achieve going back to work 8
- 26 September [Therapist Name] was pleased that I was trying to start making children bracelets to sell on a craft stall / It helped because I felt pleased about it and [Therapist Name] seemed so pleased that it gave me a boost 8
- 2012
-

Note. 9 = extremely helpful, 8 = greatly helpful, 7 = moderately helpful

The Helpful Aspects of therapy form also asked the patients to note any aspect of the session which they experienced as hindering or unhelpful. They were asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering.

Table B2 – Ms A view of Hindering Aspects of Therapy Sessions

Month	Hindering Aspect	Rating
07 December 2011	Talking about someone else's problems with rape	2
21 December 2011	I thought [Group Member A] one of the group held (?) against me a dispute we had in an earlier session	3
22 February 2012	People in the group playing illness one up manship	2
11 June 2012	I said I believe I was born with this illness, [Group Member B] said if I was born with it I can just say nothing is my fault, I told him I feel everything is my fault and I got very upset	3
04 July 2012	[Group Member A] asked [Therapist Name] how many suicides she had under her belt, I didn't like it and I don't want to know	2

Note. Ms A was asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering.

Change Interview Data

Each patient engaged in two Change Interviews (Elliott, Slatick and Urman, 2001); one six months into therapy and one after a year. This process involved asking the patients to reflect on the therapeutic process and to note the specific changes experienced in themselves over the course of therapy. At each Change Interview they were asked to identify key changes that had taken place, and to make attributions regarding these changes (see Tables C1 and C2).

TABLE C1 – Ms A Change Interview Record At 6 Months

Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. My confidence is better	Somewhat surprised by it	Very unlikely	Extremely important
2. I am calmer	Very much surprised by it	Very unlikely	Extremely important
3. Motivation to deal with me	Very much surprised by it	Very unlikely	Extremely important

4. Drinking is more under control	Somewhat expected it	Very unlikely	Extremely important
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5. Mood is not so flat	Somewhat surprised by it	Very unlikely	Extremely important
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* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

TABLE C2 – Ms A Change Interview Record At 1 Year

Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. I have got a lot more confidence and improved self-esteem	Very much surprised by it	Very unlikely	Extremely important

2. I can walk around and not feel that everyone is staring at me / I don't get the panicky feeling I used to / less paranoid / engaging more with people	Very much surprised by it	Very unlikely	Extremely important
3. Not letting people crossing over me (hardly at all)	Very much surprised by it	Very unlikely	Extremely important
4. My head is not crammed with bad thoughts anymore	Somewhat expected it	Very unlikely	Extremely important
5. More on top of my housework	Somewhat expected it	Very unlikely	Extremely important
6. More organized in general	Somewhat surprised by it	Very unlikely	Extremely important
7. I look forward for my grandchildren do come / not panicking that I will mess up	Very much surprised by it	Very unlikely	Extremely important

8. Drinking has reduced / it is a lot better	Somewhat expected it	Very unlikely	Extremely important
9. Less impulsive and unstable	Very much surprised by it	Very unlikely	Extremely important
10. Less temper outburst	Very much surprised by it	Very unlikely	Extremely important
11. Less isolated socially	Very much surprised by it	Very unlikely	Extremely important

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

No Changes for the Worst Reported

Summary of Key Descriptions in Change Interview at 1-Year

The following tables provide a summary of the key descriptions that Ms A offered during her change interview at 1-Year . A reference to its place in the transcript of the interview is given at the end of each quote.

TABLE C3: Helpful therapy processes

After a while therapy started to kick in and make sense and it is now helping

For the first while, when we first started, like the last time we spoke I didn't... it wasn't I didn't trust it... I didn't feel like it was... um... I felt happy to come twice a week but I didn't really understand how it was supposed to help me. Um... my views have really changed. It really has, um, started to kick in and I don't know how that happens or why it happens but... and I can't examine it... I just know that it makes a change in me. And it has made a change in me (P101, one-year change interview)

So I would say that whatever it is supposed to do it is doing for me because it's started to make sense and it's... What I mean is that I don't know how it's doing it but it is helping me (P103, one-year change interview)

I'd say in general I'm doing a lot better (P104, one-year change interview)

Um I, I, really can't explain it but I'm over the blip now, I think, and I'm getting back on track (P104, one-year change interview)

I know the difference between six months ago and now is that I've got slightly more confidence (P105, one-year change interview)

Learning that it is OK to be open and honest with the group which allows to integrate aspects of self perceived as shameful

Um a couple of weeks ago I had a really bad, a really bad (...) really went downhill, um drunk loads and loads, you know I had some really bad problems and then when I came on the Monday that was not this Monday but last, the Monday previous, I spoke with the group about it and er I was brutally honest, which is something I've learned, because sometimes you think the things you do are too shameful to talk to people about. But I've really learned that I can talk to them about it and people said some things and, and I went away and it really pulled me up, and it's really made a difference to me (P102, one-year change interview)

On the one hand I don't feel that I can tell people because I think it's shameful but on the other hand I feel very privileged that I'm getting help (P103, one-year change interview)

(...) on the Monday when I'd said everything that I had to say and I felt quite embarrassed and ashamed with myself I couldn't make it on the Wednesday because I was hiding away so, but that, but I just, I told them that, you know, and um that was just a reaction I think to what I'd told them. But on the other hand I came back and at the minute if I didn't have the therapy I don't really know what I'd be doing (P104, one-year change interview)

Knowing that someone is helping and paying attention (feeling held and contained)

I feel very privileged that I'm getting help at last for something that I think has been wrong with me for many, many, years I'm so grateful that I'm at last feeling like I'm getting somewhere and I'm getting some help and someone's paying attention to the fact that all the time I've been going 'help, help, help' and no one's helped me and now I'm getting some help (P103, one-year change interview)

I would say that it's the fact that first and foremost knowing that you're getting help over a period of time... I think that means the world so I think that inside I feel like I've got to help myself as well as this helping me... (P121, one-year change interview)

Therapy as a secure base and Ms.A safe haven

I don't know how I'd get through (P103, one-year change interview)

(...) if I didn't have the therapy I don't really know what I'd be doing (P103, one-year change interview)

(...) all I know is that this is my little haven and when I come here twice a week I don't have to hide like I do to everybody else (P122, one-year change interview)

Therapy helps to see things more clearly and to define priorities

Um I, I, really can't explain it but I'm over the blip now, I think, and I'm getting back on track and err I feel like I'm starting to see things more, starting to see what I need to do more clearly than I did before (P104, one-year change interview)

Therapy is helping being more confident and outspoken and also less panicky and paranoid

I know the difference between six months ago and now is that I've got slightly more confidence (P104, one-year change interview)

I'd say I'm more confident than I ever used to be um and more outspoken even than I've ever been (P105, one-year change interview)

I've got more, a lot more confidence. I go, I can go out, I can walk round to my, to Tesco's and not feel that everybody's staring at me,

that I'm not a freak and um I can cross, I used to have a big problem with crossing on the crossings because I didn't want the cars to stop so that I would have to walk in front to see the people looking at me, and um I completely don't even think about it now um I can walk around Tesco's and only very now and again do I get the panicky feeling; that completely seems to have disappeared, um... (R: That's quite a big change). It's a very big deal for me, very big deal, um I mean I used to wear a coat with a hood on it, you know, and um I don't do that anymore, um... (P109, one-year change interview)

And the other is the complete paranoia that people would look at me and think, well you know... I don't even know what used to get in my head "is she too ugly to be on the street?", "has she got something wrong with her?" or "am I dressed right?" Which is why I used to wear a coat with a hood, you know. I don't do that anymore... (P110, one-year change interview)

I'm more confident to go out and walk into a shop and go and get shopping where as I wouldn't... it would have just taken me an age to me, I'd rather go without stuff (P110, one-year change interview)

I've noticed a difference because I feel like I can question people about things you know, like, I've always been the type that if what, what example can I give you... I was in a shop the other day and I couldn't find, I was going to make this chicken with stuffed cream cheese and it's a garlic one, and I couldn't find it and it wasn't in the place it used to be. Number one, I would never have asked I'd have just left without it (...) (P110, one-year change interview)

I'm more confident around.. I know that for a fact, I'm more confident around the grandchildren now I don't always think I'm gonna mess up so I look forward to them coming more whereas I used to panic because I desperately wanted to see them, if I was having them for a weekend I would be desperate for them to come but then I wouldn't relax because I would think "Oh, you're gonna screw it up in some way, you're not gonna you know" I don't know, I used to just really get out of control with it but I'm more relaxed now and they'll come over and I'll have a little bit of anxiety but nothing like it used to be. It was like torture before (...) (So you're not panicking that they're coming...) I am not panicking that I'm not gonna make a good job of it... so that's getting really good because that's more of a relief to me.. than anything you know... (P114, one-year change interview)

Very much surprised, because it's been there so long that panic (P118, one-year change interview)

(...) see I would put that in like being able to talk with the shop assistant xxx you know what I mean that sort of thing I would never utter a word to anybody err before but now I don't think anything of sort of saying "excuse me blah blah blah" or even going out with [PARTNER] now and if we if he take me out to dinner I would talk to the person you know engage with people I cou... I didn't before...(P133, one-year change interview)

It has changed signi-significantly because it was there (pointing to initial PQ) I never saw anybody or I went anywhere I didn't go to the shops that's what I call social isolation, I didn't go anywhere or venture out.... I live in flats, I live in the ground floor and it's phone controlled and I would wait up to the night to run out to my post box to get my post, that's what I call being isolated... (...) I'm not isolated

and I do talk to my neighbours now (P134, one-year change interview)

Others are noticing the improvements which makes things improve even more (snowball effect)

I think they see an improvement, vastly um a lot of, like my children would probably say 'yeah I see a big improvement in her' (P106, one-year change interview)

Greater self-worth, power and sense of entitlement

I was in a shop the other day and I couldn't find, I was going to make this chicken with stuffed cream cheese and it's a garlic one, and I couldn't find it and it wasn't in the place it used to be. Number one, I would never have asked I'd have just left without it, but I did ask and number two she huffed and puffed and she come over to the shelf and she picked up this garlic cheese and went like that to me. Well it, it wasn't even the right one and I looked at her and I said 'I don't even want to buy that now because you're so rude' I said 'and that isn't even what I was looking for because I'm not that blind I could see that one'. But I used to let people treat me like that I would go 'oh' you

know and, and I don't mean I was stroppy with it, I wasn't, I just pointed out to her she was being rude. But to me that's a big difference because I'm not letting people... Because in the old days I would have gone home and thought 'oh that's just me she did that to because I'm a useless person'. But I didn't feel that and I don't feel that so much now, I feel like I've got as much right to be treated properly as everybody else (So you're not letting people crossing over you?) No not at all now, well hardly at all nowadays. I don't let them do it you know because I can be bullied and pushed around and I think I always have been (P111, one-year change interview)

Therapy has provided inner resources for improved emotional regulation (i.e. mentalizing)

My thinking's changed definitely because I don't, my head would be crammed with horrible thoughts all the time that... Something bad was going to happen or I would remember like the children growing up and that I wasn't that great a mum and, and I manage to these days, a lot of the time, if they start to creep up I can go 'Ms A that was in the past, you're doing the best you can now' (P112, one-year change interview)

Sitting whit it, you know...that's what people say in here...they say we've got to sit with it. So rather than go home and knock a lot of drinks down I go home and try and sit and think, right...what happened today...you known...bla,bla,bla this, bla, bla, bla this...T said that...I think a lot about it, I do think a lot about it... you known, trying to make sense of everything... (P125, one-year change interview)

Yeah, I think that's all to do with the flat mood thing and not I can't... that... but that's what I'm saying I have more better days now than I have bad days (P136, one-year change interview)

Internal change was translated into behavioural external change

I'm doing, I'm doing, like this is going to sound trivial but I'm more completely on my housework. I mean I've always quite clean and tidy I'm not, I've never been one that could live in dirt but I'm more really on top of everything, I don't leave it and leave it and leave it until one of my kids is going to pop round and then I think oh "I've got, I'd better get this cleaned up" (I don't think it's trivial at all I think it's very important and it's a sign that things are...) I'm more organised, do you know what I mean? I'm more on top of everything really, that's... Yeah, I suppose that is quite a big change really, yeah (P113-114, one-year change interview)

I'm not seem to be dwelling on the past (P114, one-year change interview)

In general I'm keeping more on top of... bills, phone calls that I need to make, they don't, I don't let them slip, maybe a couple of days but I will do them you know... (P118, one-year change interview)

Therapy has allowed her to let go from habitual 'crutches'

Before therapy started I drank daily (...) it's got it's A LOT better (...) It's a big change... because I would always have a drink in the house (P120-121, one-year change interview)

The nature of the group and the fact that they all had similar problems (e.g. using substances)

(Referring to previous groupanalytic psychotherapy) and err I didn't find that helpful because they all seemed to be have particular different problems to me and they weren't using anything (R: So the fact that people are using... substances) Yeah substances has made a big difference I think because it's like when you say I had a relapse and I did this I did that, you know you're telling people that know exactly how it feels, that you've got to cut those thoughts off, whether they are using alcohol or not, or taking too many pills or smoking weed or whatever it is they do they're doing it to cut off the crap... (P122-123, one-year change interview)

I would say it's a group of people who have different issues of the same problem, who all had incidents or childhoods that have left them with problems....and we help each other (P124, one-year change interview)

Acceptance of Ms. A and the instillation of hope and trust by the therapist and the group

I just think that when I talk to the others and when I hear what T has got to say, it is oh how can I explain it, I'm not very good at explaining but it just makes me feel I can be better, I can, because I've been this way all this time, it's not to say that when I talk to the other people that they've got these problems and they've all got their different problems but some of the things that they say to me completely make sense, and what T says will make sense, and then that particular time I go home and I think about it err, so I can't say to you exactly how it's helping, all I know is that this is my little haven and when I come here twice a week I don't have to hide like I do to everybody else, what is going on I can tell them and then they'll tell me back, whether it be good or bad (P122, one-year change interview)

The way the therapist talks to Ms A and explains things

Err and [Therapist Name]... err when she is talking, like... I can't, let me think for instance, you know I get so... (R: Take your time...) I just get jumbled up...its just like if one of us says something, and then [Therapist Name] will take it and then she will explain... or not explain, but say what you are thinking, and I think "that's exactly what I wanted to say but I didn't know how to say that"... err...I don't know like things like when I (inaudible) a lot of the times I've been such a useless mother and you know I've tried but I was crap and...

she'll say to me... she said to me on a number of occasions, you weren't parented... You were very young, you weren't shown the right way, you got pregnant... She doesn't say it like that, but in a way she says it, makes me go away and think about it... Then I think, yeah, my poor kids you know, but then I wasn't shown not to... I wasn't shown, how was I to know?... It didn't take away the guilt, but it makes me think, I'll think of what she said, you know... That's sort of example. I'll take away what she says, and then I sort of process it and think yeah that makes sense, and then it starts to make more sense to me, all of it... (P123, one-year change interview)

The qualities of the therapist, the consultant and the overall structure of the program were important to create a sense of security that appears to be gradually internalized

[Therapist Name] is my rock, she is brilliant, [Therapist Name] and [Consultant Name] between them... [Consultant Name] helps me, she always seems to give me somewhat of a plan in my head and... but [Therapist Name] is brilliant, about the things she will say and... It-its just... sometimes the way she explains something or make perfect sense to me... and I think, why didn't anyone else explain that to me before or... you know... (P123, one-year change interview)

(Referring to the consultant) She puts things in my head that I think "that might be a possibility" (...) and then like with the drinking, she talks to me about that and she will say... she will just talk to me properly about it, like "when you're telling me should I double that?" she's pretty straight with me (P123)

So I would say we have a psychotherapists who is trained in that sort of thing (referring to MBT), who will make us think, and give us things to think about, and we talk to each other and give ourselves things to think about...(P124, one-year change interview)

(...) they give you options don't they, [Consultant Name] says to me "if you need to see me phone to make an appointment", [Therapist Name] likes to talk to you after the session if you need a bit of extra help so to me it's all quite flexible, there's a psychiatric nurse if you need to see her so I would say there's quite a lot you feel quite cushioned so no I wouldn't change anything... (P127, one-year change interview)

Therapy facilitated insight

(...) of something I ignored it was actually going on in my life so (insight) it's a surprise that I am actually controlling it... (P129, one-year change interview)

TABLE C4: Helpful factors in Ms A Life Situation

Ms A's Partner is acting differently and is more supportive now

(...) it highlights things to me about my partner that maybe he should be certain way, or doing certain things for me... but that's not for the worst, I can't say it's for the worst because when I spoke to him at length we've worked together on it (...) I mean, for instance err my drinking you know [Partner Name] wouldn't put any (inaudible) on me if I decide to go and buy a box of wine he won't say to me "you are not doing that, that's ridiculous", he would just let me go and do it but we spoke at length about it... because I used to think "oh he doesn't care because.." I would let him do it if I feel he had a problem... but we spoken at length and he is completely different, he does support meand he does... (P119, one-year change interview)

TABLE C5: Ms A's personal attributes/resources that may have helped her use therapy

A fighter who tries hard to maximize the opportunity

(self-description) ...I'd say um... someone who's striving to get back into the world. That's my aim um I'd describe myself as I'm trying very hard um, um (P106, one-year change interview)

At this stage now I'm a person who's definitely trying to find somewhere where I can do something with myself, properly you know, get into something (P106, one-year change interview)

(...) they'd probably describe me as 'have been ill' but they know that I'm trying to improve and I'm working at it (P107, one-year change interview)

(...) inside I feel like I've got to help myself as well as this helping me... (P121, one-year change interview)

Kind and Caring and Loving

I'm kind and caring and err loving (P107, one-year change interview)

Committed to the treatment program

...because I think we have to put as much as with respect to [Therapist Name] and [Consultant Name] do... I think we've got to be committed to it (P127, one-year change interview)

TABLE C6: Difficult but potentially beneficial processes (in and out of therapy)

Being in the treatment program helped her to face problems instead of resorting to the habitual pattern of running away

About a few months when [Group Member A] had a big problem with me, that was unhelpful to me. That's way back now... ..err...we did...she...for some reason...and I felt I was being bullied, and I didn't want to come, bla,bla...is all sorted now. And that's a really good thing that came out of that, because I did face it I did come back and I'm really good at running away. I would run 100 miles from a problem and then hold up in doors and not you known...But I did come back and faced it...And in a way it's made me... that's helped me being stronger, because now I will sit... I'll be completely honest with you and not think "oh I'm frightened because she might have a go at me and err and she's decent with me now, we have got quite a good bond. That was a big letdown for me at the time. (R: What do you think helped you go through that and and err overcame that event?) I think exactly what made me overcame that was that...when that happened...and I missed the next one...and then I felt I felt jealous because I thought "she's probably sitting there and I am frightened to go in there and I wanted this help for so long, why should I be missing it because of a bully" which is how I saw it at the time, and then I didn't come at the next one and then I did come back and err... I did, well, I did say the word "I thought you had been bullying me and blah blah blah it was all very sticky... and it was sticky for a while to be honest but I did come back... I mean what pulled me back was... because I thought if I don't come to this, then I have got nothing. I will be back at...you know...right back where I was, and I'm kind of scared of going back there. (R: If I remember correctly [Consultant Name] and [Therapist Name] have have helped you to or convinced you in a way to come back?) Yeah, they did... yeah...Absolutely. I had a couple of phone calls from [Therapist Name] and then I went to see [Consultant Name] and I was scared of coming back err but I did say to them that I did want, I wanted to be there...you known ...and

err... so that was an hindrance to me at that point... (P126, one-year change interview)

Learning to deal and cope with different personalities

(...) err I will say that sometimes I feel Mr W, I'm pointing at the chair because he sits there... ...gets a bit aggressive, it doesn't happen very often but when it does I am a little bit.....cant's cope can't cope ...but that's only because I have been with very aggressive partners and I do get scared but I've got that's for me to deal with. Because I know that he wouldn't attack me, that is ridiculous. But I do get a bit on hedge. That's a bit of a down side... (P126, one-year change interview)

TABLE C7: Helpful aspects of taking part in the research

Knowing that the research may help other people

(...) if the research is been done to help other people then yeah I'd love to be part of it... (R: Has it has it helped you or has it been any

hindrance for you?). No certainly not an hindrance err it's not unhelpful I just think it's part of something we have to do... yeah it's not unhelpful though or a hindrance ... (P127, one-year change interview)

Ms A was interested in looking at preliminary results

(Looking at PQ results from the last year) Oh that's interesting to look at isn't it...? (P128, one-year change interview)

Hindering therapy processes

TABLE C8: Hindering therapy processes

Ms A did not report any hindering therapy processes

TABLE C9: Hindering factors in Ms A's life situation / generic problems or symptoms that may have affected the therapy negatively

Occasional and severe relapses into drinking

In general up until last, like that last couple of weeks, I thought I was doing OK in general but I did have a complete drinking and everything relapsed (P105, one-year change interview)

Persistent Insomnia

I cannot sleep I have insomnia... (P130, one-year change interview)

(...) and the flat mood I think it's a lot to do with not sleeping because I'm desperately tired all of the time (R: All of the time (unclear) sleeping... how many hours do you sleep?) Oh, I would say a good night 3 hours... Yeah... if.. but that's sort of on the verge thing because I could hear everything I know what's going on you know I could hear an attack or (pipes?) or it's never that deep lovely sleep... ever (R: I'm sure that affects you) Oh I know it definitely is affecting me, definitely (P136, one-year change interview)

(...) in fact the sleeping pattern is worst... well I would say that I think it's worst because I don't drink so often... Because it can make yourself like go to sleep with drink and I think I used to use that a lot to get to sleep but I don't do it now so now I am noticing more and more that I'm not sleeping at all... (P136-137, one-year change interview)

The possible negative impact of medication

I'm still trying to combat... but but I do think maybe it's something to do with the tablets that I'm on I don't know whether they're... that's what I keep thinking.... (P133, one-year change interview)

Yeah, I think that's all to do with the flat mood thing and not I can't... that... but that's what I'm saying I have more better days now than I have bad days but I still have the you know those really flat where I've got... things might be coming up that I should be looking forward to and I think "why am I not looking forward to it, why am I just like... but, I have spoke to [Therapist Name] about it and I think that's down to my tablets (P132-133, one-year change interview)

I know it's wrong to be controlled by tablets but I think this tablets are quite suppressing me (P136, one-year change interview)

Ms A feels that her GP does not trust her and is not interested

... I have been to the doctor and he said he wouldn't give me anything for fear that I would try to commit suicide again but that's not that's stupid because I could go and get a box of paracetamol.. you know what I mean.. (...) they're just not interested he keeps putting in my

certificate fit for work and I don't say that I'm not fit to work but I do keep saying to him, I'm doing my therapy twice a week, I would do 16 hours of work a week but the job centre cannot find me anything (unclear) to fit in those days but he just thinks I just want to sit about and not work, it truly gets me down but anyway... (P137, one-year change interview)

TABLE C10: Ms A personal attributes that may have hindered her in therapy

Deeply rooted feelings of shame

However, on the Monday when I'd said everything that I had to say and I felt quite embarrassed and ashamed with myself I couldn't make it on the Wednesday because I was hiding away (P104, one-year change interview)

Poor reflective function, impulsivity and inability to regulate negative self states

(R: you are not quite sure what brought the relapse on?) I'm not really sure, I don't, nothing major happened um I just started to feel a bit low and, I don't know what happened, everything, the little, all the tiny things that usually started getting and building up and I'm not quite sure what brought that about (P105, one-year change interview)

The only real thing I struggle with still is if I've got a problem the first thing I want to do is have a drink (P107, one-year change interview)

My drinking... will go from one extreme to the other. I'm not drinking at the minute I mean I look crap because I'm tired I never sleep but I'm not drinking and then I get to a point where I don't want to, but then click (clicking her fingers) like a couple of weeks time I just might "oh I need some wine" and go and get it... that's what I wanna control... I don't want to do that... (P120, one-year change interview)

...and I was one of those I would wait until say about 4 o'clock in the afternoon and think I've done well and then I would think "oh it's 4 o'clock I can have a drink now you know.. it's not the morning, I'm not an alcoholic but basically I was (P121, one-year change interview)

... I don't know because when I say that it would mean that I would just take in my head to go out and spend money I haven't got or I would take it in my head to go somewhere like the pub or something drunk and just get drunk, I don't I haven't done anything like that for a long time... I haven't I can still be a little bit impulsive when money is concerned but it has gone it's gone (inaudible) down yeah... (P129, one-year change interview)

that would be due to drinking I would just get nasty... (P130, one-year change interview)

(referring to flat mood) ...Yeah it's gone down drastically I'll fight it, it will come over me I just go flat, I have those days when I think "yeah everything is great, I'm gonna do this and gonna do that" and before where it would be like down most of the time all was like it... it's not

all the time now, it just catches up on me and I get fed up when I get it so... (P133, one-year change interview)

Exasperating

(...) exasperating I think people that know me would say, like close people, because I can be (R: Exasperating?) Yeah, you know doubting everything, worrying about everything and err I think they get all a bit like 'shut up' with me and I think that's it really (P107, one-year change interview)

Lack of self-confidence and self-esteem

(...) the main thing I would like to change is to be stronger in that way... Because I can be strong but then I will just fall down (P107-108, one-year change interview)

I've put you see that's the thing it tells you where you are in the day because I've put 3 today because... (pause) it's funny, I know why I've put 3 today because I got up late and I didn't wash my hair I've put it up and I was a bit embarrassed like "do I look Ok today" whereas when I've put the 2 I probably (unclear) my hair and felt... you know what I mean it's really funny little tinny things yeah... (P132, one-year change interview)

Withdrawing tendencies

I've got one really good friend and she we normally see each other every week and it depends on the month because sometimes I will put

her off because my mood is flat and I think "I can't do it"... And then... and I know it's social isolation because then I say to my daughter can you not bring the kids on Wednesday home because (unclear) I'm not feeling that great... (P134, one-year change interview)

TABLE C11: Hindering aspects of taking part in the research

None reported

TABLE C12: Missing aspects of therapy

None Reported

Therapist's adherence to MBT principles

To assess whether the therapist was adhering to MBT principles a self-rating scale was completed by the therapist every time a HAT and/or PQ was completed by the patient.

TABLE D1 – Therapist Adherence to MBT

	09.11.11	07.12.11	11.01.12	08.02.12	12.03.12	11.04.12	09.05.12	14.05.12	11.06.12	13.06.12
Framework of Treatment	94 %	66 %	55 %	100 %	100 %	100 %	83 %	89 %	77 %	89 %
Mentalization	81%	69 %	87 %	100 %	88 %	100 %	100 %	88 %	81 %	75 %
Working With Current Mental Sates	100%	80 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Bridging the Gaps	86%	43 %	86 %	100 %	100 %	100 %	100 %	86 %	86 %	100 %
Affect Storms	100%	87 %	87 %	100 %	100 %	88 %	100 %	88 %	88 %	100 %
Use of Transference	60 %	90 %	80 %	100 %	80 %	80 %	100 %	80 %	70 %	90 %
Overall Adherence	86%	70 %	77 %	100 %	94 %	89 %	94 %	88 %	86 %	89 %

TABLE D1 – Therapist Adherence to MBT (Cont.)

	04.07.12	13.08.12	
Framework of Treatment	94 %	94 %	
Mentalization	100 %	94 %	
Working with current mental states	100 %	100 %	
Bridging the gaps	100 %	86 %	
Affect Storms	63 %	88 %	
Use of transference	70 %	100 %	
Overall Adherence	84 %	94 %	

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APPENDIX B**AFFIRMATIVE BRIEF**

Note: The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

The job of Researcher 1 (Principal Investigator) was to find corroborated, positive evidence pointing to therapy as a major cause of patient change. The search for evidence was divided into five different sections. To make a reasonable case for the causal role of therapy in patient change, HSCED requires that at least two different kinds of evidence support the therapy-change link (Elliott et al, 2009).

1. Change in stable problems

A change in long-standing or chronic psychological difficulties during therapy is thought to be indicative of therapy efficacy (Kazdin, 1981). In her Personal Questionnaire (PQ), Ms A identified ten significant problems that she wanted to work on in therapy. She rated all of these problems as long-standing (ten years or more).

Despite not having pre-therapy measures for Ms A, a reliable and substantial drop was observed in the patient's PQ ratings from month 1 in therapy to One-Year, moving the patient very close to the non-clinical range (see Table A3 and Figure A1). Ms A reported positive change in 9 out of the 10 individual items, ranging from 2 to 5 points [3.1 (mean), 3 (median), 3 (mode)] (see Table A3). Taking in consideration the duration and consistency of Ms A problems it is unlikely that these changes would occur without the influence of therapy.

The change in the PQ is also corroborated by changes in several other measures used (see Tables A1 and A2). Clinical significance was used in three of these measures and two of them (PQ and CORE) show reliable change at the $p < .05$ level which is above what Elliott (2002) recommends as evidence that change was not due to chance or measurement error.

In addition, the judgement of the consultant psychiatrist in psychotherapy during the three monthly reviews suggests that the patient has changed. Although not analysed for clinical significance the improvement in the GAF and Mentalizing Capacity scales (subjectively evaluated by the consultant) show considerable positive change (see Table A2).

2. Retrospective Attribution

In HSCED the patient is at the centre of the discussion; for that reason, we explored Ms A's opinions about the changes she experienced and how she attributed those changes.

Clear support for the therapy efficacy hypothesis was found in Ms A's 'likelihood without therapy' ratings and her descriptions of the role therapy played in achieving these changes. During both her 'change interviews', at 6 months and one-year into therapy, all of the changes reported by Ms A were considered to be 'very unlikely without therapy'. She rated all of these changes as 'extremely important' to her (see Tables C1 and C2). Not only did Ms A give the maximum possible rating for the importance of the changes and the likelihood without therapy but she also expressed how the scale given was sometimes not enough to convey the full magnitude of the change. So, for example, when rating the importance of the change "I have got a lot more confidence and improved self-esteem" Ms A commented emphatically "Oh, extremely important, I can't say..." (p115 one-year change interview transcript). For the wide-ranging change of "I can

walk around and not feel that everyone is staring at me / I don't get the panicky feeling I used to / less paranoid / engaging more with people" Ms A said "It's a surprise, I'd never had thought a year on... that I could be ... you know..." (p115 one-year change interview transcript). She said that without therapy this change would have been "very unlikely, I would still be sitting indoors and not going out" (p115 one-year change interview transcript). For the third reported change "not letting people crossing over me (hardly at all)" Ms A said that she was surprised with the change. When asked to rate the extent of the surprise she stated "oh very much... never had a voice (smiling)" (p116, one-year change interview transcript). She commented that without therapy this change "wouldn't have happened" and that this was extremely important: "oh, it's o-one of the most important things, to me..." (p117 one-year change interview transcript). The fourth reported change was "my head is not crammed with bad thoughts anymore"; when asked to rate the importance of this change Ms A said with enthusiasm "oh God, extremely" (p118, one-year change interview transcript). The fifth change the patient reported was "more on top of my housework". She rated this change as "extremely important" and said that without therapy "hmm there wouldn't have been any change" (p119, one-year change interview transcript). In the final and spontaneously reported change "I look forward for my grandchildren to come / not panicking that I will mess up" Ms A said she was "very much surprised, because it's been there so long that panic"; in the likelihood without therapy rating she responded "oh, I don't think it would have happened at all"; this was of the utmost importance to her as she was able to emphasise with her grave tone of voice "oh extr, well, the most extremely (p119, one-year change interview transcript).

After revising the scores on the PQ Ms A added another four changes to the list. "Drinking has reduced / it is a lot better" was the first added change; she said "It's a big change... because I would always have a drink in the house and I would definitely"; this was rated as extremely important "Ohh extremely" and very unlikely without the therapy "I'd probably be dead" (p122, one-year change interview transcript).

Ms A was very much surprised that she was “less impulsive and unstable” which she attributes to the insight therapy induced in her: “surprised actually because out of something I ignored it was actually going on in my life so it’s a surprise that I am actually controlling it”. She considered this change to be very unlikely without the therapy “I can’t see it being any different” (p130, one-year change interview transcript). Regarding the change “less socially isolated” she commented “It has changed significantly because it was there (pointing to initial PQ) I never saw anybody or I went anywhere I didn’t go to the shops that’s what I call social isolation, I didn’t go anywhere or venture out.... I live in flats, I live in the ground floor and it’s phone controlled and I would wait up to the night to run out to my post box to get my post, that’s what I call being isolated...” (p136, one-year change interview transcript).

In the following examples Ms A generically attributes her reported changes to the influence of therapy and tries to explain what caused the changes:

- “Yeah I would say that it’s the fact that first and foremost knowing that you’re getting help over a period of time... I think that means the world so I think that inside I feel like I’ve got to help myself as well as this helping me... err that’s number 1 but number 2 I just think that when I talk to the others and when I hear what [Therapist Name] has got to say, it is oh how can I explain it, I’m not very good at explaining but it just makes me feel I can be better, I can, because I’ve been this way all this time, it’s not to say that when I talk to the other people that they’ve got these problems and they’ve all got their different problems but some of the things that they say to me completely make sense, and what [Therapist Name] say will make sense, and then that particular time I go home and I think about it err, so I can’t say to you exactly how it’s helping, all I know

is that this is my little haven and when I come here twice a week I don't have to hide like I do to everybody else, what is going on I can tell them and then they'll tell me back, whether it be good or bad" (p132, one-year change interview transcript)

- "It really has, um, started to kick in and I don't know how that happens or why it happens but... and I can't examine it... I just know that it makes a change in me. And it has made a change in me" (P102, one-year change interview transcript).

Ms A has reported a number of other helpful factors of therapy. These can be found in more detail on Tables B1 and C3.

The fact that the changes reported are specific and idiosyncratic to Ms A gives greater weight and credibility to the retrospective attribution argument (Bohart, 2008).

3. Process-outcome mapping

HSCED also makes an attempt to link the content of the patient's post-therapy changes to specific events, aspects, or processes within therapy. Ms A reported 8 helpful events in her HAT forms. Three of these were rated as 'moderately helpful', two as 'greatly helpful', two between 'greatly' and 'extremely' helpful and one event as 'extremely helpful'

In the table below it is possible to observe a link between psychotherapy processes (Ms A's HAT forms, Table B1) and the changes she later reported in the change interview at One-Year (see Table C2).

TABLE E1 - Process Outcome Link (HAT / Change Interview)

Qualitative Outcome	Nr of sessions in which process occurred	Examples of Process (HAT Form)
I have got a lot more confidence and improved self-esteem	3	<p>May 2012: group noticed I had fluff in my hair and removed it / I felt like they cared (rated 'extremely helpful')</p> <p>August 2012: [Group Member A] saying she is going to work a day and a half a week, gave me a lot of hope for myself / I feel maybe I could achieve going back to work rated 'greatly helpful')</p> <p>July 2012: The group was happy for me that my brother was here from Malaysia, I felt great support / It made me feel I had people that cared about me (rated between 'greatly helpful and extremely helpful')</p>

<p>I can walk around and not feel that everyone is staring at me / I don't get the panicky feeling I used to / less paranoid / engaging more with people</p>	<p>2</p>	<p>December 2011: I was really worried about my actions on Saturday after a row with my partner. I discussed it with the group and they made me see things in a different way / I went back and had a long talk with my partner and sorted my feelings out (rated between 'greatly helpful and extremely helpful')</p> <p>March 2012: I think [Group Member A] and I have solved some problems / Feel more relaxed about coming (rated 'greatly helpful')</p>
<p>Less socially isolated</p>	<p>1</p>	<p>January 2012: To talk about isolation / Talking about it (rated 'moderately helpful')</p>

In addition, an analysis of the Change Interview at one-year can provide further cues about the link between process and outcome. Even if the link is not entirely obvious it is plausible to assume that therapeutic processes had a direct impact on the changes experienced by Ms A (Table C3 provides further details about helpful therapy processes).

TABLE E2 - Process Outcome Link (Change Interview / Theory and Technique / Outcome)

Example of Process (Change Interview)
(...) you think the things you do are too shameful to talk to people about. But I've really learned that I can talk to them about (P102, one-year change interview)
(...) all I know is that this is my little haven and when I come here twice a week I don't have to hide like I do to everybody else, what is going on I can tell them and then they'll tell me back, whether it be good or bad (P121, one-year change interview)
And that's a really good thing that came out of that, because I did face it I did come back and I'm really good at running away. I would run 100 miles from a problem and then hold up in doors and not you known...But I did come back and faced it... (p125, one-year change interview)
I did, well, I did say the word "I thought you had been bullying me and blah blah blah it was all very sticky... and it was sticky for a while

to be honest but I did come back... (p125, one-year change interview)

My thinking's changed definitely because I don't, my head would be crammed with horrible thoughts all the time that... Something bad was going to happen or I would remember like the children growing up and that I wasn't that great a mum and, and I manage to these days, a lot of the time, if they start to creep up I can go 'Ms A that was in the past, you're doing the best you can now' (P112, one-year change interview)

Sitting with it, you know...that's what people say in here...they say we've got to sit with it. So rather than go home and knock a lot of drinks down I go home and try and sit and think, right...what happened today... (P125, one-year change interview)

...I don't know like things like when I (unclear) a lot of the times I've been such a useless mother and you know I've tried but I was crap and... (referring to Therapist) she'll say to me... she said to me on a number of occasions, you weren't parented...You were very young, you weren't shown the right way, you got pregnant...She doesn't say it like that, but in a way she says it, makes me go away and think about it...Then I think, yeah, my poor kids you know, but then I wasn't shown not to...I wasn't shown, how was I to know?...It didn't take away the guilt, but it makes me think, I'll think of what she said, you know...That's sort of example. I'll take away what she says, and then I sort of process it and think yeah that makes sense, and then it starts to make more sense to me, all of it... (P123, one-year change interview)

(R: So the fact that people are using... substances) Yeah substances has made a big difference I think because it's like when you say I had a relapse and I did this I did that, you know you're telling people that know exactly how it feels, that you've got to cut those thoughts off, whether they are using alcohol or not, or taking too many pills or smoking weed or whatever it is they do they're doing it to cut off the crap... (P122-123, one-year change interview)

I would say it's a group of people who have different issues of the same problem, who all had incidents or childhoods that have left them with problems....and we help each other (P124, one-year change interview)

[Therapist Name] is my rock, she is brilliant, [Therapist Name] and [Consultant Name] between them... [Consultant Name] helps me, she always seems to give me somewhat of a plan in my head and...but [Therapist Name] is brilliant, about the things she will say and... It-Its just... sometimes the way she explains something or make perfect sense to me... and I think, why didn't anyone else explain that to me before or...you know... (P123, one-year change interview)

(Referring to the consultant) She puts things in my head that I think "that might be a possibility" (...) and then like with the drinking, she talks to me about that and she will say... she will just talk to me properly about it, like "when you're telling me should I double that?" she's pretty straight with me (P123, one-year change interview)



Contingent Marked Mirroring / Bio-Social-Feedback (Fonagy, Gergely, Jurist and Target, 2002).

Learning to receive feedback from others; “encouragement to think about her depressive and anxious state” (taken from therapist 9 month progress report) and learning about ‘self’ through the feedback of others whilst distinguishing that they have a mind that is separate from hers.

A Secure Base (Bowlby, 2008)

The gradual experience of safety based on the support from the MBT team, the therapist and the group’s “reassurance, support and empathy enabled her to stay and mentalize rather than to leave her to be overwhelmed with her emotions” (taken from therapist 9 month progress report).



Related Outcome

I have got a lot more confidence and improved self-esteem

I can walk around and not feel that everyone is staring at me / I don’t get the panicky feeling I used to / less paranoid / engaging more

with people
Not letting people crossing over me (hardly at all)
My head is not crammed with bad thoughts anymore
I look forward for my grandchildren do come / not panicking that I will mess up
Drinking has reduced / it is a lot better

4. Within-therapy process-outcome correlation

In addition, theoretically central in-therapy process variables (e.g. adherence to treatment principles) may be found to co-vary with month-to-month shifts in patient problems (Elliott, 2002).

We did not find a correlation between overall levels of MBT adherence and the results in the PQ. This may be due to the inefficiency of the measure used, which is a self-rated questionnaire (Bateman and Fonagy, 2006), and the possible desire of the therapist to perform well vis-à-vis the consultant (who is also her supervisor) and the principal investigator. Despite this fact it is possible to observe the consistent high self-ratings of the therapist regarding 'working with current mental states', 'bridging the gaps' and 'use of transference' which seems to go accordingly to her three monthly progress reports. In her reports the therapist highlights the importance of working relationally in the here-and-now for the positive outcome of therapy: "we have moved from the stage of pretend mode where stage of protection for themselves and for one another to daring to take risks and explore how the other perceives the other to be" (taken from therapist 6-month progress report).

5. Event-shift sequences

Elliott (2002: p.7) mentions that “an important therapy event may immediately precede a stable shift in client problems, particularly if the nature of the therapy processes and the change are logically related to one another (e.g. therapeutic exploration of an issue followed the next week by change on that issue)”. Since the ratings for the present study are only undertaken monthly it may not be meaningful to relate a drop in the PQ with the HAT from the previous month. Because both forms (PQ and HAT) were completed once a month at the end of the session it made more sense to relate the PQ rating with the HAT from the same session.

So, for example, for Ms A the two helpful events in the HAT that seem more logically related to changes in the PQ are the ones in May 2012 and July 2012. Both events relate to Ms A’s desire to be cared, noticed and appreciated by others (see Table B1). The PQ mean score for those two sessions show a reliable drop (see Figure A1). The individual items of “low self-esteem” and “social isolation” seem related to this therapeutic event and they show a reliable drop in July for “low self esteem” (from 6 to 3) and in both May and July for “social isolation” (7 to 5 and then 5 to 2 respectively)

Whilst only two shifts on the PQ are reliable, a gradual and statistically significant drop can be observed in the mean PQ score, particularly from March onwards. From that stage in therapy the reduction on the PQ average score is so accentuated that it drops to the non-clinical range in July 2012 with only a small increase in the months following that (see Figure A1). Though there may be a questionable link due to the time gap, it is possible to observe a significant reduction in the PQ mean immediately following the helpful event mentioned in the March HAT form “I think [Group member A] and I have solved some problems / Feel more relaxed about coming”. As Ms A explained during the change interview this event represented a fundamental shift for her as it helped her to change the habitual maladaptive pattern of running away from problems. She said, for example “and that’s a really good thing that came out of that, because I did face it I did come

back and I'm really good at running away. I would run 100 miles from a problem and then hold up in doors and not you know...(...) that's helped me being stronger, because now I will sit... I'll be completely honest with you and not think oh I'm frightened because she might have a go at me and err and she's decent with me now, we have got quite a good bond. (...) it was all very sticky... and it was sticky for a while to be honest but I did come back..." (P112, one-year change interview transcript). It is also possible to observe reliable drops in related Individual items in the PQ following the March 2012 therapeutic event, for example, "Unstable and Impulsive" (drop from 7 to 4), "Constant worry about everything" (from 7 to 4), "Temper outbursts" (from 5 to 2), "Difficulties engaging with people" (from 7 to 6 and then 4 and 3 over the following months), and finally "Socially isolation" (from 7 to 5)

Conclusion

The affirmative brief provides strong evidence that:

- Significant changes have occurred in Ms A stable and chronic problems
- Ms A clearly attributes these changes to the influence of therapy

There is evidence, although not sufficiently clear, to infer that:

- The process of therapy in general is linked to the positive outcomes
- Significant therapy 'events' have helped to reduced the severity of the patient's problems

Only indirect evidence was found to:

- Support the link between specific MBT processes or techniques and positive outcome

According to Elliott (2002) two pieces of evidence would be enough to support the therapy efficacy hypothesis. Since it was possible to find evidence for all the five steps followed (very clearly and strongly in steps 1 and 2) we can confidently assume that the client has changed significantly and that the change was unquestionably caused by the therapy.

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APPENDIX C

SCEPTIC BRIEF

Note: The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

Competing explanations for apparent client change

1. Trivial or negative change

This argument posits that any change found was trivial or negative. An assessment of Ms A's Outcome Data (Table A1) - PQ, CORE-OM and WSAS - highlights that all of these measures persisted in the clinical range from pre-therapy up to one year. Although some of these outcome measures show significant positive change ($p < .05$), it would be anticipated that substantial and meaningful therapeutic change would move the client out of the clinical range after one year on at least some of the indicators. The fact that this did not occur suggests that therapeutic change was trivial as opposed to substantial.

In addition, CORE-OM, Mentalizing Capacity, and GAF show no categorical improvement between seven months and one year. The WSAS score is much higher at one year than it is at seven months, proposing a negative change for Ms A on this dimension and no change on the other indicators (with the exception of PQ). Furthermore, changes in PQ did not occur globally, for instance 'lack of sleep' did not

change between pre-therapy and one year (Item 4, Table A2); it seems unreasonable to assume that other substantial changes could truly occur to dimensions such as worry and anxiety (Item 3, Table A2) without affecting the quality of the client's sleep.

Likewise, the information presented in the PQ and TOP (Table A1), which both suggest overall a steady reduction in alcohol intake, is inconsistent with the qualitative data whereby the client reports a relapse in her drinking problems as going 'downhill' (One Year Change Interview, p.60) and the therapist notes that Ms A is 'drinking every day and doesn't know how to change it' (Process Notes, 23 July 2012). Therefore, the quantitative data propose that the therapy was unable to shift the client out of the clinical range on any measure even after one year of the MBT program and that the client got worse between seven months and one year on a key measure (WSAS). Itemised changes in PQ are inconsistent with one another and with the qualitative results. Following this, the data are insufficiently persuasive to allow substantial therapeutic change to be inferred and any change can be said to be at best trivial or, in the case of WSAS, negative.

2. Statistical artefacts

This explanation details the manner in which the results may be due to statistical error. The majority of Ms A's Outcome Data (Table A1) appear to meet the Reliable Change Index ($p < .05$). However, one important exception is the WSAS score at one year, which was not found to be statistically significant. The negative change between seven months and one year reported on the WSAS could be viewed as casting doubt on the other statistical measures since any reliable change in those dimensions has not been comprehensively replicated across all indicators. The inability to replicate the results suggests the possibility that, where significant difference was asserted, it occurred by experiment error and it does not embody the pattern of Ms A's global functioning. This therefore limits the extent to which affirmative conclusions can be inferred from the statistical data presented.

3. Relational artefacts

This section, divided into three sub-sections, presents the argument that the self-presentational tendencies of the client and interpersonal dynamics between the client and the researcher confound the data.

a. Relational response tendencies

There are strong indications that the changes noted in both the quantitative and qualitative data are due to the relational response tendencies of the client. Evidence suggests that Ms A acts in a way that pleases others. The therapist's three month Progress Report states that Ms A 'lives in a perpetual pretend mode and would not be able to attend group or go anywhere without wearing make-up and hiding behind a façade'. Likewise, one Helpful Aspect of Therapy (Table B1) for the client was pleasing the therapist by making bracelets to sell on a craft stall, which gave the client a 'boost' (26 September 2012).

Therefore, receiving positive feedback from others is very important to Ms A and her tendency to please and seek approval would bias the client to emphasise the helpful aspects of therapy and the progress she has made. This self-presentational strategy challenges the validity of the client's responses in this research and suggests that her account cannot be taken as literally definitive. Instead, the data represents the way that Ms A has become dependent upon the treatment ('I'm quite dependent on it', One Year Change Interview, p.104) and how she acts to sustain its presence by justifying, pleasing and rewarding the therapy team and the researcher.

b. The plausibility of reported therapy attributions

Following this, it seems that Ms A gave a positive narrative account of her therapy in order to please the researcher and the therapy team (the 'hello-goodbye' effect, Elliot, 2002, p.11). Bohart and Boyd (1997 cited in Elliot, 2002: p.11) assert 'plausibility criteria' to test for the validity of subjective descriptions. One such criterion is differentiation: for an account to be plausible it must be differentiated, containing a mixture of positive, negative and neutral descriptions. However, at the One Year Change Interview, Ms A failed to report any hindering therapy processes (Table C8), whilst listing a great variety of helpful therapy processes (Table C3). Likewise, the client did not report any hindering aspects of taking part in the research (Table C11), whereas she was able to point out helpful aspects of taking part in the research (Table C7).

Ms A also describes her therapist in an almost unrealistically positive way at the One Year Change Interview (p.80): 'T is brilliant, about the things she will say and... it, it's just... sometimes the way she explains something or makes perfect sense to me...'. Likewise, at the One Year Change Interview (p.122) the client is dismissive regarding her previous experiences of therapy both with CBT: 'I only been to one therapy, I had CBT with a, just a one-to-one person which I didn't have any value from, at all...'; and when referring to her previous group psychotherapy: 'And err I didn't find that helpful'.

However, the sense of previous therapy as having been no value or unhelpful is not supported by the therapist's Process Notes. In an initial session with her current MBT therapist (Process Notes, 11 July 2011), the therapist noted that Ms A 'felt she was doing well in [previous psychotherapist's] group' and she 'spoke about her life as being better than ever'. This highlights how any reported therapy attributions in this research must be treated with caution since they are likely to be an amplified reflection of Ms A's desire to please the researcher and the therapy team.

c. Interview strategy

The account given by the client is also open to question due to the interview style adopted by the researcher, for example in the One Year Change Interview (p.107):

Ms A: Um a lot of, like my children would probably say 'yeah, I see a big improvement in her'

Researcher: Right, that's great

Ms A: Yeah

This shows how Ms A was encouraged by the researcher ('Right, that's great') to provide a positive account of therapy. Furthermore, in an early part of the One Year Change Interview the interviewer offered quite lengthy advice about the available local alcohol services. This may have added to Ms A's belief that she had to show the researcher how she was 'getting better' and provide a progressive account of her therapeutic experiences and personal changes. This non-neutral research stance may be especially problematic with a client such as Ms A, who has been shown to be a 'people pleaser'. Therefore the data are confounded by the interpersonal dynamics occurring between the client and the researcher.

4. Expectancy artefacts

This argument shows how the client's personal expectations of change account for the progress she reported. Ms A was described as a patient who 'wanted to feel better and have a normal life' (Appendix A). She had participated in CBT and weekly group psychotherapy

prior to referral to the MBT program. Ms A also described herself as 'trying very hard' (One Year Change Interview) and reported that others would describe her as 'trying to improve' (One Year Change Interview, p106). In addition, Ms A emphasised her commitment to the treatment program 'I think we've got to be committed to it' (One Year Change Interview, p.127). Ms A reported having embarked on therapy as she had recently met a 'good man' who she wanted to keep and she thought that therapy would help her to not 'mess it up' (Referral Route).

It seems to be clear that Ms A embarked upon the MBT program determined to change and with some degree of awareness of how to facilitate this change based on her previous sessions of CBT and group psychotherapy. This drive to 'feel better' is likely to account for the client's expectation-driven narrative of getting better (Elliot 2002:12), being scripted in such a way as to conform with her inner desire to change, her drive to please others and her avoidance of any information that may disconfirm these attributes. For example, at the pre-therapy referral interview, Ms A said that she was drinking on four to five days per week. However, at the Year One Change Interview, Ms A recalled this drinking pattern as having been daily in frequency. This shows how the client sought to exaggerate the differences pre-and-post therapy in order to confirm her expectations and what she felt were the expectations of others, accounting for the changes observed.

5. Self-Correction Processes

This argument posits that self-correction processes and not therapy was responsible for any change observed. Ms A had a sense of 'trying very hard' and emphasised her use of self-help techniques: 'I feel like I've got to help myself as well as this helping me' (One Year Change Interview). This is supported by the client's description of being able to try out new behaviours outside of the therapy group, such as going to a supermarket or crossing the road more confidently (One Year Change Interview, p109). Ms A's positive engagement in these

experiences would have allowed her to increasingly develop her abilities and create a 'snowball' effect of change. In this way, the client's personal attributes allowed her to engage in self-generated change processes that were more important than the therapy was.

6. Extra-therapy events

Ms A attributed every change that she recognised at the One Year Change Interview as being 'very unlikely' without therapy. Nevertheless, it is essential to recognise that a number of very significant extra-therapy events occurred in the client's life during the treatment period and to be mindful to their potential effects. At the time of starting treatment, Ms A had recently started educational courses that she felt she had not completed at school. Therapist Process Notes describe how '[Ms A] was now on educational courses that she had missed out on', having left school at fourteen due to bullying (11 July 2011).

In addition, at the time of referral, the client was not in a relationship; however, soon afterwards she discussed her new relationship with a 'good man'. At the One Year Change Interview, Ms A acknowledged her partner as being supportive. The therapist's Process Notes comment that 'he loves her for who she is and finds her very attractive and she is beginning to believe this for the first time' (20 August 2012). Likewise: '[Ms A is] only OK because of [partner]; dependent on him, can't be on her own' (2 July 2012). This suggests that her relationship with her partner, instead of the treatment, may have catalysed any observed changes in Ms A.

Moreover, at the time of referral Ms A had a brother who she reported as having been missing in Malaysia for 11 years (Appendix A). However, on 4 July 2012, Ms A described one Helpful Aspect of Therapy (Table B1) as having been that the group was happy for her when her brother visited from Malaysia. This suggests that at some point during the therapy Ms A's brother was no longer absent from her life and this may have created a profound personal change for the client. The therapist's Process Notes also highlight the importance of Ms A's

brother: '[Ms A] wishes her brother could stay permanently because she is feeling so much better. Feels she will go back to depression once he has gone' (4 July 2012).

Given this contextual information it appears that the client's description of every change having been 'very unlikely' without therapy does not show that she has realistically considered the impact that these very significant extra-therapy events may have had on her life. These events have the potential to make an unsuccessful therapy appear successful (Elliot 2002:14).

7. Psychobiological causes

There had been a persisting change to Ms A's medication (Psychopharmacological Medication Record) seven months prior to the One Year Change Interview (around three months after the MBT program began). This change in medication and the psychobiological effects experienced by Ms A could account for the larger and more significant quantitative changes found in the Outcome Data (Table A1) at seven months compared to those at one year. In other words, Ms A had a medication change early in the MBT program which allowed her to experience changes that then stabilised and persisted until the one year mark, accounting for the larger alterations observed for Ms A in the earlier part of the program. Therefore, any recorded change has a psychobiological as opposed to psychotherapeutic origin.

8. Reactive effects of research

Ms A participated in the research in a self-conscious way and was positive about taking part in the project: 'if the research is being done to help other people then, yeah, I'd love to be part of it' (One Year Change Interview, p.126). The therapist's Process Notes highlight

the importance that Ms A gave to the research project and the therapeutic potential that it had for her: '[Ms A] commented how she was surprised that the scores she went through with [interviewer] had improved – she must have done so' (1 October 2012).

Each month the client was required to reflect on and complete the PQ and the HAT. Furthermore, a Change Interview was undertaken six months into therapy and again after one year. These procedures alone would have given the client significant opportunity to reflect on the process of therapy and personal change. The MBT treatment may or may not have been helpful on its own but in this instance it is impossible to separate whether any changes in the client were due to therapy, research, or a combination of therapy and the research (a conjunction that was described by the researcher as a 'package' of treatment in the One Year Change Interview, p.127). Therefore, it is unreasonable to assert that any client change noted can be due to the MBT program alone.

Conclusion

This sceptic argument has established compelling evidence that competing explanations explain the data presented. In particular, it is asserted that:

- Ms A's apparent changes were trivial or negative; substantial therapeutic change cannot be established
- The possibility of statistical error cannot be excluded
- Ms A is a 'people pleaser' and this self-presentational strategy plus interpersonal dynamics between Ms A and the researcher account for reported changes
- Ms A's evidence was influenced by her own expectation-driven narrative of getting better
- Ms A was determined to help herself; this accounts for any change observed

- Significant extra-therapy events occurred in Ms A's life during the MBT program, providing a satisfactory explanation of change
- An alteration in Ms A's medication caused any changes recorded
- Ms A's participation in the research cannot be causally separated from her participation in the MBT program.

Following this, the sceptic argument asserts that the client did not change substantially over the course of the MBT program. Furthermore, any change observed was not due to the effect of MBT; various other factors have been shown to be in operation.

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APPENDIX D

AFFIRMATIVE REBUTTAL OF THE SCEPTIC CASE

The purpose of this rebuttal is to challenge the arguments put forward in the sceptic brief that Ms A changed little during therapy and that evidence exists to support alternative explanations for Ms A changes. A refutation is presented for all the eight arguments made by the sceptic researcher.

1. Ms A's apparent changes were trivial or negative; substantial therapeutic change cannot be established

The first argument made in the sceptic brief to support the trivial change hypothesis was that the client did not move to the non-clinical range in the three outcome measures (Table A1) analysed for clinical significance (RCI) and therefore that change was not substantial. According to the scores in the PQ and CORE-OM (Table A1), Ms A moved from severe pathology/problems to only mild pathology/problems, indeed very close to the cut-off point in both measures. Whilst it would be ideal that Ms A would be in the non-clinical range after one year, the changes observed are substantial and remarkable having in mind the severity and duration of Ms A's problems (over 10 years). Figure A1 shows that nine months into therapy her PQ was in the non-clinical range with only a minor increase over the following months. Furthermore, Table A1 shows unequivocally a consistent, gradual and reliable drop on the PQ and CORE-OM. The WSAS has also dropped showing reliable change at 8 months.

When using three outcome measures, the probability of one or more measures of three showing reliable change by chance is .49; the solution proposed by Elliott (2002: p.11) is to require reliable change in two of three measures at the $p < .2$ level (corresponding to a probability of .10) or on one measure at a more conservative level such as $p < .05$. In this study, Ms A has shown reliable change at the $p < .05$ level in two of the three measures used; this is indeed above the minimum requirements suggested by Elliott (2002) which leaves no doubt that significant change has occurred.

The second argument made in the sceptic brief was that the CORE-OM, Mentalizing Capacity, and GAF did not show categorical improvement between eight months and one year. In reality, there isn't a categorical improvement from 8 months to one-year in these measures but instead a gradual and sustained change from month one which is very significant and even unusual for a patient diagnosed with personality disorder and with such serious problems as observed in Ms A.

The third argument posed was that the increased WSAS score at one-year suggested a negative change in Ms A. This increase, however, does not meet the threshold for reliable clinical change (see Table A1) and therefore is not significant. Also, instead of focusing on the lack of change observed between 8 months and one-year in the CORE-OM and WSAS the affirmative brief sees as much more significant the fact that the positive changes are sustained during this period and that there is no deterioration observed or a return to previous levels of distress.

The fact that Ms A's sleep has not improved was also argued by the sceptic brief. This is indeed a problem that has not changed but a neuro-chemical hypothesis can be posed that the decrease in alcohol use as well as the need for a medication review can be affecting this dimension. Ms A supports this argument in her change interview:

- ‘I mean I’ve got to get them changed because I’m not sleeping at all’ (P81 one-year interview transcript, referring to her medication).
- ‘in fact the sleeping pattern is worst... well I would say that I think it’s worst because I don’t drink so often..’ (P119, one-year interview transcript).

The sceptic brief also mentions that there are inconsistencies in the data regarding the suggested improvements in drinking behaviour. This argument, however, doesn’t take into account the global change in this dimension and looks at this problem only partially. Ms A has indeed had periods of relapse but these last only for a few days in the form of binge drinking as opposed to daily and dependent drinking as at the beginning of therapy. The quote from the therapist process notes chosen by the sceptic brief mentioning that Ms A is ‘drinking every day and doesn’t know how to change it’ (Process Notes, 23 July 2012) is not contextualized and hides the fact that this was a binge period rather than a sustained problem. Both the patient and the therapist comment on the global decrease in alcohol consumption:

- “It’s a big change... because I would always have a drink in the house” (P120, one-year change interview).
- “[Ms A] continues to try hard to cut down on her intake of alcohol and stay with the unbearable feelings of hopelessness rather than disconnect to the point of unconscious” (9-month individual progress report).

The sceptic brief then mentions a second time about the negative changes on the WSAS, again not taking into consideration the minimum RCI values necessary to assume that change has happened (see Table A1).

In conclusion, the affirmative brief argues that 1) more than the minimum requirements in the outcome measures were reached suggesting very confidently that change has occurred; 2) the patient and therapist agree that there was a change and 3) the subjective

evaluation of the Consultant (through the GAF and Mentalizing Capacity scales for example) also points to significant change. The triangulation of such a strong body of evidence does not leave room to accept the sceptic arguments as valid.

2. The possibility of statistical error cannot be excluded

The sceptic brief starts by referring the lack of change observed in the WSAS at one-year and even commenting on the deterioration of this dimension. Once more the sceptic argument does not take into consideration the minimum RCI levels required for assuming reliable change has occurred (see Table A1). The criteria established by Elliott (2002) on the minimum requirements needed to assume that change has happened and was significant (two measures at the $p < .2$ level or one measure at the $p < .05$ level) were also ignored. This case surpasses the minimum requirements, with change reported in two measures at the $p < .05$ level, making it hard to give credibility to the sceptic argument.

3. Ms A is a 'people pleaser' and this self-presentational strategy, plus interpersonal dynamics between Ms A and the researcher, account for reported changes

This section was divided into three subsections and a rebuttal of each is done separately:

a) Relational response tendencies

Whilst this is a valid argument it cannot deter the fact that change has occurred, as all the quantitative and qualitative indicators suggest. At five months, the therapist report regarding the group as a whole states that 'we have moved from the stage of pretend mode

where stage of protection for themselves and for one another to daring to take risks and explore how the other perceives the other to be'. In her individual 5-month report the therapist wrote to Ms A saying: 'I continue to believe that you are making steady progress and show signs of a greater stability within yourself'. Direct feedback to the patient is part of MBT treatment and whilst it can collude with the relational tendencies of the patient it is thought to be an important element to allow the patient to learn about themselves through the mind of others (contingent marked mirroring).

Dependency is indeed present but it is a normal and important stage in many psychoanalytically informed treatments; the fact that the patient is aware of this suggests that she will be able to work on the separation from treatment over the final year of the programme.

Furthermore, during the 5-month progress report (Feb 2012) the therapist comments on Ms A's tendency to please others saying that 'this has lessened as this propensity has been realized and worked with' suggesting that this is now a conscious process.

b) The plausibility of reported therapy attributions

The 'hello-goodbye' effect mentioned in the sceptic brief was carefully considered by the research team and it is not a valid argument since the treatment lasts for two years and is now only half-way. Along these lines, Ms A's reported changes and her attributions to the influence of therapy are unlikely to be made as a desire to express gratitude or to justify the end of therapy (Elliott, 2002).

The sceptic brief also mentions the 'plausibility criteria', in particular regarding 'differentiation'. The affirmative brief response is that even if Ms A did not report hindering therapy processes she was nonetheless able to point out difficult events in therapy and the way she was affected by them (table C6). The idiosyncrasy of her account suggests that this is a valid reflection exercise and not pseudo-

mentalization. Ms A was also able to identify aspects that have not changed without apparent concern with disappointing the interviewer or the MBT team (e.g. the increasing difficulties in sleeping).

Continuing further, the sceptic brief argues that Ms A describes her therapist in an almost unrealistically positive way going on to give an example. It is difficult to assert any value to the sceptic argument here and the subjective interpretation made of Ms A's statement. What the sceptic researcher believes to be an unrealistic positive statement can indeed reflect the importance of the positive bond Ms A has established with her therapist. This is reflected on the high score of the WAI-S at one-year (see Table A2) which several studies show is a fundamental variable in affecting positive change (Horvath, 1994).

C) Interview strategy

Although it is possible to understand the concerns of the sceptic researcher, the interviewers' comment was not intended as an encouragement to hear positive accounts but rather to show a human response to a patient who reports significant improvements on her quality of life. The interviewer attempts to gather negative evidence were as serious and neutral as the ones to gather positive evidence. For example, shortly after the 'that's great' comment the interviewer asks:

- "Ok. Now if if you've been telling me good things about the therapy, what about things that are not so good, any problematic areas, things that have been unhelpful, disappointing... (P124, one-year interview transcript).

The sceptic brief also contests against the effects of giving advice regarding drug and alcohol services and the apparent lack of neutrality of the interviewer: although this is a valid point, this was carefully looked at within the clinical and research team before being introduced to the patient. In MBT the entire treatment and research team is taken as a whole to avoid splitting mechanisms by the patient

(Bateman and Fonagy, 2004). Since the interviewer also works within the Drug and Alcohol Services it would make practical sense to inform the patient about how best to access the service. As previously mentioned the same attention was paid to unhelpful and helpful factors and no preference of direction was suggested to the patient.

4. Ms A's evidence was influenced by her own expectation-driven narrative of getting better

The first sceptic argument is acceptable and valid, suggesting that Ms A's personal attributes (moderator variables) may have facilitated the change. This variable is expected to play a part in every treatment but it does not seem sufficient, however, to fully explain the patient changes.

In relation to the second sceptic argument, even if the possibility of exaggeration is plausible, the affirmative brief counter-argues the sceptic point since most of Ms A's descriptions are idiosyncratic and specific to her situation, giving more credibility to her arguments (Elliott, 2002).

5. Ms A was determined to help herself; this accounts for any change observed

I believe this sceptic argument supports the therapy efficacy hypothesis rather than casting doubt on it. The fact that Ms A has said "I feel like I've got to help myself as well as this helping me" is indicative of how she trusted the therapy process and understood the importance of being involved. The 'snowball' effect mentioned by the sceptic researcher seems to be a reality but since her problems were chronic and with over 10 years duration it is very unlikely that self-correction processes by itself could explain the patient changes.

6. Significant extra-therapy events occurred in Ms A's life during the MBT program, providing a satisfactory explanation of change

a) The fact that Ms A has engaged in educational courses prior to the start of MBT

The affirmative brief argues that there is no evidence that this extra-therapy event had a significant impact on Ms A's generic sense of well-being as it can be observed by the severity of all the outcome measures used at the beginning of the programme together with the Consultant and Therapist subjective evaluations. A good example to support this can be found in the risk assessment undertaken by the Consultant at the beginning stage of treatment. The risks identified were "drinking heavily"; "poor impulse control"; "severe anxiety" and "relationship problems". This contrasts with only one risk at the review undertaken at one-year which only mentions "risk of relapse into alcohol use".

b) The new relationship that Ms A has started

Although it seems clear that this relationship with a 'good man' had a positive impact on Ms A, it can be inferred that the possibility of sustaining this relationship and maintaining it reasonably 'healthy' was influenced by her involvement in therapy. Ms A had a history of failed and dysfunctional relationships and reported being with very aggressive partners in the past (see 'the patient' section or interview transcript for examples); she mentioned that she would like therapy to help her deal with this relationship in a different manner. One of her helpful events in the HAT, rated between 'greatly helpful' and 'extremely helpful' (see Table B1), states the positive impact of discussing her new relationship with the group helping her to see a recent row with her partner in a different way. We cannot discard the fact that her partner was also occasionally seen together with her by the Consultant for couples work which Ms A thinks helped her partner not to 'feel on his own

with it' (P54, 6-month interview transcript). The therapist 7-month report (April) also states the importance of Ms A having resolved the conflict with another group member making it 'more likely to increase your confidence with future relationships'.

The sceptic brief also raises the issue of dependency on her partner. It is clear that Ms A has strong dependency traits, as also confirmed by the SCID-II during the assessment stage. However, we cannot isolate the process notes of one single session to assume that this is the overall opinion of the therapist. It is clear from her progress reports that the therapist believes the patient has changed internally and that the change is not caused solely but external factors such as the partner:

- "You (...) show signs of greater stability within yourself" (7-month progress report)
- "You are beginning to move out of the victim position and beginning to be able to protect yourself" (7-month progress report)

Ms A's global awareness of dependency traits seem also to be increasing as suggested by her comments at the one-year interview: (referring to the therapy) "I depend on it being here because I don't know how I'd get through" (P103, one-year interview transcript).

c) The issue of the reunion with her brother

This appears to be a significant life event and it is likely that this impacted positively on Ms A's life. However, as argued above it can be speculated that her improved capacity for interpersonal relationships was induced by the therapy and that this in itself has facilitated the reunion with her brother.

All the above, together with the patient likelihood without therapy ratings (Tables C1 and C2) leaves little doubt that therapy was the major influence in the patient's change.

7. An alteration in Ms A's medication caused any changes recorded

The medication may have indeed facilitated the patient's change as it was reviewed 3 months into therapy. However, the amount of changes reported by the patient, the therapist and the consultant (also a psychiatrist) seem to make a clear point that these were not unidirectionally caused by the medication. In fact, the patient has commented negatively on her medication during the one-year interview and was about to book an appointment with her psychiatrist at CMHT following a discussion with her therapist:

- (commenting on her flat mood) "It's a not a major change to me because I'm still trying to combat... but but I do think maybe it's something to do with the tablets" (P132, one-year interview transcript).
- "I think these tablets are quite suppressing me and the flat mood I think it's a lot to do with not sleeping because I'm desperately tired all of the time" (P135, one-year interview transcript).

8. Ms A's participation in the research cannot be causally separated from her participation in the MBT program

It is difficult not to agree with the sceptic argument on this point since Ms A was one of the most dedicated group members in responding to the research questionnaires and other requests. However, during both change interviews, when asked about what had brought about the changes she made no mention to the research. Also, even admitting that the research provided this 'extra reflective space', when asked about helpful aspects of the research she did not spontaneously refer to this fact.

In this way it is not possible to conclude that the positive outcome reported was affected mostly as a function of being part of the research.

Conclusion

The affirmative team considered most of the sceptic arguments to be flawed, partial and misleading. We ask you to consider the following points:

1. Ms A's quantitative data unequivocally points to reliable and substantial change, surpassing even the minimum criteria suggested by Elliott (2002);
2. Ms A's attributions are realistic and backed up by the therapist reports and the results of the consultant reviews;
3. Ms A's relational tendencies to please do not influence the results as she also reports difficult processes and aspects that have not changed. Furthermore, the 'reverted' items in Ms A's outcome measures (usually used to detect lies or inconsistencies) matched with the other 'normal' items.
4. The warm responses of the therapist and researcher do not encourage the patient to simulate change but are, instead, a fundamental therapeutic process for this patient. This is reflected on the WAI-S high score (Table A2).
5. It is not possible to isolate the influence of extra-therapy events and its cumulative, snowballing effect with the therapy programme.
6. The medication by itself cannot explain such a range of internal and external changes.
7. The research, whilst not hindering, does not seem to be a fundamental helpful factor and did not, therefore, caused the changes.

8. Mr Z seemed to take the research as more of an inconvenient than a benefit or, at best, he was neutral about his participation making it very unlikely that the research was solely responsible for the changes observed.

References

- Bateman, A. W. and Fonagy, P. (2004) *Psychotherapy for Borderline Personality Disorder: mentalization based treatment*. Oxford: Oxford University Press.
- Elliott, R. (2002) Hermeneutic single case efficacy design. *Psychotherapy Research*, 12, pp.1-20.
- Horvath, A. (1994) Research on the alliance. In: A. Horvath and L. Greenberg, eds. *The Working Alliance: theory, research and practice*. New York: Wiley, pp. 259-286.

APPENDIX E

SCEPTIC REBUTTAL OF THE AFFIRMATIVE BRIEF

The affirmative brief argues that Ms A's stable and chronic problems did change substantially during the MBT program and that the therapy was the cause of this change. This sceptic rebuttal challenges the validity of these conclusions and demonstrates that both the quantitative and qualitative data on which they are based is intrinsically unreliable.

1. No substantial change in stable problems

The affirmative argument concluded that 'significant changes have occurred in Ms A's stable and chronic problems'. However, this sceptic rebuttal argues that the client is still experiencing many of these issues and can be described, at best, as working towards change. Furthermore, it is not sufficient for the affirmative argument to show mere change in Ms A: for the stance to be successful it must illustrate that any change has been substantial; the sceptic rebuttal contends that this criterion has not been met.

As the initial sceptic argument outlined, the client remains in the clinical range on each measure of the Outcome Data (Table A1), even after one year of treatment. In addition, the observed changes were not replicated across all quantitative indicators (see WSAS, Table A1) and there has not been a global drop in the client's PQ ratings (see Item 4, Table A3); these examples highlight the unreliability of the quantitative data. This is supported by the client's own assertions in the One Year Change Interview, where she openly describes herself as

'someone who's striving to get back into the world' (p.105) and 'I'd describe myself as someone who's trying very hard' (p.105). Ms A is unable to describe herself as someone who has already changed substantially, only as someone who is trying to change.

The therapist's Nine Month Report confirms this: 'Ms A continues to try hard to cut down on her intake of alcohol and stay with the unbearable feelings of hopelessness' and 'she is building on her low self-esteem'. Descriptions such as 'trying hard' and 'building' do not support substantial change; they illustrate a process that may or may not lead to future change. Therefore, both quantitative and qualitative data highlight that it is not possible for the affirmative brief to illustrate a truly substantial change in the client's stable and chronic problems.

2. Problems with retrospective attribution

The affirmative brief indicates that Ms A clearly attributed any that she noted changes to therapy. However, this sceptic rebuttal asserts that Ms A's reports cannot be taken at face value and that a more profound examination reveals the way in which the evidence she presented is distorted. It is also suggested that Ms A benefited from aspects of the group setting other than specifically the MBT.

a. The client's retrospective attributions are unreliable

The affirmative brief makes the argument that Ms A considered all changes recorded to be 'very unlikely without therapy' and also all changes were rated by the client as 'extremely important'. However, Elliott et al (2009) emphasise that clients almost always rate their changes as 'important' in the Change Interview, confounding the results and suggesting that this is not a reliable indicator. These consistently maximum ratings also support Bohart and Boyd's (1997 as cited in Elliot, 2002: p.11) assertion of the implausibility of the

evidence due to lack of differentiation in the data. Therefore, the client's retrospective attributions are unreliable gauges of the processes behind any change.

Furthermore, the sceptic brief has already outlined that Ms A is a 'people pleaser' who acts to sustain the therapeutic relationship. The client rewards the therapist and the research team by exaggerating her progress in therapy and maintaining that it is 'special' through her dismissal of previous therapeutic experiences (see Sceptic Argument, Section 3). The therapist's Six Month Report highlights how, although the therapist hypothesises this process, the client remains unaware of this practice: 'I am sure that you do not feel that to be the case'.

This self-presentational manner is at work in the affirmative evidence. For instance, the client reports, in relation to her drinking problems, that without therapy 'I'd probably be dead' (One Year Change Interview, p.105). However, this is unlikely since Ms A's drinking had been a persistent and stable issue for her for over 10 years prior to therapy. Therefore the positive therapeutic attributions made by the client are unreliable due to relational artefacts and the affirmative assertions must be rejected.

b. Client did not benefit specifically from MBT

Following this, the affirmative brief also highlights how Ms A 'generically attributes her reported changes to the influence of therapy' but struggles to explain why: 'I don't know how that happens or why it happens' (One Year Change Interview, p.102). However, evidence in the One Year Change Interview (p.122) suggests that Ms A attributed her improvement to being in a group with individuals with substance misuse problems:

Ms A: And err I didn't find that helpful because they all seemed to have particular different problems to me and they weren't using anything

Interviewer: So the fact that people are using ... substances?

Ms A: Yeah substances has made a big difference I think because it's like when you say I had a relapse and I did this, I did that, you know, you're telling people that know exactly how it feels, that you've got to cut those thoughts off, whether they are using alcohol or not, or taking too many pills or smoking weed or whatever it is they do they're doing it to cut off the crap...

This suggests that the client did not retrospectively attribute any changes in her functioning to features of the treatment that were specific to MBT; instead, Ms A found being in a generally supportive group with other individuals experiencing substance misuse problems to be the key helpful factor in the therapy.

3. Insubstantial process-outcome mapping

The affirmative brief has attempted to map changes reported in the One Year Change Interview (Table C2) to specific therapeutic events or processes (HAT, Table B1). However, this sceptic rebuttal argues that the mapping process undertaken is extremely tentative and requires a 'leap of faith' to be believed. In addition, it has already been shown that observed changes in Ms A were due to other factors (outlined in the initial Sceptic Argument). Furthermore, there is direct evidence that to show that the therapist's adherence to MBT (Table D1) and the Helpful/Hindering Aspects of Therapy (Tables B1/B2) do not co-vary reliably, suggesting that a clear process-outcome mapping is not possible.

Ms A reported eleven Qualitative Outcomes at the One Year Change Interview (Table C2). However, the affirmative argument has only been able to map three of these – briefly: improved confidence and self-esteem; less paranoia; and reduced social isolation - onto specific therapeutic processes described by the client as helpful (Table B1). This suggests that the remaining eight Qualitative Outcomes (or 88% of the reported changes) are not related to the MBT program; therefore, factors external to the treatment must be of greater importance in this instance.

Following this, the three factors that have been mapped in the affirmative brief are extremely circumspect and are not supported by other evidence, such as the monthly PQ ratings (Table B2). For example, the Qualitative Outcome 'Less socially isolated' has been mapped onto one helpful therapeutic event that occurred in January 2012 'To talk about isolation'. However, the PQ data for Social Isolation reveal that the ratings were higher for January 2012 (7), February 2012 (7) and March 2012 (7) than the first rating in September 2011 (6) was. This highlights that the helpful event reported in the affirmative brief did not actually create any change in the client.

Likewise, the affirmative argument maps the Qualitative Outcome referring to paranoia and social engagement onto two therapy events, one in December 2011 and one in May 2012. However, there are no large changes in the client's PQ ratings for 'Difficulties engaging with people' for these months, with the December 2011 rating as 7 and the May 2012 rating reported as 6. This shows that the process-outcome mapping asserted in the affirmative brief is insubstantial, supporting the notion that the changes experienced by Ms A were due to other factors, such as extra-therapy events. The therapist's Nine Month Report confirms the importance of such events for the client: 'I hope you will continue to think about the idea of finding some part-time work, continue to look after your grandchildren, and to support your friends, as these activities are more likely to lessen your flat mood and to boost your morale'.

Furthermore, convincing evidence suggests that the therapist's adherence to MBT (Table D1) and the client's experiences of helpful or hindering aspects of therapy (Tables B1 and B2) were not related. For example, in February 2012 the Therapist Adherence to MBT was 100% (the highest rating received). However, in the same month, the client reported the Helpful Aspects of Therapy to be 'Nothing' and stated that a Hindering Aspect of Therapy was 'people in the group playing illness one-upmanship'. This suggests that, contrary to the affirmative brief, it cannot be assumed that therapeutic processes had a direct impact on the changes experienced by Ms A.

4. No within-therapy process-outcome correlation

The affirmative brief has found no evidence to support a relationship between in-therapy process variables and shifts in client problems. As stated by the affirmative argument: 'we did not find a correlation between overall levels of MBT adherence and the results in the PQ'. Therefore, despite the high adherence that the therapist has shown to MBT principles in her self-report statements, these cannot be correlated with client changes and do not stand alone as evidence for a connection between the therapy and the client outcome.

5. Difficulty in inferring event-shift sequences

The affirmative argument has attempted to suggest that important therapy events led to a stable shift in client problems. The sceptic rebuttal advances that in fact, due to the methods used in the affirmative brief, no stable shift in client problems can be asserted; at best only a fluctuation in post-therapy interpretations by Ms A can be inferred.

The affirmative brief has related the PQ and HAT ratings to each other from the same session in an attempt to show a stable shift in client problems. However, this strategy cannot be used to associate a stable shift in client patterns with events in therapy since, when

completing both questionnaires (PQ and HAT) on the same week, directly following the therapy session, it is not possible to infer that a therapeutic event caused a stable shift in client functioning; the method employed at best reveals the way that the client's feelings may briefly waver following a therapeutic event. Therefore, stable event-shift sequences cannot be inferred.

It must also be noted that the affirmative brief suggests that a significant drop can be observed on the PQ, particularly from March 2012 onwards. However, it is essential to acknowledge that the data for April 2012 are missing, thereby distorting and accentuating such a drop. The affirmative argument makes the case that a Helpful Aspect of Therapy (Table B1) in March 2012 had a dramatic and stabilising effect on the PQ scores thereafter. However, this is a highly tentative conclusion that is impossible to sustain given the missing data for April 2012. In other words, the affirmative position is asking us to accept - without any direct evidence in support - that something that happened in a therapy session in March 2012 is responsible for the changes observed in the next data collected in May 2012. This represents an unreasonable and unsubstantiated 'leap of faith'.

Furthermore, this Helpful Aspect of Therapy described by Ms A in March 2012 related to solving some problems with another group member (Table B1). Despite this, Ms A's PQ ratings (Table B2) for 'Low self-esteem' and 'Difficulties relating to people' either did not change, or changed by only one point, between March 2012 and May 2012. This casts doubt over the importance that the therapeutic event in March 2012 held for Ms A's overall reported changes. Therefore, it is necessary to reject the affirmative argument that therapy events led to a stable shift in client patterns. Instead, any changes observed can be said to be the result of other factors as outlined in the original sceptic brief.

Conclusion

The sceptic rebuttal has examined the affirmative brief in good faith and makes the following assertions:

- There was no substantial change in Ms A's stable problems
- The case for retrospective attribution advanced by the affirmative argument is unreliable and evidence shows that Ms A did not attribute any changes in functioning to aspects of the therapy that were specific to MBT
- The process-outcome mapping posited by the affirmative brief cannot account for the majority of the qualitative outcomes; instead, it has been shown that MBT adherence and HAT do not co-vary positively
- No within-therapy process outcome correlations have been established
- Therapy events cannot be shown to have led to a stable shift in client patterns.

Therefore, there is insufficient evidence to support the therapy efficacy hypothesis; competing explanations for apparent client change must be accepted.

References

- Elliott, R. et al (2009). An adjudicated hermeneutic single-case efficacy design study of experiential therapy for panic/phobia. *Psychotherapy Research*, 19 (4-5), 543-557.
- Elliott, R. (2002) Hermeneutic single case efficacy design. *Psychotherapy Research*, 12, 1-20.

APPENDIX F

AFFIRMATIVE NARRATIVE SUMMARY

Ms A was 55 years old when she started the MBT programme. She had long standing and severe difficulties, all lasting for over 10 years. Her presenting problems included low self-esteem and self-confidence, extreme mood swings, and a history of suicide attempts and overdoses. At one point, when she was 34, she spent 7 weeks in a psychiatric hospital. Ms A has developed maladaptive strategies (e.g. drinking) to disconnect from her daily self-harming thoughts and feelings of emptiness and insecurity. She reported a history of abusive relationships and a pattern of drinking and having unprotected sex with random men, ending frequently with intense feelings of guilt. She had been previously diagnosed with borderline personality disorder and this diagnosis was confirmed during the current treatment episode; she also met the criteria for depressive and avoidant personality disorders. Her SCID-II, undertaken at assessment, scored high for a number of other personality traits, with particular emphasis on dependency. Ms A had 8 sessions of CBT and was in once-weekly group psychotherapy for one year before joining the complex needs service and the MBT programme.

With such a dramatic history and presentation, the affirmative position made a very convincing argument that Ms A has shown 'global reliable change' (Elliott, 2002) following one-year of MBT and that this change was due to the therapy programme. Clinically reliable change (Jacobson and Truax, 1991) was achieved at the $p < .05$ level in two out of three outcome measures which is above the criteria defined to assume that this change was not due to chance or measurement error (Elliott, 2002). Ms A also clearly attributed these changes to effects of therapy (e.g. Tables C1 and C2). The sceptic position's persistent attempts to claim that the changes were trivial and that statistic artefacts

were in play are not meaningful as they completely ignore the importance of clinical significance methods (Jacobson and Truax, 1991) and statistical confidence intervals (Smithson, 2003). The affirmative brief also backed up the argument for change with the subjective evaluation of both the therapist (through her process notes and progress reports), the consultant (through, for example, the rating of the GAF, TOP and Mentalizing Capacity) and the patient HAT forms and change interviews. They all point towards significant and substantial change.

On the other hand, a closer look into the sceptic initial brief and rebuttal also shows that in a number of occasions the sceptic position has admitted, potentially inadvertently, that change has occurred: for example, 'it has already been shown that observed changes in Ms A were due to other factors'; or 'Ms A's brother was no longer absent from her life and this may have created a profound personal change for the client'; or even 'which allowed her to experience changes that then stabilised and persisted until the one year mark'. All these assertions admit that change has happened, even if a valiant effort is made to attribute the change to other factors.

According to Elliott (2002) two pieces of evidence would be enough to support the therapy efficacy hypothesis. In addition to the strong evidence for 'change in stable problems' and 'retrospective attribution', the affirmative position also makes a case for process-outcome mapping, the link between MBT principles and outcome and how significant therapeutic events facilitated the positive outcomes. These final three pieces of evidence do not seem immediately logic or clear and the sceptic argument picks up on this to attempt to disconfirm the therapy efficacy hypothesis. In the affirmative rebuttal, however, it is possible to see how the sceptic arguments are unsustainable and ignore a number of subtle processes that are of fundamental importance as reported by the patient and the therapist. Most of those processes relate to a positive bond and a strong working alliance (see Table A2) and the impact that this 'safety' engenders in Ms A, allowing her to take risks and confront her fears and avoidance tendencies. The ability to 'think in the heat of the moment' for example, a fundamental feature of MBT, is mentioned by the therapist in her 7-month report.

Furthermore, the sceptic effortful position has shown a tendency for partial arguments, concealing in this way important elements. For example, the March helpful event reported in the HAT (Table B1) was repeatedly brought to the conversation by Ms A during both change interviews and also by the therapist in her several reports. Despite this fact, the sceptic position states that the affirmative brief argues for this process-outcome link 'without any direct evidence in support'.

The affirmative position has a strong and convincing case that a) Ms A has changed substantially and b) these changes are substantially due to the effects of MBT.

Finally, it is anticipated that the changes reported by Ms A will now be consolidated during the next year of treatment and there is a good chance that these will be sustainable and lasting. These hypotheses will be tested at the end of treatment and at 6 months follow-up.

References

- Elliott, R. (2002) Hermeneutic single case efficacy design. *Psychotherapy Research*, 12, pp.1-20.
- Jacobson, N., and Truax, P. (1991) Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59(1), pp.12-19.
- Smithson, M. (2003) Confidence intervals. *Quantitative Applications in the Social Sciences Series*, 140, pp. 96-106.

APPENDIX G
SCEPTIC NARRATIVE SUMMARY

The affirmative case, in its brief and rebuttal, has sought to demonstrate that Ms A changed substantially during the MBT program and that the therapy was the cause of this change. However, the sceptic position has advanced convincing arguments to the contrary, both in its initial brief and in its rebuttal of the affirmative standpoint. Following this, the only reasonable conclusions that can be reached are that: Ms A did not change substantially during the first year of the MBT program; and any changes that were recorded have not been shown to be reliably related to the therapy.

The sceptic argument has assuredly illustrated that changes in Ms A were not substantial: the Outcome Data (Table A1) did not move out of the clinical range at any point during treatment and the client can only describe herself as 'striving' in the One Year Change Interview, not as having already changed substantially; this position is corroborated by the therapist's Reports. In addition, the quantitative indicators have been shown to not consistently support one another and there are discrepancies in the quantitative and qualitative data. Furthermore, Ms A is a 'people pleaser'; the lack of differentiation in her narrative descriptions of therapy (One Year Change Interview) and her Qualitative Outcomes (Table C2) support the centrality of this self-presentational tactic to the data. The strategy adopted by the interviewer was collusive with this. Although the affirmative rebuttal suggests that by the six month therapy mark, rewarding others had become a 'conscious process' for Ms A, the therapist's Six Month Report highlights how the client may remain unaware of such characteristics.

Ms A placed great importance on the research. The affirmative rebuttal suggests that: 'Ms A was one of the most dedicated group members in responding to the research questionnaires and other requests' and this highlights the degree to which the presence of the investigative process is likely to have confounded the results in this case. Moreover, any failure of the client to spontaneously mention the importance of the research during the Change Interviews (asserted by the affirmative rebuttal) merely confirms the sceptic argument that the interview strategy did not allow her to be open and reflexive: Ms A voluntarily discussed the value of the research enterprise with her therapist (for instance, Process Notes, 1 October 2012).

Furthermore, the client was driven to 'have a normal life' (Appendix A). This desire and expectation, coupled with the significant period of time that she had previously spent in therapy and momentous life events - returning to education for the first time since she was fourteen years old, being visited by a brother who was previously 'missing', and finding a positive relationship with a supportive partner – would easily explain the changes observed in Ms A.

Therefore, the sceptic summary concludes that Ms A did not change substantially during the course of the MBT program. Moreover, the therapy was merely one of many factors that might explain any changes reported. The affirmative position has been unable to convincingly demonstrate a link that tolerates reasonable scrutiny between the MBT program and client functioning. Consequently, the sceptic argument must be accepted.

APPENDIX H
INTERVIEW TRANSCRIPTS

(This section was removed to protect the participant identity – sections of the interview are found in Tables C3 – C12 and also throughout the analysis)

APPENDIX I
ADDITIONAL TABLES

Table F1: Ms A Monthly PQ ratings for each item

Item	09/11 1	average 2	16.01 3	22/02 4	12/03 5	No data 6	09/05 7	11/06 8	04/07 9	13 .08.12 10	11 26.09.12
1. Unreliable (due to drinking)	7	6	4	4	7		4	3	3	3	3
2. Unstable and Impulsive	7	5	5	5	7		4	4	3	4	2
3. Constant worry about everything	7	7	6	6	7		4	4	3	4	4
4. Lack of sleep	6	7	7	7	7		6	6	5	6	6
5. Temper outbursts	6	4	4	5	5		2	3	1	1	2
6. Low self-esteem	7	7	7	7	7		7	6	3	2	3
7. Flat mood a lot of the time	6	7	6	6	7		5	4	2	3	3
8. Difficulties engaging with people	7	7	7	6	7		6	4	3	4	4

9. Social Isolation	6	7	7	7	7		5	5	2	5	4
10. Cry easily	6	7	7	7	7		5	5	4	3	3

Table F2: Ms A Mean Scores on the Personal Questionnaire

Sessio n Date	Base	1	2	3	4	5	6	7	8	9	10	11
	09/11/1 1	09/11/1 1	Ave 7/12 and 21/12	16/01/1 1	22/02/1 2	12/03/1 2	Missing data	09/05	11/06	04/07	13.08	26.09
Mean PQ	6.5	6.5	6.4	6.0	6.0	6.8		4.8	4.4	2.9	3.5	3.4

APPENDIX J
ADJUDICATION

HSCED Instructions for Judges
(Adapted Version, October 2012)*

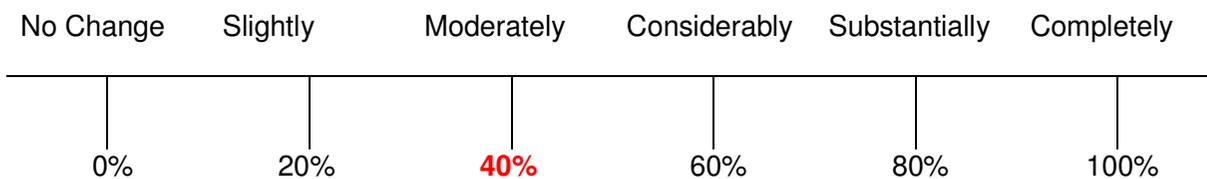
JUDGE A

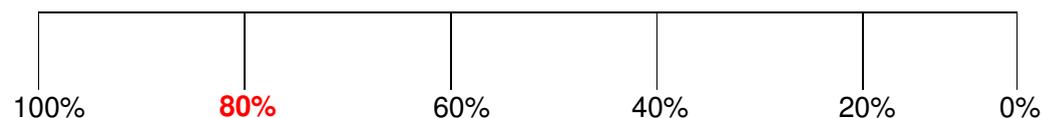
Completing the adjudication process

Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.)

In answering the rest of the questions, please use whatever space you need in order to give a full response.

1a. To what extent do you think this patient *changed* over the course one-year of therapy?



1b. How certain are you?**1c. Please describe the basis for your judgement:**

In taking in both the affirmative and sceptic arguments I feel there is a good, but not an overwhelming case for improvement in symptomatology and distress at a moderate level. I think the question as to whether this can be fully maintained, and further built on remains open at this stage. I do share concerns that the presentation of improvement by the patient is at least partially dependent on the wish to please in therapy. I would agree that for a stronger improvement to be argued that values moving below clinical cut-offs would be more convincing. I agree to some extent that the issue of on-going alcohol consumption, even if much reduced, but still at times in binge fashion, means that judgement of improvement has to be qualified. I would regard the patient as to be still likely to be markedly vulnerable to relapse as a result and demonstrating reduced capacity to mentalize in the lead up to these episodes.

I do share the affirmative position that the positive statements of the patient recounting some important areas of improvement are meaningful however in the main despite the concerns about some of the dynamics behind this, and they do demonstrate an ability to thoughtfully reflect on how change has been encountered, in itself an improvement in Mentalization capacity. To my mind the in-

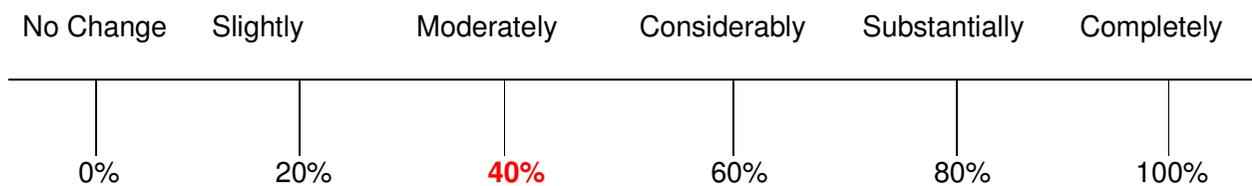
group experiences described are evidence of some positive change interpersonally and I would expect that some of this will prove translatable to outside therapy settings in a durable way.

1d. How much did you weigh (take into consideration) the following case elements in evaluating *patient change* over the course of therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data					Y	
b. Quantitative outcome data					Y	
c. Change Interview transcript (including qualitative coding)					Y	
d. HAT data					Y	
e. Affirmative Case						Y
f. Sceptic Case						Y
g. Affirmative Rebuttal/Closing argument				Y		
h. Sceptic Rebuttal/Closing argument				Y		

i. Other			Y			
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2a. To what extent do you think that the patient's changes were due to the therapy?



2b. How certain are you?



2c. Please describe the basis for your judgement:

Having said that I agree that moderate, real change has taken place I do not share any of the certainty of conclusion about what these link with. I would very much concur with the sceptic argument that the linkage between the in –therapy events and changes in score is in many cases weak or at most moderate. I would have a very strong expectation that out- of therapy events and other in programme interventions, such as the psycho-social nursing contact, and involvement in further education to be very powerful factors potentially as well. You could also argue that in some instances the important therapy work was maybe being done in the weeks preceding the change and the any association in the transcript about therapy events was actually the resultant better functioning being noted for the first time by the subject. I do see that you have to see the transcribed material as evidence of some change and that the therapy was useful, but not to the degree or specificity that is flagged up here in the affirmative perspective. In a sense the qualitative data helps identify the possible nature of some of the change, better than it does the processes behind the change I feel. Part of the reason for this is the retrospective nature of it and some because of the complex other factors that maybe have played a part.

2d. How much did you weigh (take into consideration) the following case elements in evaluating the extent to which client change was due to therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data					Y	
b. Quantitative outcome data				Y		
c. Change Interview transcript (including qualitative coding)					Y	
d. HAT data					Y	
e. Affirmative Case						Y

f. Sceptic Case						Y
g. Affirmative Rebuttal/Closing argument				Y		
h. Sceptic Rebuttal/Closing argument				Y		
i. Other			Y			

3. Which therapy processes (mediator factors) do you feel were helpful to the client?

I do think the evidence shows that the group context of the therapy was probably useful for her and alongside that of course the characteristics of MBT will have helped her deal with a range of interpersonal stresses and relationships in general in a more helpful way. I would see the very well supported therapeutic programme, with twice week therapy, psycho-social nursing and psychiatric contact will have also played a useful role through its structure and consistency.

4. Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled her to make best use of her therapy?

The fact she was now in relationship she was happier with, the fact that family circumstances were more settled. Also, the positive effect of drinking to a lesser degree. All these are positive factors. The transcripts and record also demonstrate a motivated patient, a very important factor. Finally, I think also her ability to form a sustained therapeutic alliance was demonstrated, which is probably the most crucial fact.

*adapted from "unpublished research procedure, Counseling Unit, University of Strathclyde, Glasgow, UK

HSCED Instructions for Judges
(Adapted Version, October 2012)*

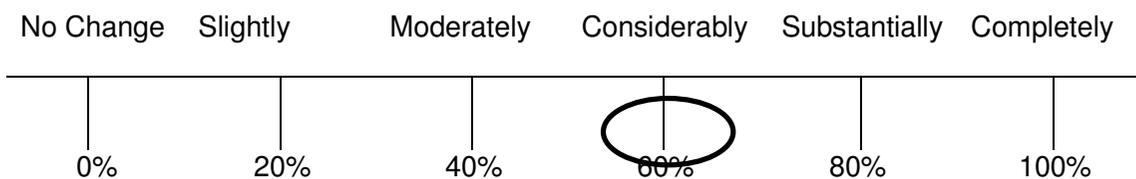
JUDGE B

Completing the adjudication process

Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.)

In answering the rest of the questions, please use whatever space you need in order to give a full response.

1a. To what extent do you think this patient *changed* over the course one-year of therapy?



1b. How certain are you?**1c. Please describe the basis for your judgement:**

Ms A still in the clinical range in all the three outcome data but she presents reliable positive change at 8 months and at one year of therapy, considering pre-therapy scores.

Although Ms A is still in the clinical range I believe Ms A has done considerable and meaningful change, especially considering her chronic problems and the problematic at hand (personality disorder). I don't believe Ms A changed substantially but I do believe she is starting to construct a new self-narrative, making considerable changes but not yet sustained change. Consistently during one-year change interview Ms A repeatedly makes references that is "getting back on track" in more than one problem.

Sceptic brief relies extremely on the outcome measures and although I agree with some inconsistencies in those measures the qualitative data gives a more relevant picture/portrait, in my point of view, of how Ms A experiences change and her therapeutic process.

Important change regards being less paranoid, more confident facing others (e.g. episode with other member of the group)/ strangers (e.g. situation at the supermarket). Ms A used to run away when feeling exposed and shamed and now is facing it, not hiding from others.

Still a bit of anxiety when grandchildren come to visit her but not like it was before and she feels more relaxed which gives her a sense of relief. More aware of her problems and how to deal with some of them – “It didn’t take away the guilt (...) I’ll take away what she says, and then I sort of process it and think yeah that makes sense, and then it starts to make more sense to me, all of it...” (P123, one-year change interview). Ms A still recognizes the guilt but she does not let the guilt be overwhelming and is able to deal with it.

Despite considerable change Ms A still refers that are some problems that need to be worked on

- “Slightly more confidence” (P 104, one-year interview) even though it is more than she ever used to be. (inconsistency with PQ where she reports “a lot more confidence” which can be explained by her pleasing behavior)
- More outspoken than ever had been
- Sharing her shameful problems despite shame; learned to be honest despite shame; but still dwelling on it (P103, one-year interview).
- Flat mood – although she is having “more better days now than bad days” (P132, one-year interview)
- Even without sleeping (this problem even got worse due to stop drinking) Ms A didn’t go back to her pattern of drinking regularly. Ms A still experiences difficulties controlling the urge to drink but she has improved and still working hard to control it.

Ms A expresses a lot of contrast of how she is now comparing of how she used to be – although Ms A is not in the non-clinical range and she refers that she needs to work and fight more, she undoubtedly made important progress and considerable personal changes (change in her self-organization). And these structural changes were the ones experienced as “very much surprised”, I do believe that for Ms A these are really important changes whilst a lot of her problems still need to be worked on. And I believe these changes are due to therapy.

Ms A seems to construct change in a preferable/desirable manner and this is clear in page 126 of one-year change interview. Although Ms A exhibits a tendency to please others and exaggerates in some degree the changes she experiences, I believe most of them occurred and were due to therapy.

I also believe that feeling of empowerment and entitlement are important self-changes and Ms A reported that is feeling that she has “got as much right to be treated properly as everybody else” (P 111, one-year change interview)

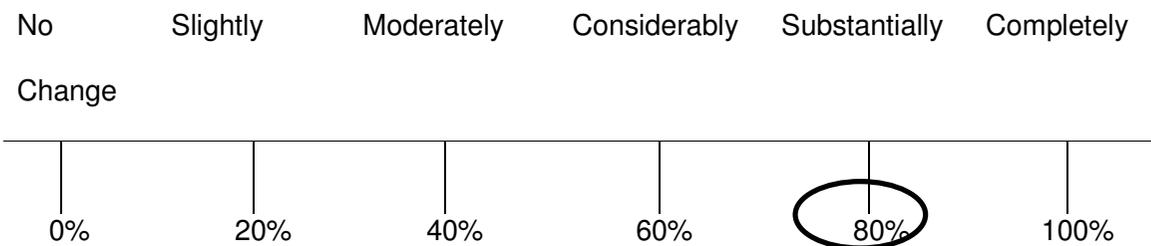
“I’d say in general I’m doing a lot better” (P. 104, one-year change interview)

1d. How much did you weigh (take into consideration) the following case elements in evaluating *patient change* over the course of therapy?

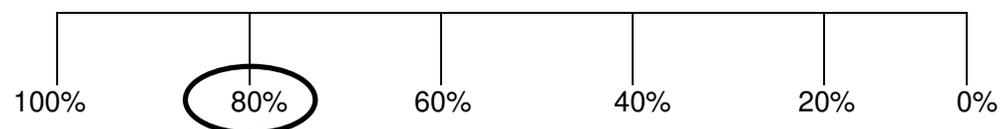
	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data			●			
b. Quantitative outcome data				●		
c. Change Interview transcript (including qualitative coding)						●
d. HAT data				●		
e. Affirmative Case					●	
f. Sceptic Case				●		
g. Affirmative Rebuttal/Closing argument			●			
h. Sceptic Rebuttal/Closing			●			

argument						
i. Other						

2a. To what extent do you think that the patient's changes were due to the therapy?



2b. How certain are you?



2c. Please describe the basis for your judgement:

I truly believe that Ms A progress is due to therapy.

Ms A refers that now is “starting to see things more clearly than I did before” (P.104, one-year interview) and that Ms A didn’t know where she would be if it wasn’t therapy. How the feeling of being helped is helping her to pursue her goals and help herself.

She feels supported and she identifies this more than once as one of the most important aspects of therapy. It’s her little “haven” (P. 122, one-year change interview)

Ms A learned to face her shameful aspects, to accept herself through the acceptance of the other group members and the acceptance and support of her therapist and consultant.

2d. How much did you weigh (take into consideration) the following case elements in evaluating the extent to which client change was due to therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data		●				
b. Quantitative outcome data		●				
c. Change Interview transcript (including qualitative coding)					●	
d. HAT data					●	
e. Affirmative Case				●		
f. Sceptic Case					●	
g. Affirmative Rebuttal/Closing					●	

argument						
h. Sceptic Rebuttal/Closing argument				●		
i. Other						

3. Which therapy processes (mediator factors) do you feel were helpful to the client?

Be with what is happening at the moment “sit with it”; “So rather than go home and knock a lot of drinks down I go home and try and sit and think, right...what happened today...” (P125, one-year change interview)

Ability to tolerate negative feelings/ emotions is a major achievement, especially considering her drinking problem and the diagnosis of BPD (her therapist referred Ms A’s ability to “stay with the unbearable feelings of hopelessness”).

Good therapeutic alliance and facilitation of awareness and insight although these are common factors in psychotherapy.

4. Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled her to make best use of her therapy?

“I’d describe myself as someone who’s trying very hard” (P 105, one-year change interview).

Ms A commitment to therapy - “I go home and try and sit and think... trying to make sense of everything” (P 125, one-year change interview)

Going twice a week to a place where she feels supported, where she feels that people understand her (other group members experience problems with substances).

Motivation to work on her problems and make use of therapy as much as possible, even making much use of the research program as she referred that that was an opportunity to reflect on herself, her path in therapy and what has changed, paying attention to little things that to her mean great changes.

New relationship and the support of this new person in her life and the visit of her brother (getting connected with him again) play a role in the snowball effect of change.

* adapted from “unpublished research procedure, Counseling Unit, University of Strathclyde, Glasgow, UK”

HSCED Instructions for Judges
(Adapted Version, October 2012)*

JUDGE C

Completing the adjudication process

Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.)

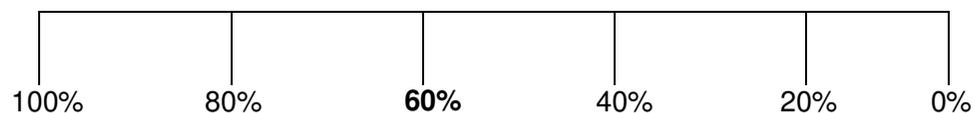
In answering the rest of the questions, please use whatever space you need in order to give a full response.

1a. To what extent do you think this patient *changed* over the course one-year of therapy?

No Slightly Moderately Considerably Substantially Completely

Change



1b. How certain are you?**1c. Please describe the basis for your judgement:**

Firstly, I must state that these judgements are made very much with an understanding that the patient met the diagnostic criteria for BPD and presented with chronic/long-standing difficulties at the beginning of therapy. It would be unrealistic to expect clear, linear, positive gains for an individual with such a presentation. So please regard my responses with the affixation “given the complexity and severity of the presentation” in mind ... In other words, I have judged the changes RELATIVE to the nature of the presentation.

I have made my judgement, first and foremost, based on the information coming straight from the client; that is the quantitative data and the change interview record and transcripts.

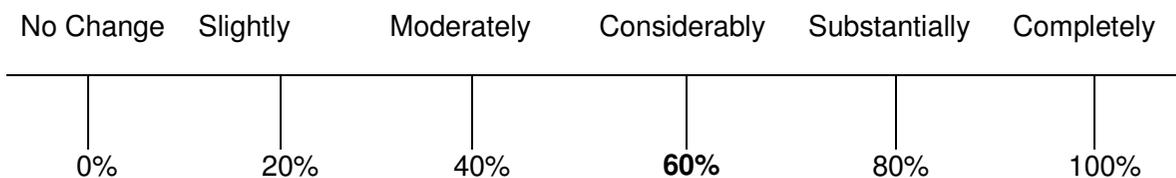
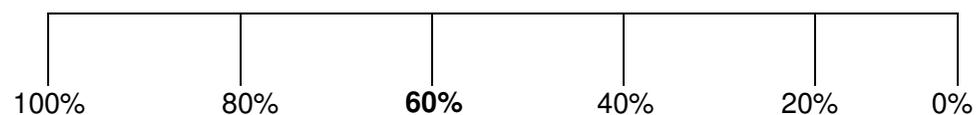
I read the Affirmative and Sceptic Arguments with interest, and took heed of their comments, but ultimately relied on the information coming DIRECTLY from the client. I found study of the interview transcripts particularly important to gain a true understanding of the messages coming from the client about her experience of therapy. The sceptic brief suggests that her account of therapy may be over-positive (thus

questioning the credibility of her account), however the transcript shows that she actually gives quite a bit of detail about the difficult aspects of therapy. For example, she talks at length about her difficulties with Group member A, and the effect this had on her. My judgement was also influenced by the client's ability to give clear examples of her own change. She also mentions being angry with the facilitator for not intervening when she felt threatened in the group. Most notably, the story about finding the right cream cheese in the supermarket is wholly convincing as it is detailed, explained with understanding of her own process, and evidence of her acting differently in her life in a way that was meaningful to her.

1d. How much did you weigh (take into consideration) the following case elements in evaluating *patient change* over the course of therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data				x		
b. Quantitative outcome data					x	
c. Change Interview transcript (including qualitative coding)						x
d. HAT data				x		
e. Affirmative Case				x		
f. Sceptic Case				x		
g. Affirmative Rebuttal/Closing argument				x		

h. Sceptic Rebuttal/Closing argument				x		
i. Other						

2a. To what extent do you think that the patient's changes were due to the therapy?**2b. How certain are you?****2c. Please describe the basis for your judgement:**

Again, the client's description of her own process in the change interview was the main basis for this judgement. In particular, her talking about how it was difficult to hear some of the disclosures made by other group members and her description of how she responded to that demonstrated vital therapeutic work, which I am confident that client would not have fabricated or exaggerated.

I would like to explain my low rating of how I used the HAT data in my evaluation: The sceptic arguments went to great lengths to highlight that there was a lack of mapping between HAT data and changes on the PQ (and mapping between various other sources), and the use this as evidence that the influence of therapy on the client's change was minimal. While this may be an appropriate stance in HSCED studies where the presentation is less complex or uni-dimensional, I believe it is naïve to expect evidence of linear and neat change-sequences when the presentation is of this complex nature. In my own clinical experience, therapy can go on for months and even years with ups and downs that do not always reflect the quality of work directly week-on-week. It is the cumulative effects of therapy, rather than week-to-week processes that count, in my experience, when working at the end of the spectrum of presentation.

2d. How much did you weigh (take into consideration) the following case elements in evaluating the extent to which client change was due to therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data				x		
b. Quantitative outcome data					x	
c. Change Interview transcript (including qualitative coding)						X
d. HAT data			X			
e. Affirmative Case				x		
f. Sceptic Case				x		
g. Affirmative				x		

Rebuttal/Closing argument						
h. Sceptic Rebuttal/Closing argument				x		
i. Other						

3. Which therapy processes (mediator factors) do you feel were helpful to the client?

Having the opportunity to hear and be heard by other group members, and having a space to experience and work through conflict, which may have felt intolerable outwith the safety of the group.

A trusting relationship with the group facilitators – particularly feeling they were available to her between sessions if she really needed them, and trusting their ability to respond to her in a way that was helpful in-session.

A sense of being “cradled” by the regularity and frequency of group sessions.

Exposure to difficult disclosures from other group members.

Realising the value of “sitting with it” versus reaching for avoidance mechanism such as alcohol.

4. Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled her to make best use of her therapy?

A determination to get better, demonstrated through engaging with the therapy process and taking part in the research.

Willingness to do things differently - e.g. “sit with it” instead of drinking; return to the group after conflict, being assertive in the supermarket and no longer having her hood up to cross the road. All these examples evidence the client’s willingness to step out of her comfort zone and try something uncomfortable, for the overall gain of her recovery.

Being in a good relationship, engaging with her brother and taking on educational courses are likely to have had a moderate effect, hence my scoring only 60% for therapy factors. It is my impression that overall progress began with the clients’ willingness to improve, was mediated by entering a therapy that suited her at the right time, and then perpetuated or compounded by these positive life processes.

* adapted from “unpublished research procedure, Counseling Unit, University of Strathclyde, Glasgow,

APPENDIX F

Full Analysis of Mr Z

‘What Works in Mentalization Based Treatment: systematic case studies in personality disorder and addiction’

Hermeneutic Single Case Efficacy Design for the case of ‘Mr Z’

Sub-Appendices

Appendix A: Rich Case Record

Appendix B: Affirmative Brief

Appendix C: Sceptic Brief

Appendix D: Affirmative Rebuttal of the Sceptic Brief

Appendix E: Sceptic Rebuttal of the Affirmative Brief

Appendix F: Affirmative Brief Summary

Appendix G: Sceptic Brief Summary

Appendix H: Interview Transcripts

Appendix I: Additional Tables

Appendix J: Adjudication

APPENDIX A
RICH CASE RECORD

The Patient

Mr Z is an only child; at the time of referral he was 45 years old; he looked like a meek and mild man but described himself as having a terrible temper that he loses when provoked or sometimes with an unknown trigger. He was smoking cannabis, using it as a crutch, 11-12 joints per day. He also used cocaine, speed and LSD in the past as a form of escapism but not anymore.

His parents were both retired. They split up when he was 23. He described his mother as outgoing and a 'normal' person and his dad as short-tempered with isolation tendencies.

Mr Z described difficulties at school. He felt depressed since his early teens and stated that his depression has crippled his existence, especially regarding jobs in his adult life. He described his emotions as running high since he was a teenager and was told that it was always in his head. Mr Z also complained of having nightmares and intrusive thoughts since childhood. He described mood swings and emotional outbursts. Mr Z feels that his problems have created instability in his relationships and problems with employment and in keeping hobbies.

Before the therapy started he had a spurt of unsuccessful attempts at work where he has left abruptly because of losing his temper. He describes himself getting so angry that he would lose control.

He described feeling suicidal since the age of 13 but having only acted once in the year 2001. He had been self-harming from this age.

He was taking Paroxetine and Quetiapine prescribed by his GP and he felt that it had started taking effect. He remained reliant on cannabis to calm his nerves but had made a slight reduction in his use since the medication was taking effect.

The generic psychiatrists from CMHT have made different and provisional diagnoses during the year 2011: cyclothymia, bipolar affective disorder and borderline personality disorder. These were hypothesis to be investigated by the psychotherapy department.

Music was the only thing he described has giving him satisfaction.

He was unemployed and was living with another man. The therapist had some reservations regarding his commitment to therapy but he ended up being accepted for the program following his meeting with the Consultant Psychiatrist in Psychotherapy and the application of the SCID-II. The diagnosis of borderline personality disorder was confirmed; he also met the criteria for depressive personality disorder and for substance abuse and dependency according to the DSM-IV-TR.

Mr Z wanted to gain more understanding about his mental problems to bring about change. He was hoping to get back into work.

Psychopharmacological Medication Record (incl. herbal remedies)

<u>Medication Name</u>	<u>For What Symptoms</u>	<u>Dose / Frequency</u>	<u>How Long</u>	<u>Last Adjustment</u>
Paroxetine (antidepressive – SSRI)	Depression	20 mg / Day	Since February 2010	February 2010
Quetiapine (anti-psychotic)	'To help me sleep and calm me down'	50 mg / Day	Since March 2011	March 2011

Pre MBT Program

- February 2011 – Referred to the psychotherapy department / personality disorder service by the CMHT psychiatrist
- Consultation with group therapist on April 2011
- Second consultation with group therapist on May 2011
- Consultation with the Consultant Psychiatrist in Psychotherapy to discuss the MBT program and to apply the SCID-II

Results of SCID-II and Diagnostic HypothesisDSM-IV-TR Axis I

Previous provisional hypothesis of bipolar affective disorder and cyclothymia

DSM-IV-TR Axis II / SCID-II Results

Mr Z met the diagnostic criteria for Borderline Personality Disorder (main focus of clinical attention) and Depressive Personality Disorder. He also scored high in a number of different personality traits but not enough to establish a diagnosis.

Diagnosis:

- Borderline Personality Disorder (main focus of clinical attention); Depressive Personality Disorder.

Traits:

- Narcissistic (close to border); Paranoid; Avoidant; Obsessive-Compulsive; Passive-Aggressive; Anti-social; Schizoid; Histrionic.

Substance Abuse Disorder

Mr Z met the DSM-IV-TR diagnostic criteria for Cannabis dependency and abuse. He has used cocaine, amphetamine and LSD in the past. There was no evidence of problematic use of alcohol.

Outcome Data

The research protocol called for patients to complete a battery of quantitative outcome measures at assessment, during each three-monthly review with the consultant and at the end of therapy. This battery comprised the Work and Social Adjustment Scale (WSAS), CORE-OM, Checklist of Mentalizing Capacity, Global Assessment of Functioning (GAF) Scale, Treatment Outcome Profile for Substance Misuse (TOP) and a Risk Assessment Tool. During assessment the SCID-II for DSM-IV-TR Axis II was used; The Simplified Personal Questionnaire (PQ) (Wagner and Elliott, 2001) was constructed with the patient during the assessment phase. The PQ was then used monthly as a measure of Mr Z's complaints. These measures are used to provide a quantitative account of Mr Z's change process over the course of therapy.

Three of these measures (PQ; CORE-OM and WSAS) were evaluated using clinical significance methods for determining whether Mr Z showed clinically significant change between pre-therapy and one-year (Jacobson and Truax, 1991). The other measures (WAI-S; TOP; Mentalizing Capacity and GAF) are used to provide additional information only but no clinical significance methods were used.

Cut-off measures represent the point beyond which the client can be considered to be in the clinical range on each outcome measure. Values that fall within the clinical range are highlighted in bold.

TABLE A1 – Mr Z Outcome Data (analysed with clinical significance methods)

Instruments	Cut-off	RC min (p<.2)	RC min (p<.05)	Pre-therapy	5 Months	8 Months	One Year
PQ	≥3	1.0 (↓)	1.5 (↓)	6.9	4.1 ** (+)	4.8 ** (+)	4.0 ** (+)
CORE-OM	≥1.25	0.43 (↓)	0.66 (↓)	0.82	1.56 ** (-)	2.26 ** (-)	2.65 ** (-)
WSAS	≥10	7.2 (↓)	10.9 (↓)	34	24 * (+)	25 * (+)	26 * (+)

Notes. Value in bold fall within the clinical range; *p<.2; **p<.05; ↓= decreased score indicates positive change;

(+) = reliable positive change in relation to first available score; (-) = reliable negative change in relation to first available score;

TABLE A2 – Mr Z Outcome Data (additional measures)

Instruments	Cut-off	RC min (p<.2)	RC min (p<.05)	Pre-therapy	5 Months	8 Months	One Year
WAI-S	N/A	N/A	N/A	M/D	M/D	41	56
TOP	N/A	N/A	N/A	1g cannabis / day	½ g Cannabis / Day	1g Cannabis / Day	0.6-0.7g Cannabis / Day
Mentalizing Capacity	N/A	N/A	N/A	1 (poor)	5 (moderate)	4 (moderate)	4 (moderate)
GAF	N/A	N/A	N/A	Serious Symptoms (41)	Moderate Symptoms (51)	Serious Symptoms (41)	Serious Symptoms (45)

Notes. WAI-S scores range from 12 (very weak working alliance) to 84 (very strong working alliance); TOP amounts are the average of a 28 day period; Mentalizing Capacity ranges from 0 (poor) to 12 (very high); GAF scores range from 0 (persistent and very severe impairment) to 100 (superior functioning); N/A = Non Applicable; M/D = Missing Data.

Personal Questionnaire Data

A simplified Personal Questionnaire (Wagner and Elliott, 2001) was used during screening to identify the key difficulties that Mr Z wished to address in therapy and to provide a rating of the extent to which he remained troubled by each difficulty as therapy progressed. The patient was also asked to state the duration of each item across his lifetime. Once a month Mr Z was asked to rate each item on the extent to which it had troubled him over the last week. Items were rated on a 7-point scale, from 1 (not at all) to 7 (maximum possible). Table A3 indicates the duration of each item across Mr Z's lifetime, and summarises item ratings at the pre-therapy, 6-months and one-year stages of therapy. Figure A1 illustrates Mr Z's mean PQ scores across therapy.

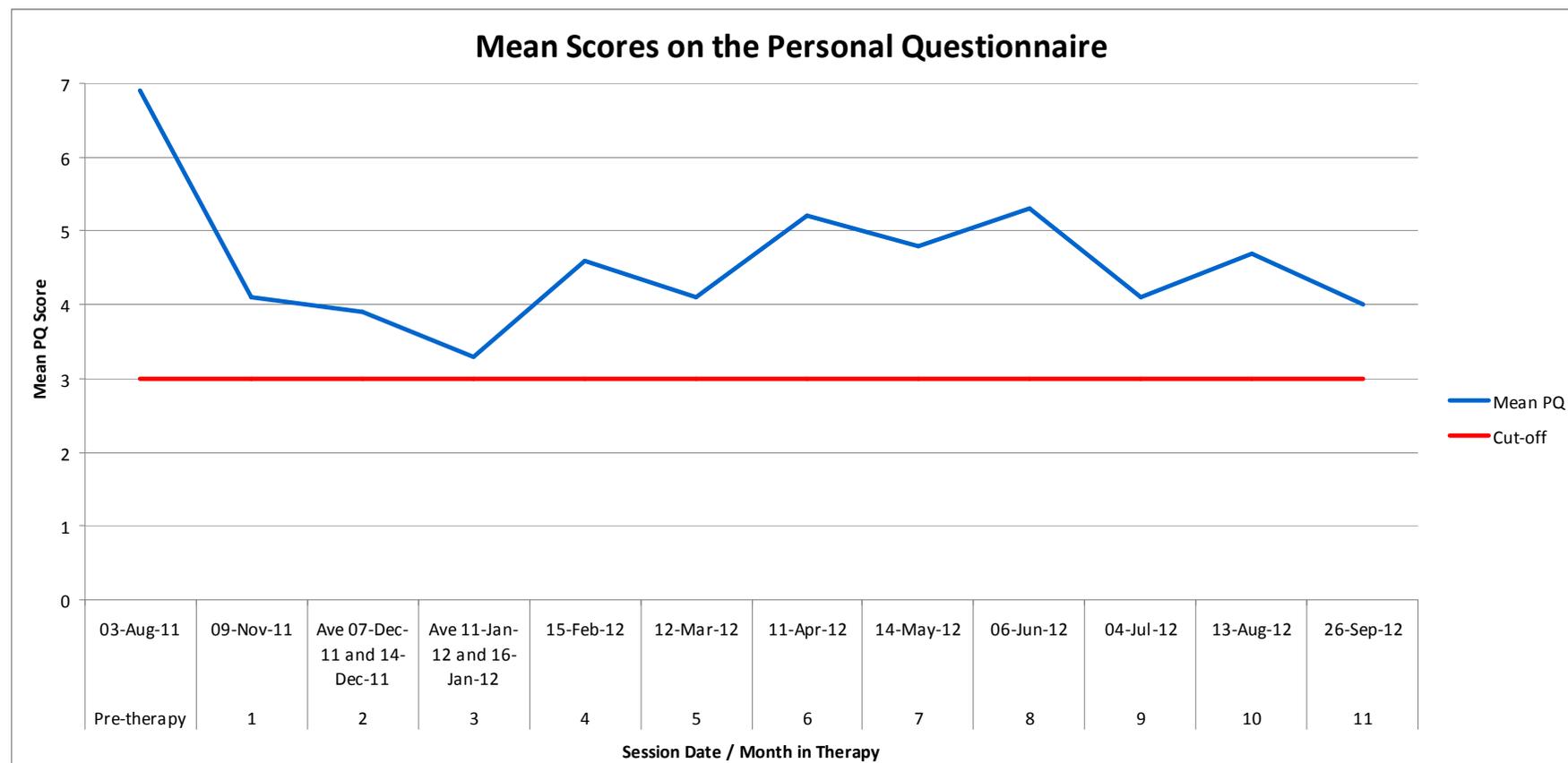
TABLE A3 – Mr Z's PQ Ratings and Duration

Item	Duration of the Problem	Pre-therapy	At 5-Months	At One-Year
1. Not believing in myself	more than 10 years	7	2	6
2. Not knowing when to stop	more than 10 years	7	5	5
3. Depressive spirals	more than 10 years	7	2	3

4. Disorganized thinking	more than 10 years	7	7	4
5. Taking things too far in relationships	more than 10 years	7	3	1
6. Self-loathing and negativity	more than 10 years	7	4	5
7. Poor sleep	more than 10 years	7	5	5
8. Dark disturbing thoughts	more than 10 years	7	4	6
9. Not knowing how to manage myself in any relationship	more than 10 years	7	2	3
10. Financial problem	more than 10 years	6	7	2

Notes. Instructions: Please complete before each session. Rate each of the following problems according to how much it has bothered you during the past seven days, including today. Anchors: Maximum possible (7), very considerably (6), considerably (5), moderately (4), little (3), very little (2), not at all (1).

FIGURE A1 – Mr Z's Mean PQ Scores Across Therapy



Note. The red line indicates the cut-off point between the clinical and non-clinical range on this measure (3.0).

Qualitative Data

Client's View of Helpful Aspects of Therapy

The Helpful Aspects of Therapy (HAT) measure (Llewelyn, 1988) was completed by each patient once a month in order to document the aspects of therapy that were especially meaningful to their therapeutic process. The HAT was completed together with the PQ and referring to the same session. Patients were asked to note the most helpful aspect or aspects of that session and to apply a helpfulness rating to that aspect on a 9-point scale from 9 (extremely helpful) to 1 (extremely hindering).

TABLE B1 – Mr Z's view of Helpful Aspects of Therapy

Month	Helpful Aspect / What made it helpful / Where in the session / How long did the event last	Helpfulness Rating
09 November 2011	Something someone else said about slowly losing control of temper over the course of a time scale and as (exploding temper) ...	8,5

December 2011	-----	---
January 2012	-----	---
15 February 2012	Mentions of compulsive lying / I have had this problem / Beginning / All session	7
12 March 2012	Nothing	---
11 April 2012	All of it, talking about self hatred / Been thinking like that lately	8
11 April 2012	-----	7

14 May 2012	[Group Member B] spoke up and what he had to say seemed very useful + insightful; unfortunately his negativity got in the way he didn't find his thought / he was touching upon something that had relevance to me	8
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14 May 2012	I was able to clarify what I think I am and what I want to get out of this session	7
06 June 2012	Whole session was helpful; all was able to open up somewhat including myself. Also everybody turned up!! / Not entirely sure yet	8
04 July 2012	Not sure yet / NA	---
04 July 2012	Light heartedness	---
13 August 2012	Realizing that cannabis is my mask not just part of it / I hadn't looked at it that way before	8
13 August 2012	Something about the past – present; how can we leave the past behind and move forward / Just a new way of looking at things	8
13 August 2012	[Group Member A] talking about her past and her problems	8
26 September	Not sure	---

2012

Note. 9 = extremely helpful, 8 = greatly helpful, 7 = moderately helpful

The Helpful Aspects of therapy form also asked the patients to note any aspect of the session which they experienced as hindering or unhelpful. They were asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering.

TABLE B2 – Mr Z's view of Hindering Aspects of Therapy Sessions

Month	Hindering Aspect	How Hindering
12 March 2012	Not in my field; alcohol related problems	
14 May 2012	[Group Member B] did not finish in what he was saying or at least left no time to discuss it properly	4

06 2012	June	The things I mentioned; not sure how relevant it was	
26 Sept 2012		Been finding it hard not to take everything negatively	3

Note. Mr Z was asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering.

Change Interview Data

Each patient engaged in two Change Interviews (Elliott, Slatick and Urman, 2001); one six months into therapy and one after a year. This process involved asking the patients to reflect on the therapeutic process and to note the specific changes experienced in themselves over the course of therapy. At each Change Interview they were asked to identify key changes that had taken place, and to make attributions regarding these changes (Tables C1 and C2).

TABLE C1 – Summary of Mr Z's Changes – At 6 Months

Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
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1. I have more understanding and can focus more	Very much expected	Very unlikely	Extremely important
2. Things are changing	Neither expected nor surprised	Very unlikely	Extremely important
3. More hopeful	Somewhat surprised by it	Very unlikely	Extremely important
4. Not acting-out so much; checking with others first	Very much surprised by it	Very unlikely	Extremely important
5. More able to control impulses	Very much surprised by it	Very unlikely	Extremely important

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

TABLE C2 – Summary of Mr Z's Changes – At 1 Year

Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. Control a little bit more my aggression (able to put a lid on it)	somewhat surprising	very unlikely	extremely important
2. Gained more control over emotions in general	somewhat expected	very unlikely	extremely important
3. Stopped taking things too far in relationships	somewhat expected	Neither likely or unlikely	extremely important
4. Managing myself better in relationships	somewhat expected	somewhat likely	extremely important

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

Summary of Key Descriptions in Change Interview at 1 Year

The following tables provide a summary of the key descriptions that Mr Z offered during his change interview at One Year. A reference to its place in the transcript of the interview is given at the end of each quote.

Table C3: Helpful therapy processes

Seeing the benefits of therapy helps to keep the determination

I'm seeing, starting to see some of the benefits (...) Which is sort of strengthened my resolve (R: Mmm) Yeah I'm really starting to think this is a good idea this is (p.132, one-year change interview)

Therapy has promoted and improved emotional regulation and a greater sense of control

I seem to be able to control... (Pause) A little bit more. I seem to be able to keep a lid on, especially aggression. When I'm feeling particularly. Um... (Pause) I don't know what the word for it is. I suppose it is aggression. When I'm feeling particularly aggressive, um, I seem to be able to put a lid on that a little bit easier than I used to be able to (...) Not saying the lids fully on but... (Pause) I seem to have it under control where I can get myself to a private place and then let it out instead of just letting it out there and then (p139, one-year change interview).

I think it's, in general I've, I seemed to have um, gained a little bit more control over my emotions in general (...) And my mood in general (...) Episodes don't seem to last quite as long, they, there not quite as intense as they were (R: And not just in aggression you say, in general?) In, in general I think. Yeah I've, I think aggression is where I've noticed it more because that's more of an explosive sort of emotion. But I think, I think I'm right in saying that yeah I think all across the board I've got a little bit more of a sense of control (p140, one-year change interview).

...as I said I seem to have a little bit more control over my feelings than I used to have, but, or that I had maybe a year ago. They still get the better of me but I do seem to be able to sort of push the weaker ones down a bit more (R: The weaker ones, what?) Well you know, when you have like an intense, if I have an intense sort of emotional um, response to something. Um, that's still going to get me. But the weaker ones, the ones that have an impact, but there just some that I'm able to have the impact but still keep it (...) Push it down and keep it under control. And not just sort of like burst out crying or getting angry. Doesn't work all the time as I said, you know, the intense ones still get the better of me but... only again just the feeling of a little bit more control over it (p141, one-year change interview).

I m not having as intense episodes (...) they are not so extreme (...) because I seem to have got that control a little bit more of the extremities... (p143, one-year change interview).

I didn't even realise I was doing it until... (Pause) I think a couple of weeks ago when I was out with my father shopping and he was

getting annoyed and I was sort of saying to him, 'no calm down, let's just go outside and we'll take a breather' and I realised that I was doing exactly the same thing but in my own head. I was sort of going (breathes in and out audibly). And I, I sort of was staying calm in a stressful situation, I knew it was stressful because my dad was getting stressed by it (R: And you didn't even realise you were doing that?) I didn't realise, no and that's when I suddenly thought hang on, I'm getting a bit, you know, I would normally explode by now (p.65, one-year change interview)

It's more like I can't, I haven't got the control over the way my mind works but I'm getting more control over how that then outwardly is expressed (...) I can't stop the depressive cycles or the dark thoughts but I can control how that affects me outwardly. How that effects how I talk to other people or whatever (p.169, one-year change interview)

The consultant drafted a 'sort of a plan' with Mr Z that helped him reduce the use of cannabis

I have cut down. I've had help with [Consultant Name] and she's got me on a sort of a plan to sort of bring me down off of that and I'm sticking to that (R: So you are still smoking but you say less or?). I'm smoking less yes (p144, one-year change interview)

(R: Six a day and how much were you smoking a year ago?) Maybe sort of ten, eleven, twelve (p145, one-year change interview)

I'm buying in smaller quantities now (p145, one-year change interview)

Hearing other people with similar experiences and trying to put to practice what they suggest

Well obviously inside the therapy we talk about these things, other people have gone through that, exactly the same (...) And some of them have sort of said have you tried this? Have you tried that? (...) Yeah they, they've been trying to find their own ways through it as well as I have, so yeah combinations work (p149, one-year change interview)

The non-judgemental aspect of therapy helps Mr Z to be open and honest; this creates a 'snowball' effect with a positive impact in relationships (e.g. being honest outside therapy generates greater understanding from others)

I mean I do have a lot of understanding that I never expected (R: Understanding) Yeah, now you know because obviously kept it secret, hidden for so long. Now that I'm being open about it I find that people are not judging me the way I thought they were going to and I think that might have helped (R: Mmm. So people in general or?) Um well friends and family (...) But yeah people in general have been quite accepting of the fact and I've found that quite surprising (R: Surprising. And do you, what do you think caused you to be more open in the first place? Or honest with those people?) Because I was being honest in therapy. I was happy to come out with these things in therapy and sometimes it overflows and I have to, if I've got a friend round or I see my dad or something, I will talk about some of the things that I've talked about in therapy. (pp150-151, one-year change interview)

What is said in the group 'over spills' to Mr Z's home life

(R: Okay. So in a way, correct me if I'm wrong, you are saying that you feel what caused this change was (loud noise) the group and what you, what people say here in the group?) Yeah and how that over flows into my, you know, obviously I go home and I think about what's been said and I come up, and you know oh yeah, yeah I forgot about that. I should have mentioned that. But I'm, obviously that gets me thinking about it and you know. You know it does over spill. My therapy does over spill in my own head, to my home life as well (p.151, one-year change interview)

Mr Z recognizes his symptoms in other members of the group and sometimes what is said in the group triggers past memories, allowing Mr Z to work through his difficulties

...it's just a combination of lots of different things. You know, one person opening up about something and suddenly it triggers a memory Um... it, its combinations of things like that, just little things that people mention or people talk and it'll trigger something and I think 'oh hang on I, I recognise that symptom' or 'I've been through that', but not quite the same so I can either talk about it or I go home and it goes through my mind (p.152, one-year change interview)

Having one-to-one sessions with the psychosocial nurse attached to the programme, a space just for Mr Z

I had a check with [Psychosocial Nurse Name] the psy...Psychiatric Nurse and that was incredibly helpful (R: Was it very helpful?)

Yeah

(R: What was helpful about it?) Um I don't know I think it was just the one on one aspect of it. It's been a long time since I've talked to somebody one on one um, just about me sort of thing. See what I mean because this is not a one, this is (R: This is research) Yeah

exactly and [Consultant Name], um yes we have a one on one but it's more concerned with how the therapy goes and what I can do

(R: Right) That was, it was nice to talk to somebody just about yourself, yeah, just, and I found that more came out than I was quite prepared for (pp.152-153, one-year change interview)

The reflective stance of the therapy setting spreads out into his personal life, increasing Mr Z's sense of self and the capacity to put boundaries and set limits

I think, I have got a, I think that is one of the ones that I've got control over. I seem to be getting more control over, um (R: In relationships?) In friendships and relationships yeah, I seem to be able to take a step backwards and go 'oh no, no, no, no, it's going to far', no actually thinking to myself, 'that's going too far hold back' (p.169, one-year change interview)

Table C4: Helpful factors in Mr Z's Life Situation

Friends and family seem more understanding and accepting

I do have a lot of understanding that I never expected (R: Understanding) Yeah, now you know because obviously kept it secret, hidden for so long. Now that I'm being open about it I find that people are not judging me the way I thought they were going to and I think that might have helped (R: Mmm. So people in general or?) Um well friends and family, but yeah people in general have been quite accepting of the fact and I've found that quite surprising (R: Surprising. And do you, what do you think caused you to be more open in the first place? Or honest with those people?) Because I was being honest in therapy. (pp.170-171, one-year change interview)

A greater understanding of Mr Z's diagnosis

Because I know what a difficult time it is diagnosing mental health problems. A lot of them so disguise themselves as other things are so similar. And I explained to my dad and he found it, he found that he could go home and he could look it up on the internet and go 'oh yeah now that explains that, that explains that' and he had some idea of, not necessarily a complete but he had some small understanding of what I go through and that helped him understand and helped me be able to communicate with him more. (p.164, one-year change interview)

Table C5: Mr Z's personal attributes/resources that may have helped him to use the therapy

Mr Z actively wanted to be different

I'm seeing, starting to see some of the benefits (R: Right...) Which has sort of strengthened my resolve.

Table C6: Difficult but potentially beneficial processes (in and out of therapy)

Talking about himself with the group / becoming more open

...if I've had a particularly personal (emphasised) therapy session then yes that can be quite exhausting to me (...) talking particularly about myself, yes... (Coughs and pauses) um, yeah its (R: Has that happened often that you have a therapy session where you talk about yourself?) It's happening more and more, not, it's not just about myself is it? But... there's been times were I have spent the entire session and I haven't said a word about my own problems. It's getting more and more that I'm bringing something to the group, every time (R: So you've noticed a difference in you?) A more openness yeah into the group yeah (p.133, one-year change interview)

Processing what the therapist says and realizing that what seemed offensive was probably taken the wrong way

I had a moment with [Therapist Name] (R: You had a moment with?) A couple of weeks ago but I was just over reacting a little bit, I realise that now so, then that put me back about, oh goh 10 minutes (laughs) (R: Put you back 10 minutes?) Yeah (R: What do you mean by put you back?) It was the last 10 minutes she said something to me that I took the wrong way (...) so I was silent for the rest of the 10 minutes because I was just brooding because I was pissed off um, but by the next session I've completely forgotten it had happened (said with humour) (R: And she didn't?) I don't think she knew anything had happened, I think it was all in my head (R: Right so you never brought it up, you never brought it up. Okay) Maybe I should have done, but (R: And do you feel that was unhelpful for you to keep that inside and not telling anything?) Um, maybe it was more helpful than anything, It enabled me to keep control over that because, basically she said something I took it the wrong way, I thought she was being insulting towards me (...) once I got home I realised that, in fact, no probably was in my head. I just imagined that slight (...) Um, so it was probably helpful for me not to have said anything at the time. If I'd have said something then that would have I don't know, it's hard to. That's the only altercation I've actually had (pp.157-158, one-year change interview)

Difficult interactions in the group provide helpful 'learning' about interpersonal relationships in general

In the long run I think it's going to, it will teach me that, you know there are going to be moment that I cannot control and I just have to, I've got no, I can't say anything therefore I just have to accept the situation and they, those situations do happen if I am in a low mood and somebody comes in and they are quite manic. Of course that's going to hinder because I'm not going to want to, I'm going to let them take the centre stage, even more than I would normally. I might be in the middle of saying, and they might interrupt me and that's

going to annoy me (...) So, it's not that they are trying to be difficult it's just that I'm taking negative things out of it. But I'm sure in the long run that it will be helpful because as I said there might be situations that I can't control and I'm going to have to sit and bite my tongue (p.159, one-year change interview)

Table C7: Helpful aspects of taking part in the research

None reported

Table C8: Hindering therapy processes

When people in the group are in the 'wrong state of mind'; that can cause clashes

Yeah, yeah they can be as helpful as they are hindering sometimes, as I'm sure I am to them as well. When they're in the wrong state of mind they're in an opposite state of mind to what I'm feeling. Obviously things are going to clash. I'm not going to agree with them. Um, so... (Pause) yeah the people that I'm in therapy can be as much help as they can be as hinder (p.156, one-year change interview)

Table C9: Hindering factors in Mr Z's life situation

Financial difficulties

Usually I'm just in pretty much financial poo (p.173, one-year change interview)

Table C10: Mr Z's personal attributes that may have hindered him in therapy

Deeply rooted low self-esteem

(Describing himself) ...unconfident... self loathing. Um... (Pause) I'm not very complimentary about myself anyway (R: Unconfident and self loathing is what comes to mind?) Yeah (R: anything else?) Ugly (...) I don't think I'm a bad person on the inside I just think I'm quite repulsive on the outside... Um... I just you know (exhales) that's what comes to mind (pp.135-136, one year change interview)

(How others would describe him) A bit strange, but nothing that they can't handle. Might think I am a freak (R: You think you are a freak?) They, yeah, they say I'm a bit weird or maybe a little bit odd sometimes. But they don't think I'm a freak, I think I'm a freak (...) coz I do act weird sometimes (R: What do you mean by weird?) (Exhales) impulsive (R: Impulsive aggressive or?) Sometimes, impulsive

aggressive, impulsive. I wind people up. Yeah, I find it deliberately funny to annoy someone (p.138)

(R:... if you had to change something about yourself what would that be?) Negativity (...) the way I see myself, well just the constant stream of negative thoughts that enter my head about myself. I would like a more positive outlook towards myself (p.138)

Passive-aggressive

It was the last 10 minutes she (therapist) said something to me that I took the wrong way (...) so I was silent for the rest of the 10 minutes because I was just brooding because I was pissed off (p.157, one year change interview)

Scared, lazy and resistant to change

[Psychosocial Nurse Name] mentioned, the psychiatric nurse, mentioned that I may need to, it may be helpful to have a review, maybe up my meds, but I haven't done that (...) I haven't done that and that's pure laziness and scaredness on my account (p.160)

Hiding behind the diagnosis of bi-polar disorder advanced by his generic psychiatrist before the MBT program; this stops him from mentalizing further about self-states

It hasn't been a particularly good month for me. Before that I was fairly okay, but this last month or so I've been very low (R: Anything happened, anything outside therapy?) Not that I can really pinpoint. No. Um, not to say there that there isn't a cause, but I haven't been able to see it, I just went... very low...(...) Over the last sort of couple of days or so since the weekend it's been (R: Do you relate it in any way with the therapy?) (exhales) not as such no (R: Okay. When you say feeling low, could you say a bit more or how you were feeling?) Bad thoughts, dark. Unable to sleep properly, unable to stay asleep. You know, just general sort of dark feelings (R: Can you give me an example of a dark thought or a dark feeling?) Well (exhales) well I'm not going to say that I've been feeling suicidal, but the thought of me not existing (pause) has been quite (R: Has been on your mind) Yeah, yeah thoughts of, thoughts of death rather than actual (pause) desire for death. Dark, dark thoughts (...) it does tend to go hand in hand with sort of depressive phase (pp.133-134)

Table C11: Hindering aspects of taking part in the research

The HAT forms are difficult to fill in

(R:...How do you find these forms, the ones about helpful events?) Sometimes they can be quite difficult (p.176, one year change interview)

Table C12: Missing aspects of therapy

The integration with CMHT and generic psychiatric services is unclear and creates difficulties; Mr Z splits the services

(R: Anything has been missing in your treatment or in other words what would you make different if you could?) I've got to phone up [CMHT General Psychiatrist Name] and have my medication looked at... [Psychosocial Nurse Name] mentioned, the psychiatric nurse, mentioned that I may need to, it may be helpful to have a review, maybe up my meds, but I haven't done that (...) I haven't done that and that's pure laziness and scaredness on my account (R: And do you think there is anything people could have done here?) No they pushed me as much as they could, it's down to me, I mean I wish it was a bit easier to make an appointment with her, but can't help that (R: Right. So it's not easy making an appointment, is that?) I can't make an appointment through this, so I can't just come in here and go oh, go through reception and go make an appointment. I got to phone up and that where it (...) I got to phone and I find that rather difficult so it doesn't get done (Exhales) but, it's nobody's fault really. (p.191, one year change interview)

Mr Z would like more labels and diagnosis; then he would know what he is dealing with and he could explain it to other people

I've heard [Therapist Name] say a lot about the fact that labels aren't important and they don't do labels (...) Many in our group shown similar but different symptoms (...) Yeah but quite similar symptoms but other symptoms that are very, very different from each other (...) And I find labels quite helpful (...) not a lot of people agree with me, but I do find labels quite. It's nice to know that, that's why I said I didn't want to explain it because it's hard to explain(...) A lot of people say it doesn't really matter what illness I have, what my label is. What matters is getting better from it (...) Whereas I find it does help knowing what you are dealing with (...) It helps you explain it to

other people. You know, to say you've got pathological grief tendencies with ADHD or something. Is a lot different from saying you've got bipolar disorder with avid OCD or something like that (R: Okay) and I think, you know, it does help to know that I have got a diagnosis of this and this. To be able to go into the world and know what you are dealing with (R: So the fact that there is no labels in here you find it unhelpful, you would like to see...) I (exhales) (...) I like labels, I like departmentalising or compartmentalising, whatever you call it (R: Okay). I find that quite helpful to all of, because my mind is so like a maelstrom that I find it helpful, when I can, to be able to go, that, that, that and put and order into things. It helps to clarify in my own mind (R: And [Therapist Name] said there is no labels here) [Therapist Name] doesn't do labels, she doesn't refer to anybody as being depressive, bipolar, ADHD, whatever the many, many different things there are (p.162-163 one year change interview)

(R: Nobody here talked to you about diagnosis or labels) No one has really no (R: Okay and you would find that helpful) I would yeah, because as I've said I, I got the diagnosis of bipolar disorder. I'm not sure if that's right or not or whether any additions need to be made to that (p.164)

Therapist's adherence to MBT principles

To assess whether the therapist was adhering to MBT principles a self-rating scale was completed by the therapist every time a HAT and/or PQ was completed by the patient.

TABLE D1 – Therapist Adherence to MBT

	09.11.11	07.12.11	11.01.12	08.02.12	12.03.12	11.04.12	09.05.12	14.05.12	11.06.12	13.06.12
Framework of Treatment	94 %	66 %	55 %	100 %	100 %	100 %	83 %	89 %	77 %	89 %
Mentalization	81%	69 %	87 %	100 %	88 %	100 %	100 %	88 %	81 %	75 %
Working With Current Mental States	100%	80 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Bridging the Gaps	86%	43 %	86 %	100 %	100 %	100 %	100 %	86 %	86 %	100 %
Affect Storms	100%	87 %	87 %	100 %	100 %	88 %	100 %	88 %	88 %	100 %
Use of Transference	60 %	90 %	80 %	100 %	80 %	80 %	100 %	80 %	70 %	90 %
Overall Adherence	86%	70 %	77 %	100 %	94 %	89 %	94 %	88 %	86 %	89 %

TABLE D1a – Therapist Adherence to MBT (continuation)

	04.07.12	13.08.12
Framework of Treatment	94 %	94 %
Mentalization	100 %	94 %
Working with current mental states	100 %	100 %
Bridging the gaps	100 %	86 %
Affect Storms	63 %	88 %
Use of transference	70 %	100 %
Overall Adherence	84 %	94 %

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APPENDIX B

AFFIRMATIVE BRIEF

Note: The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

The job of Researcher 1 (Principal Investigator) was to find corroborated, positive evidence pointing to therapy as a major cause of patient change. The search for evidence was divided into five different sections. To make a reasonable case for the causal role of therapy in patient change, HSCED requires that at least two different kinds of evidence support the therapy-change link (Elliott et al, 2009).

1. Change in stable problems

A change in long-standing or chronic psychological difficulties during therapy is thought to be indicative of therapy efficacy (Kazdin, 1981). In his Personal Questionnaire, Mr Z identified ten significant problems that he wanted to work on in therapy. He rated all of these problems as long-standing (ten years or more). It is possible to observe a reliable and substantial drop in Mr Z's ratings in the PQ after only one month of therapy (Figure A1 and Table A3). This drop is then sustained over the year, despite some fluctuations. Mr Z reported positive change in all of his ten reported problems [2.9 (mean); 4 and 2 (mode); 3.5 (median)]. Taking into consideration the duration and consistency of Mr Z's problems it is unlikely that these changes would have occurred without the influence of therapy.

The change in the PQ is also corroborated by changes in several other measures used (see Tables A1 and A2). Clinical significance was used in three of these measures and two of them (PQ and WSAS) show reliable change, one at the $p < .05$ level. This is above what

Elliott (2002) recommends as evidence that change was not due to chance or measurement error. The negative change shown in CORE-OM could, however, be due to measurement error in the pre-therapy assessment (see Table A1); this is likely to be the case since the low score observed, below the clinical range, stands in isolation against all the other quantitative and qualitative data.

The judgement of the consultant psychiatrist in psychotherapy during the three monthly reviews also suggests that the patient has changed. Although not analysed for clinical significance it is possible to observe a drop in the use of cannabis and an improvement in the patient's mentalizing capacity (Table A2). In the Global Assessment of Functioning (GAF) the consultant considered Mr Z to still show serious symptoms but there was a slight increase in functioning from pre-therapy to one-year (from 41 to 45). Also, during the 5-month review the patient was considered to have only moderate symptoms (GAF results, Table A2).

It is also worth mentioning that some of the measurements were undertaken at a time when Mr Z said he was having a 'bad' day. He used to have these days which he attributed to being bi-polar. Regardless of the accuracy of this diagnosis, and despite some fluctuation in the results, it is still possible to see 'global positive change' as explained above.

2. Retrospective Attribution

In HSCED the patient is at the centre of the discussion; for that reason, we explored Mr Z's opinions about the changes he experienced and how he attributed those changes.

Clear support for the therapy efficacy hypothesis was found in Mr Z's 'likelihood without therapy' ratings and his descriptions of the role therapy played in achieving these changes. During his 'change interviews', at 6 months and one-year into therapy, seven out of the nine

changes reported by Mr Z were considered to be 'very unlikely without therapy'. He rated all of these changes as 'extremely important' to him (see Tables C1 and C2).

During the 6-month change interview, Mr Z clearly attributes the changes to the 'whole' therapy program (p.116, 6-month change interview):

P: And I tried to explain what was going on in my head, he didn't believe me

J: Mm

P: He didn't have any understanding he just said that I was a waste and things. So now that I've got a diagnosis and he understands that, he's read books and

J: Mm

P: Um I can talk to him about it and that helps but it's mostly the group

J: So do you feel this, the fact that your dad understands a little bit better has helped you in achieving these changes

P: Yeah, yeah

J: OK. What else do you think was responsible for the changes?

P: Group therapy

J: The therapy, the group, yeah

P: Oh yeah the group has been 99% and you know the fact that I've got a bit of understanding outside of group helps

J: Yeah, so 99

P: But it's mostly the group

J: So 99%, 99% you'd say it's the group. The group, the therapist or?

P: The whole, the whole process

J: The whole process

P: The whole... you, [CMHT Doctor], [MBT Consultant], the whole team

J: The whole thing

P: The whole team yeah

J: The research?

P: Yes, yeah, the whole, the whole team has helped

At the one-year change interview he continues to attribute the changes to the therapy (p.149):

R: (...) So if you told me that, these changes will be very unlikely without therapy. So in general what do you think has caused these changes, um, I mean including things both outside the therapy and in the therapy?

P: Well obviously inside the therapy we talk about these things, other people have gone through that, exactly the same

R: Exactly the same

P: And some of them have sort of said have you tried this? Have you tried that?

R: Uhuh

P: Yeah they, they've been trying to find their own ways through it as well as I have, so yeah combinations work

R: Okay, so you feel like hearing other people with similar experiences

P: Yeah

R: And the things that they have done and, you then try them out as well?

P: Exactly yeah, yeah

(...)

R: Okay. So in a way, correct me if I'm wrong, you are saying that you feel what caused this change was (loud noise) the group and what you, what people say here in the group?

P: Yeah and how that over flows into my, you know, obviously I go home and I think about what's been said

R: Right

P: And I come up, and you know 'oh yeah', yeah I forgot about that'. I should have mentioned that. But I'm, obviously that gets me thinking about it and you know. You know it does over spill. My therapy does over spill in my own head

R: Okay

P: To my home life as well

Some of Mr Z's replies were unequivocally attributing the changes to the therapy. For example, when commenting on the change "I have more understanding and can focus more" Mr Z commented (p.103, 6-month change interview):

P: No, no, I was getting nowhere without therapy, absolutely nowhere, I was just going round in circles

J: So would you say very unlikely without therapy or somewhat unlikely?

P: I'd say virtually impossible

Regarding the change 'not acting out so much' Mr Z said that without therapy this 'wouldn't have happened' (p.115); he also made a number of very revealing comments about the change 'feeling a bit more hopeful' (p.114):

J: OK. And how likely do you think this would be happening without the therapy?

P: Not at all

R: Again not at all

P: Not at all. I've spent 20 years run... walk... you know just going round and round and round in circles

(...) even when I knew, or I suspected what it was I was still going round and round in circles until I actually

R: So feeling hopeful is, is a bit of a new thing?

P: Yeah it is. I'm not entirely sure how to deal with it at the moment so that's why I'm a bit

R: Yeah

P: Uh, um

R: It may sound silly but sometimes even positive things are difficult to feel positive...

P: It is, yeah. Um, it is a very weird thing that I never expected to feel hope even though I wasn't feeling hopeless exactly before

R: Yeah

P: And now I realise I, I actually was

R: Mm

P: I had lost hope

R: So I, I imagine this is very important for you to feel hope?

P: Yeah

Mr Z has reported a number of other helpful factors of therapy. These can be found in more detail on Tables B1 and C3. The fact that the changes reported are specific and idiosyncratic to Mr Z gives greater weight and credibility to the retrospective attribution argument (Bohart, 2008).

3. Process-outcome mapping

HSCED also makes an attempt to link the content of the patient's post-therapy changes to specific events, aspects, or processes within therapy. Mr Z reported nine helpful events, two 'moderately helpful', six 'greatly helpful' and one between 'greatly helpful' and 'extremely helpful' (see Table B1).

In the table below it is possible to observe a link between psychotherapy processes (Mr Z's HAT forms, Table B1) and the changes he later reported in the change interviews (see Table C1 and C2).

Table E1 - Process Outcome Link (HAT / Change Interview)

Qualitative Outcome	Nr of Sessions in Which Process Occurred	Example of Process (HAT form)
<ul style="list-style-type: none"> - Control a little bit more my aggression (able to put a lid on it) - Gained more control over emotions in general - More able to control impulses 	1	<p>November 2011: Something someone else said about slowly losing control of temper over the course of a time scale and as (exploding temper)... (rated between 'greatly' and 'extremely' helpful).</p>

<p>I have more understanding and can focus more</p>	6	<p>Feb 2012: Mentions of compulsive lying / I have had this problem (rated 'moderately helpful')</p> <p>April 2012: All of it, talking about self hatred / Been thinking like that lately (rated as 'greatly helpful')</p> <p>May 2012: [Group Member B] spoke up and what he had to say seemed very useful + insightful; unfortunately his negativity got in the way he didn't find his thought (?) / he was touched upon something that had relevance to me (rated as 'greatly helpful')</p> <p>May 2012: I was able to clarify what I think I am and what I want to get out of this</p>
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		<p>session (rated as 'moderately helpful')</p> <p>August 2012: Realizing that cannabis is my mask not just part of it / I hadn't looked at it that way before (rated as 'greatly helpful')</p> <p>August 2012: Something about the past – present; how can we leave the past behind and move forward / Just a new way of looking at things (rated as 'greatly helpful')</p>
Managing myself better in relationships	1	<p>6th June 2012: Whole session was helpful; all was able to open up somewhat including myself. Also everybody turned up!!</p>
More Hopeful	1	<p>August 2012: Something about the past –</p>

		present; how can we leave the past behind and move forward / Just a new way of looking at things (rated as 'greatly helpful')
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In addition, an analysis of the Change Interviews can provide further cues about the link between process and outcome. Even if the link is not entirely obvious it is plausible to assume that therapeutic processes had a strong influence on the changes experienced by Mr Z (Tables C3 and C6 provide further details about helpful therapy processes).

TABLE E2 – Process Outcome Link (Change Interview / Theory and Technique / Outcome)

Example of Process (Change Interviews)
<p><u>Having one-to-one sessions with the psychosocial nurse attached to the programme, a space just for Mr Z</u></p> <p>(...) I found that more came out than I was quite prepared for (p.153, one-year change interview)</p> <p><u>Difficult interactions in the group provide helpful 'learning' about interpersonal relationships in general</u></p> <p>(...) it will teach me that, you know there are going to be moments that I cannot control (...) I just have to accept the situation and they,</p>

those situations do happen (...) I might be in the middle of saying, and they might interrupt me and that's going to annoy me (...) So, it's not that they are trying to be difficult it's just that I'm taking negative things out of it. But I'm sure in the long run that it will be helpful because as I said there might be situations that I can't control and I'm going to have to sit and bite my tongue (p.130, one-year change interview)

Processing what the therapist says and realizing that what seemed offensive was probably taken the wrong way

(...) I think it was all in my head (R: Right so you never brought it up, you never brought it up. Okay) Maybe I should have done, but (R: And do you feel that was unhelpful for you to keep that inside and not telling anything?) Um, maybe it was more helpful than anything, It enabled me to keep control over that because, basically she said something I took it the wrong way, I thought she was being insulting towards me (...) once I got home I realised that, in fact, no probably was in my head.

Therapy has promoted and improved emotional regulation and a greater sense of control

(...) I seem to be able to control... (Pause) A little bit more. I seem to be able to keep a lid on, especially aggression. (...) I seem to have it under control where I can get myself to a private place and then let it out instead of just letting it out there and then (p139, one-year change interview).

I didn't even realise I was doing it until... (Pause) I think a couple of weeks ago when I was out with my father shopping and he was getting annoyed and I was sort of saying to him, 'no calm down, let's just go outside and we'll take a breather' and I realised that I was

doing exactly the same thing but in my own head. I was sort of going (breathes in and out audibly). And I, I sort of was staying calm in a stressful situation (p.147, one-year change interview)

It's more like I can't, I haven't got the control over the way my mind works but I'm getting more control over how that then outwardly is expressed (...) (p.169, one-year change interview)

The consultant drafted a 'sort of a plan' with Mr Z that helped him reduce the use of cannabis

I have cut down. I've had help with [Consultant Name] and she's got me on a sort of a plan to sort of bring me down off of that and I'm sticking to that (p144, one-year change interview)

I'm buying in smaller quantities now (p145, one-year change interview)

Hearing other people with similar experiences and trying to put to practice what they suggest

(...) inside the therapy we talk about these things, other people have gone through that, exactly the same (...) And some of them have sort of said have you tried this? Have you tried that? (p149, one-year change interview)

The non-judgemental aspect of therapy helps Mr Z to be open and honest; this creates a 'snowball' effect with a positive impact in relationships (e.g. being honest outside therapy generates greater understanding from others)

I mean I do have a lot of understanding that I never expected (R: Understanding) Yeah, now you know because obviously kept it secret, hidden for so long. Now that I'm being open about it I find that people are not judging me the way I thought they were going to and I think that might have helped (R: Mmm. So people in general or?) Um well friends and family (...) But yeah people in general have been quite accepting of the fact and I've found that quite surprising (R: Surprising. And do you, what do you think caused you to be more open in the first place? Or honest with those people?) Because I was being honest in therapy. I was happy to come out with these things in therapy and sometimes it overflows and I have to, if I've got a friend round or I see my dad or something, I will talk about some of the things that I've talked about in therapy. (pp150-151, one-year change interview)

Mr Z recognizes his symptoms in other members of the group and sometimes what is said in the group triggers past memories, allowing

Mr Z to work through his difficulties

You know, one person opening up about something and suddenly it triggers a memory (...) and I think 'oh hang on I, I recognise that symptom' or 'I've been through that', but not quite the same so I can either talk about it or I go home and it goes through my mind (p.152, one-year change interview)

The reflective stance of the therapy setting spreads out into his personal life, increasing Mr Z's sense of self and the capacity to put boundaries and set limits

I seem to be getting more control over, um (R: In relationships?) In friendships and relationships yeah, I seem to be able to take a step backwards (p.169, one-year change interview)



Therapist and Consultant Views of the Process + Links with Theory

Affect Focus / Contingent Marked Mirroring / Bio-Social-Feedback (Fonagy, Gergely, Jurist and Target, 2002).

'The more he finds his voice the more visible he is becoming and this is helping him to form more of a sense of self and a relationship with the group' (Quote from therapist 12 month report).

'Being challenged by the group has at least made him feel more accountable when he misses sessions rather than a belief that no-one cares and that he would disappear without being noticed' (Quote from therapist 12 month report).

'The repetition, the stopping and rewinding has helped him to formulate his narrative, the more he seems to be making connections within himself and with others in the group, the more relational he is becoming within the group (Quote from therapist 12 month report).

Past-present links / Attachment / Mentalizing the Transference

'She (therapist) feels that your ability to talk about your terrifying earlier experiences, such as the incident of your rage against your mother, needs to be connected to the life you live now' (quote from 12 months MBT report by the consultant written in the first person the

patient)

'The attachment to the group is crucial as it can help to fill in some of what you missed out on an earlier experience of attachment'
(quote from 12 months MBT report by the consultant).

'The recent re-ignition of an on-going conflict between two members in the group has possibly fed into your reasons for missing occasional sessions and it has become more evident on closer examination that the conflict has made you feel quite uncomfortable. By staying with the discomfort it has allowed you to get more in touch with the triggering of memories of your parent's divorce and the exaggerated differences between them' (7-month MBT progress report by group therapist).

Team Effort

'We discussed your cannabis intake in detail and made plans for you to have small but sustainable decreases which [Psychosocial Nurse] and I will monitor and support you through' (quote from 12 months MBT report by the consultant).



Related Outcome

I have more understanding and can focus more (6 Months Change Interview)

Not acting-out so much; checking with others first (6 Months Change Interview)

More hopeful (6 Months Change Interview)

More able to control impulses (6 Months Change Interview)

Control a little bit more my aggression (able to put a lid on it) (One-Year Change Interview)

Gained more control over emotions in general (One-Year Change Interview)

Stopped taking things too far in relationships (One-Year Change Interview)

Managing myself better in relationships (One-Year Change Interview)

4. Within-therapy process-outcome correlation

In addition, theoretically central in-therapy process variables (e.g. adherence to treatment principles) may be found to covary with month-to-month shifts in patient problems.

A correlation matrix was run to evaluate the link between the PQ results and the MBT principles evaluated in the adherence scale. No correlation was found between the results in the PQ and the overall adherence to MBT.

We also analysed the correlation between the PQ results and the six subscales of MBT adherence: framework of treatment; mentalization; working with current mental states; bridging the gaps; affect storms and use of transference. The only correlation found was between 'framework of treatment' and the PQ results ($r = .722$ at the $p < .05$ level of significance).

This may indicate that generic psychotherapy elements were possibly more important than specific MBT techniques, for example: a clear rationale; an agreement of therapeutic goals; a crisis plan; the limits of confidentiality; supervision arrangements; the transparency provided to patients and other providers; the consistency of the treatment and the availability of the staff; the reliability of the treatment structure and the clarity of the boundaries.

5. Event-shift sequences

Elliott (2002: p.7) mentions that 'an important therapy event may immediately precede a stable shift in client problems, particularly if the nature of the therapy processes and the change are logically related to one another (e.g. therapeutic exploration of an issue followed the next week by change on that issue)'. Since the ratings for the present study were only undertaken monthly, the connection between the 'event' and the PQ shift may be harder to establish. However, giving that both forms (PQ and HAT) were completed once a month at the end of the group session we also looked for immediate links between these two instruments. In addition, we used the therapist session notes for that same session and the one immediately before to help us identify processes that may be linked to a shift in the PQ score.

Link between HAT 'events' and PQ rating for the same session

At the end of the 09.11.11 session, Mr Z rated a therapeutic event between 'greatly' and 'extremely helpful' (Something someone else said about slowly losing control of temper over the course of a time scale and as (exploding temper)... - rated with 8,5. His mean PQ score following the same session shows a dramatic and reliable, 2.8 points, drop in personal problems (Figure A1). Three of these problems are highly related to the helpful event described on the HAT (Table B1). 'Not knowing when to stop' shows a reliable 4 point drop; 'taking

things too far in relationships' also dropped 4 points; the same 4 point drop can be observed in another related problem 'not knowing how to manage myself in any relationship' (Table A3).

The next two reliable shifts (15.02.12 session and 11.04.12 session) are actually on the negative direction, with the mean PQ score increasing (Figure A1). The 'helpful aspects of therapy' (HAT) reported for these sessions relate to the client's insight and/or realization of features of himself that he dislikes (Table B1). This probably affects his self-esteem, which is reflected on the increased score on related PQ items (Table A3): 'not believing in myself' (from 3 to 4 in February 2012 and from 2 to 7 in April 2012); 'depressive spirals' (from 2 to 3 in February and from 2 to 7 in April); 'self-loathing and negativity' (from 3 to 5 in February and from 4 to 6 in April 2012). Nevertheless, these two temporary negative shifts do not affect the 'global reliable change' observed in Mr Z and it can be argued that these were indeed an important part of the therapy and a sign that Mr Z was connecting more with painful aspects of himself. The periodic reports from the MBT team (i.e. therapist, consultant and psychosocial nurse) refer several times to the increased engagement of Mr Z with his own 'demons', which is seen as a positive outcome.

The final reliable shift happened in the 04th of July's session (Figure A1). This is a positive shift, with a drop on the mean PQ score of 1.2 points ($p < .2$). However, Mr Z's HAT for this session (Table B1) is not very clear and it is difficult to make a judgement on whether this could link with the PQ score. He wrote 'not sure yet' and 'light heartedness' and did not rate the helpfulness of the events in the scale given. The biggest drops were observed in the individual items 'depressive spirals' and 'poor sleep' which again are difficult to link with therapeutic process for lack of appropriate data.

Link between Hat 'events' and PQ ratings of the following month(s)

The HAT event in 09.11.11 (Something someone else said about slowly losing control of temper over the course of a time scale and as (exploding temper).... rated with 8,5) may be related to some of the changes reported in the Change Interview at 6 months regarding less acting out and greater ability to control impulses. Some PQ problems related to this helpful event also seem to have a dramatic drop on the day of the event (09.11.11) and then stabilize on a lower score until one-year of therapy:

- Prob. Nr 2, 'not knowing when to stop': from 7 at baseline to an average of 4.2 over the following months
- Prob Nr. 5, 'taking things too far in relationships': from 7 at baseline to an average of 2.6 over the following months
- Prob Nr 9, 'not knowing how to manage myself in any relationship': from 7 at baseline to an average of 3.7 over the following months

The helpful event on the 11.04.12 HAT form is related to self-hatred and negativity. In the following PQ ratings, there was a drop in all related problems:

- Not believing in myself, from 7 to 6
- Depressive spirals, from 7 to 3
- Self-loathing and negative, from 6 to 5
- Dark disturbing thoughts, from 6 to 4

'Backup' evidence from therapist session notes relating to the same session of the PQ ratings and/or the session immediately before

- PQ reliable shift (09.11.11). The therapist session notes show that Mr. Z was engaging with the group and sharing his mental state with others. On the session immediately before (07.11.11) he spoke about rage, which is related to the HAT event described by Mr. Z on the 09.11.11 (Table B1). This also links strongly with the positive outcome on the individual PQ items described above.

07.11.12 session notes (extract) - Find it difficult to be heard – did well to persist. Spoke about rage (...)

09.11.12 session notes (extract) - Terrible headache, hasn't slept for nights, tries too hard. Feels out of sorts - plays the piano and tries to exhaust himself. Is beginning to talk about how different he feels to others - he seems depressed but noticed that his frozen shoulder seems better.

- PQ reliable shift (11.04.12). As explored above this negative shift could potentially represent Mr. Z's greater engagement with himself and with his feelings and be part of an important therapeutic process. The therapist process notes from both the 11.04.12 session and the one immediately before give further confirmation that Mr. Z was sitting with painful feelings and making important realizations about himself.

04.04.12 session notes (extract) – Seemed to make movements (??) more (?) he has now told us about his tics. He reiterated (?) that he is more like an 8 year old than an adult

11.04.12 session notes (extract) – Talked about the terrible debt he is in – ongoing – he just buries his head (letters) and hopes it will all go away; instead it starts vicious circle – feeds unbearable feelings and hopelessness and takes dope to repress the feelings (...)

- PQ reliable shift (04.07.11). Despite not having enough data to logically connect this outcome with the process described by Mr Z on the HAT it is possible to link, to some extent, the drop in the PQ individual item 'depressive spirals' with the fact that he is engaging more with the group and sharing negative aspects of himself.

04.07.12 session notes (extract) - joined in a more involved way - continued to speak about him being so disorganised - letting things get on top of him and then can't move

02.07.12 session notes (extract) - More able to speak out in the group as opposed to trying to be heard but lost in the crowd. He hates bodily function, spoke about the loss of teeth - hates the gaps but could never get on with false teeth - too painful. Shared that he was a whimp - frightened of everything but puts on a mask in the group

Conclusion

The affirmative brief provides strong evidence that:

- Substantial changes have occurred in Mr Z stable and chronic problems
- Mr Z clearly attributes these changes to the influence of therapy

There is some evidence that:

- The process of therapy in general is linked to the positive outcomes
- The 'framework of treatment' was linked to positive outcomes ($r = .722$ at $p < .05$) but no link was found between the use of specific MBT elements or techniques and therapeutic outcome
- Significant therapy 'events' have helped to reduce the severity of the patient's problems

According to Elliott (2002) two pieces of evidence would be enough to support the therapy efficacy hypothesis. Since it was possible to find evidence in all of the five steps followed, very clearly and strongly in steps 1 and 2, we can confidently assume that the client has changed substantially and that the change was caused, to a great extent, by the experience of therapy.

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APPENDIX C

SCEPTIC BRIEF

Note: The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

Competing explanations for apparent client change

1. Trivial or negative change

This argument asserts that any change found was trivial or negative. An examination of Mr Z's Outcome Data (Table A1) reveals that all of the measures – PQ, CORE-OM and WSAS – remained in the clinical range after one year of treatment, suggesting that any positive alterations that did occur to the patient were trivial at best. Furthermore, the CORE-OM shows steady significant negative change ($p < .05$) from pre-therapy to one year, indicating a worsening of functioning. The WSAS also shows a stable negative change from five months to one year (although these figures are unlikely to be significant and it suggests a positive change from pre-therapy to five months). Likewise, the PQ highlights a negative change between five months and eight months of therapy. Therefore, the changes in Mr Z are trivial at best and many are, in fact, negative.

In addition, Mr Z's use of cannabis (Table A2) does not appear to have changed appreciably over the course of the MBT program, with the levels of use at eight months mirroring those recorded pre-therapy and the cannabis use at one year being higher than that at five

months. Mentalizing Capacity (Table A2) has also remained 'moderate' between five months and one year, suggesting that no real improvement has been established during this time. Moreover, GAF (Table A2) is categorically the same from pre-therapy to one year and after one year of therapy the patient continues to fall in the range of 'serious symptoms'.

The Personal Questionnaire Data (Table A3) highlight that between six months and one year, three indicators improved (disorganised thinking; taking things too far in relationships; and financial problems). However, two indicators remained the same (not knowing when to stop; and poor sleep), whilst the majority of the indicators worsened (five in total: not believing in self; depressive spirals; self-loathing or negativity; dark disturbing thoughts; and not knowing how to manage myself in relationships). This suggests that any changes that were made between the baseline and six months of therapy were not globally maintained at the one year point and most of the improvements recorded declined. Therefore, the quantitative evidence powerfully demonstrates that Mr Z did not change substantially over the course of the MBT program and that any change that did occur was trivial or negative.

This trivial or negative change in the quantitative data is supported by qualitative evidence in both the Six Month and One Year Change Interviews. In the Six Month Change Interview (p.106), Mr Z described feeling that he has not changed substantially:

Mr Z: It's... Mm... I think I think the best way of describing it is changing

Interviewer: Is changing?

Mr Z: Yeah is in the process of... I don't think anything has changed at the moment.

Likewise, Mr Z continues to confirm this lack of change in the One Year Change Interview (p.142):

Interviewer: OK, if I asked you specifically any change that you notice in the way that you think or the way you behave, the things that you do? Are you doing anything differently from last year? ...From a year ago?

Mr Z: (Exhales). Not really, not that I can think of

Interviewer: Are you engaging in any activities, any new friends, any... anything that you are doing differently in your day to day?

Mr Z: No, not especially, no

Interviewer: Your routine... has it...

Mr Z: Hasn't changed

Interviewer: Hasn't changed

Mr Z: Not particularly no

Interviewer: At all, no? And the way you think? Did it change any...?

Mr Z: Um... (Pause) suppose it must have done but I can't really see any...

Interviewer: Hmm

Mr Z: Feel any change. It just seems to be the same barrage that I've always had

The quantitative and qualitative measures therefore demonstrate convincingly that Mr Z did not positively change substantially during the course of therapy; any changes that did occur were at best trivial and many were negative.

2. Statistical artefacts

The Outcome Data (Table A1) appear to meet the Reliable Change Index ($p < .05$ or $p < 2$), and represent negative changes in patient functioning as well as positive changes. However, the data are inconsistent with one another. CORE-OM shows a steady negative change

in patient functioning from pre-therapy to one year, whereas WSAS suggests an improvement from pre-therapy to five months and then a decline thereafter. PQ highlights better functioning between pre-therapy and five months, a decline between five months and eight months and a slight improvement between eight months and one year. Taken together, the majority of the statistical indicators propose that the patient did not improve and may have actually worsened during the MBT program. Following this, there is likely to be some statistical error in the PQ since this is the only measure that showed a positive change following the five month point; this error could be adequately explained by expectancy effects or relational artefacts, which are discussed later.

3. Relational artefacts

This section, divided into three sub-sections, presents the argument that the self-presentational tendencies of the client and interpersonal dynamics between the client and the researcher confound any positive changes advanced.

a. Relational response tendencies

There are strong indications that Mr Z may not be a reliable observer of his own change due to his impression management strategies. For example, in the Six Month Change Interview (p.102), Mr Z discusses how he wears a 'mask':

Mr Z: Um I suppose there are a lot of people that don't know what's going on in my head so they just see the, the, what I put on, the mask

Interviewer: Hmm

Mr Z: The act...

This extract shows how Mr Z disguises himself, which is a strategy that he may also have used in an attempt to 'please' the psychotherapy team in the research. The conviction that the patient engaged in this relational response strategy is reinforced by Mr Z commenting that he has had the problem of 'compulsive lying' (Helpful Aspects of Therapy, 15th February 2012 – Table B1). Moreover, Mr Z's impression management tendencies can be further unfolded by examining the way that he explains his difficulty with speaking in the MBT group (One Year Change Interview, p.120):

Interviewer: What would help you to, to mention things?

Mr Z: Remembering to (laughs). It's as simple as that. I, I'll leave and I'll think 'oh I meant mention that' and I then I, I will remember it the next time

Interviewer: Mm. So it's nothing about the group or the therapist

Mr Z: No

However, this extract contradicts the therapist's 12 month Progress Report, which speaks of the personal and interpersonal difficulties that Mr Z has had in finding his voice in the group. Session Notes from the psychosocial nurse (24th September 2012) support the therapist's ideas: '[Mr Z] has stopped short of telling the group the extent of his problems as he believes that his experiences are so abnormal'. Taken together, these testimonies infer that Mr Z exhibits relational tendencies and impression management strategies that prevent him from fully revealing himself; this therefore reduces the reliability of any positive therapeutic attributions he asserts in his accounts of the MBT program.

b. The 'hello-goodbye' effect

In addition to the relational response tendencies highlighted above, Mr Z explicitly discussed relational artefacts similar to the 'hello-goodbye' effect (Elliott, 2002) in the Year One Change Interview (p.149):

Interviewer: If you think about the whole programme, and I would like to include the research as well, it may have been good or not

Mr Z: I think it's a lot of, a case of, I think that's what's expected of me in this therapy so...

Interviewer: Change?

Mr Z: I'm making more of an effort to (pause) do what's expected of me (laughs). Does that make sense? It's...

Interviewer: Does it make (mumbles)...

Mr Z: It's a bit of a paradox I know but (laughs)

Interviewer: No, well it sometimes happens because people are expected to change, they change because...

Mr Z: Yeah, yeah

The patient felt that he was expected to change, which may have influenced his progress in therapy. This 'hello-goodbye' effect is also likely to have affected the way that Mr Z reported his experiences of therapy in the interview situation, pre-disposing him to highlight positive changes and therefore undermining the validity of the data.

c. Interview strategy

Moreover, the interviewer influenced the research situation to a great extent through the use of leading questions; this is evident at the Six Month Change Interview (p.106):

Interviewer: OK. So am I right to say that the only change in a way that you feel is that err you are now more aware and more able to understand that there is a possibility that... that you can get better

Mr Z: Yes, yeah

Interviewer: Maybe more hopeful?

Mr Z: Yeah, definitely

Interviewer: I don't want to put words in your mouth

Mr Z: Yeah. I'm definitely more hopeful on this.

Interviewer: OK

The above extract illustrates the way that Mr Z's narrative accounts and the descriptive terms he used to depict his inner feelings did not emerge from him spontaneously but were guided by the interviewer. This interviewer strategy calls into question the credibility of the declarations made by the patient. In addition, the interviewer deeply probed the positive changes that the patient mentioned, but appeared surprisingly disinterested in any negative data. For instance, in the Six Month Change Interview (p.114) the following exchange occurred:

Interviewer: And what about changes for the worse? Some sometimes people feel they are worse or some things have changed for the worse?

Mr Z: No

Interviewer: No?

Mr Z: No, no, nothing

Interviewer: OK

This technique biased the data and led to the over-reporting of positive changes and under-reporting of negative changes. Consequently, having examined the evidence relating to relational artefacts, Mr Z can be described as showing strong relational response tendencies. The patient also felt that he was anticipated to make changes in therapy and he is likely to have acted in accordance with these expectations. Moreover, the relational response tendencies of the patient were compounded by the interview technique adopted, which used leading questions, focused on the positive changes that had occurred during the MBT program and, in places, appeared to close down discussion of negative aspects of the therapy. Taken together, these factors confound any positive changes advanced.

4. Expectancy artefacts

This argument shows how the patient's personal expectations of change account for the progress he reported. Prior to embarking upon the MBT program, Mr Z was documented as being a person who wanted to gain more understanding of his problems and who had expectations for change (Appendix A). He was also aspiring to gain employment and he described himself as having 'resolve' (One Year Change Interview, p.79).

Following this, Mr Z's expectations in terms of alterations in his functioning are highlighted in the Six Month Change Interview (p.110):

Mr Z: I've, I've, yeah, I've finally come to terms with the fact that there is a possibility

Interviewer: OK. And was this change, if we call it a change, was this expected or was this something um you are surprised by it, or...?

Mr Z: Um, no I think I, I think that was one of my expectations of it.

This excerpt clearly illustrates the way that Mr Z had expectations of therapeutic change, which can account for any changes he reported. The way that Mr Z's expectations of therapy may have influenced the outcome is also shown by his providing 'scripted' accounts of the process of treatment as opposed to him producing idiosyncratic and experiential narratives. The Six Month Change Interview (p.117) illustrates the way Mr Z draws on such canonical narratives (Bruner, 1991) of therapy:

Interviewer: OK. Would you be able to sum up, I mean it's more or less... we, we, are doing it now, but to sum up what helpful aspects of um about the whole thing?

P: Again, it's just understanding...

J: Mm...

P: It's the fact that they will listen and not pass judgement.

Further evidence for this can be found later in the same interview, when the interlocutor finds that Mr Z is unable to specify helpful aspects of the therapy (p.118):

Interviewer: Any, anything you remember that was really, really helpful within the session?

Mr Z: I'm sure, I'm sure there was but I can't remember everything, it's just little things, little things said...

This reliance on cultural schemas when describing therapy – understanding, non-judgemental, the ‘little things said’ – reduces the credibility of Mr Z’s account regarding any usefulness of therapy and suggests that he is narrating his assumptions and anticipations as opposed to his actual experiences. Therefore, Mr Z’s predilection for change, coupled with his expectations and his resoluteness, is sufficient to explain any positive changes reported by the patient without invoking the MBT program as causative.

5. Self-Correction Processes

This argument posits that self-correction processes and not therapy were responsible for any change observed. In a Consultation Report (9th May 2011), the therapist commented that ‘Mr Z seemed enthusiastic and said he was determined to gain more understanding into his mental problems to bring about change’. Mr Z actively wanted to be different; he discussed how he engaged in self-correction processes and he appeared to be ‘resolved’ to change. The One Year Change Interview (p.132) illuminates this intention:

Mr Z: I'm seeing, starting to see some of the benefits

Interviewer: Right...

Mr Z: ...Which has sort of strengthened my resolve

The assertion that self-correction processes were responsible for any change found in Mr Z is also supported by the patient's self-reported changes in the One Year Change Interview (Table C2). The patient described three of the four changes reported as 'somewhat expected'. In addition, he felt that the change 'managing myself better in relationships' would have been 'somewhat likely' without therapy, whereas the change 'stopped taking things too far in relationships' would have been 'neither likely nor unlikely' without therapy. This suggests that Mr Z attributed a large proportion of his changes to factors other than the MBT program and considered that they would have occurred either with or without such treatment; this proposes that Mr Z was able to act as a catalyst for his own modification.

6. Extra-therapy events

Mr Z did not globally attribute his changes at the One Year Change Interview to therapy (Table C2), demonstrating that extra-therapy events may be responsible for any alterations in his functioning. Two specific extra-therapy events appear to be of particular importance for Mr Z: his first diagnosis prior to commencing the MBT program; and the understanding he received from his family and friends following this diagnosis.

The patient extensively emphasised the importance to him of a diagnosis and this was a key topic in both the Six Month and the One Year Change Interviews. For instance, in the One Year Change Interview (p.159), Mr Z says that 'I think, you know, it does help to know that I have got a diagnosis of this and this; to be able to go into the world and know what you are dealing with'. This diagnosis was provided by Mr Z's generic psychiatrist, prior to the patient's involvement with the psychotherapy team and the MBT program, and it accounts for his development at that time: 'Mr Z appears to be relatively stable and there has been significant improvement' (CMHT Consultant Psychiatrist

Report, 11 July 2011). Evidence shows that Mr Z did not attribute this beneficial diagnosis to the MBT program (One Year Change Interview, p.163):

Interviewer: Nobody here talked to you about diagnosis or labels

Mr Z: No one has really no.

Other than the personally beneficial effects that Mr Z reported from receiving a diagnosis, it also appeared to lead Mr Z's father to be more understanding towards him, which was extremely helpful for the patient. The Six Month Change Interview (p.115) highlights this:

Mr Z: No... I have got... hmm... when I started therapy and I got my diagnosis

Interviewer: Mm

Mr Z: My dad was very, very, understanding... he changed completely.

And again:

Mr Z: He's been very understanding, and that has helped

Mr Z also emphasises the importance of the understanding of others for him in the One Year Change Interview (p.97):

Interviewer: Okay. What about things outside the therapy? Was there anything outside the therapy that may have caused you to change any, anything that has helped outside?

Mr Z: (Long pause) No, I don't know (long pause). I really don't, don't know. I mean I do have a lot of understanding that I never expected.

Therefore, the diagnosis that Mr Z received prior to commencing therapy, plus the understanding that he received from others outside of the MBT program, impacted upon Mr Z and are sufficient to explain any alterations in his functioning.

7. Psychobiological causes

This is the argument that psychobiological as opposed to psychotherapeutic causes may have led to any changes in functioning experienced by the patient. Mr Z had been taking Paroxetine since February 2010 and Quetiapine since March 2011; the doses remained unchanged throughout the period of therapy. Therefore, there appears to be no connection between any changes in Mr Z's prescribed medication and his possible progress during the MBT program. However, Mr Z had also made some attempts at reducing his cannabis intake during the therapy (from one gram per day pre-therapy to 0.6 or 0.7 grams per day at one year). This reduction, which may or may not be attributable to the MBT program, could result in any observed improvement to Mr Z's wellbeing as opposed to any change originating from the therapy itself.

8. Reactive effects of research

Mr Z openly acknowledged the positive effects of participating in the research process:

Interviewer: The research?

Mr Z: Yes, yeah, the whole, the whole team has helped.

The patient also expressed an interest in seeing the results of the research (One Year Change Interview, p.178). Moreover, Mr Z acknowledged that he felt the MBT program and the research placed certain 'expectations' for change upon him that he was complying with (discussed in Section 3b when dealing with the 'hello-goodbye' effect). In addition, each month the client was required to reflect on and complete the PQ and the HAT. Furthermore, a Change Interview was undertaken six months into therapy and again after one year.

These supplementary procedures alone would have given the client significant opportunity to reflect on the process of therapy and personal change. The MBT program may or may not have been helpful on its own but in this instance it is impossible to separate whether any changes in the client were due to therapy, research, or a combination of therapy and the research. Therefore, it is unreasonable to assert that any client change noted can be due to the effectiveness of MBT alone.

Conclusion

This sceptic argument has established compelling evidence that competing explanations account for the data presented. In particular, it is asserted that:

1. Mr Z's apparent changes were at best trivial and many were negative; therefore substantial therapeutic change cannot be established
2. The positive change identified in the PQ between five months and one-year of therapy was the only positive statistical change to occur during the therapeutic period. This is likely to represent a statistical anomaly that can be explained by factors such as expectancy effects or relational artefacts

3. Relational artefacts such as self-presentational strategies, the 'hello-goodbye' effect, and the interview style adopted confound any positive changes recorded in the data
4. Mr Z's personal accounts were influenced by his expectation-driven narrative of changing as opposed to resulting from a valid experiential process
5. The patient had an active desire to bring about change and was equipped with the resolve to do so, minimising possible therapeutic attributions
6. Extra-therapy events impacted upon Mr Z and were more decisive than the therapy, specifically his initial diagnosis prior to commencing the MBT program and the understanding he received from others
7. Psychobiological causes may be minimally in operation in terms of Mr Z's reduction of cannabis
8. Mr Z participated in the research in a self-conscious way and this undertaking cannot be causally separated from his involvement in the MBT program.

Following this, the sceptic argument asserts that the client did not change substantially over the course of the MBT program; any change observed was at best trivial and there is convincing evidence for negative alterations. Furthermore, any positive modifications were not due to the effect of MBT; various other operating factors have been shown to be causally inseparable from the therapy.

References

- Bruner, J. (1991) The Narrative Construction of Reality. *Critical Inquiry*, 18(1), pp.1-21.
- Elliott, R. (2002) Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*, 12(1), pp.1-21.

APPENDIX D

AFFIRMATIVE REBUTTAL OF THE SCEPTIC CASE

Note: The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

The purpose of this rebuttal is to challenge the arguments put forward in the sceptic brief that Mr Z changed little during therapy and that evidence exists to support alternative explanations for Mr Z's changes. A refutation is presented for all the eight arguments made by the sceptic researcher.

1. Mr Z's apparent changes were trivial or negative; substantial therapeutic change cannot be established

The first argument made in the sceptic brief to support the trivial change hypothesis was that the client did not move to the non-clinical range in the three outcome measures (Table A1) analysed for clinical significance (RCI) and therefore that change was not substantial. Whilst it would be ideal that Mr Z would be in the non-clinical range after one year of therapy, the changes observed are still substantial and remarkable if we take in consideration the severity and duration of Mr Z's problems (over 10 years). The PQ revealed a reliable drop from pre-therapy to one-year at the $p < 0.05$ level of confidence. According to Elliott (2002), change at the $p < 0.05$ level in one out of three measures is enough to assume that global reliable change has occurred and that change was not due to chance or measurement error. However, in this case we can also observe reliable change in a second measure (WSAS, Table A1). This extra assurance leaves no doubt that change has occurred and was substantial.

The fact that the CORE-OM shows negative change is undeniable. However, the affirmative brief has strong suspicions that the CORE-OM score at pre-therapy is inaccurate. The score of 0.82 is indicative of a 'low distress' level; this is strange at best since all the other indicators at pre-therapy (quantitative and qualitative) suggest a very severe level of distress.

The following argument made suggesting a negative change in the WSAS and PQ is inaccurate and irrelevant, and even the sceptic team seems to be aware of this mistake when commenting "although these figures are unlikely to be significant".

The proposition advanced by the sceptic team that the use of cannabis has not changed appreciably is also unreliable. It is true that Mr Z is still smoking daily but the amounts have reduced significantly, from an average of 12 spliffs a day to about 6. In the one-year change interview Mr Z has no reservations in stating this change:

Mr Z: I have cut down. I've had help with [Consultant Name] and she's got me on a sort of a plan to sort of bring me down off of that and I'm sticking to that

R: So you are still smoking but you say less or?

Mr Z: I'm smoking less yes (...)

R: (...) Six a day and how much were you smoking a year ago?

Mr Z: Maybe sort of ten, eleven, twelve (...)

Mr Z: (...) I'm buying in smaller quantities now (pp.144-145, one-year change interview)

Not only is it obvious that there is a reduction but Mr Z also shows an increased awareness of the function of cannabis in his life, which suggests that he is moving in the cycle of change from contemplation to an action stage (Prochaska and Di Clemente, 1986). This is evidenced, for example, by the helpful aspect of therapy written in his August HAT form (Table B1).

Next, the sceptic brief argues that there was no change in the Mentalizing Capacity from 5 months to one-year. What the sceptic team omits is the remarkable change that Mr Z has shown from pre-therapy to 5 months (Table A2). The scores on the Mentalizing Capacity Scale range from 0 (poor) to 12 (very high). Mr Z has moved from poor mentalizing capacity (score 1) to a moderate mentalizing capacity which is consistent from month 5 in therapy (score varying between 4 and 5). This is undeniably a significant shift for a patient diagnosed with two personality disorder types and with severe and chronic symptoms.

Regarding the scores in the GAF it is argued that the patient has not moved beyond 'serious symptomatology'. This is indeed the case; however, the consultant has moved the score from 41 to 45 which shows some improvement in functioning. The patient was also thought to be only showing moderate symptoms at the 5-month review (Table A2).

The argument posed by the sceptic brief suggesting negative change in the PQ items from 5 months to one-year (Table A3) is, once more, unreliable and unsubstantiated. In fact, the average score at 5-months is 4.1, decreasing to 4.0 at one-year; this is not a significant drop but it is certainly not a negative change as proposed by the sceptic team. The scores in the individual items show great variation across therapy and at 5-months Mr Z rated some of the items with a very low score; this may explain the increased score noticed by the sceptic team from 5-months to one-year. Despite this fact, when looking globally at the results, it is not possible to assert that negative change has occurred.

The sceptic team substantiate their argument with a quote from the 6-month and One-Year change interviews. This gives the impression that Mr Z actually believes he has not changed. However, as it can be observed from looking at the full interview transcripts, Mr Z takes time to open up and the interviewer had to make an extra effort to get meaningful replies from him. Despite this difficulty, it was possible to hear several reports of substantial change from Mr Z; these are summarized in Tables C1, C2, C3 and C6 for example.

For all the reasons stated above the sceptic argument that change was at best trivial and, in some aspects, negative must be rejected.

2. Statistical Artefacts

The arguments of the sceptic team are not convincing. All the measures in Tables A1 and A2 change in the positive direction and two of them (WSAS and PQ) also meet the reliable change index. This correlates positively with the working alliance score given by Mr Z in the WAI-S which is higher at one-year than at 8 months.

The only inconsistency found was, in reality, the CORE-OM score at pre-therapy (and possibly at 5-months). This gives rise to suspicions regarding the possibility of measurement error in the pre-therapy score of the CORE-OM as already explained in point nr.1 (above). The slight deterioration shown in the WSAS after 5 months, and in the PQ between 5 months and 8 months, are not statistically significant and should not be used as an argument against positive change.

The argument put forward in the sceptic brief regarding the possibility of statistical error in the PQ is flawed and is not taking into consideration a number of important points. First, we are comparing the results from pre-therapy to one-year and not from 5-months to one-year. The comparison between pre-therapy to one-year leaves no doubt that change has occurred as previously explained. Second, even if

we decided to compare the 5-month measurements with the one-year measurements we could not say, as the sceptic team points out, that the PQ is the only measure showing positive change. In fact, from 5-months to one-year there is no statistically significant change in any direction in any of the measures; there is a slight deterioration in the GAF but this measure does not have reliable change indexes that we can use.

Looking at the results globally it is possible to make a very different interpretation from the one made by the septic brief; the affirmative brief argues that Mr Z achieved substantial and reliable positive change from pre-therapy to 5-months; this change is then sustained until the one-year mark with no further improvement or deterioration. We believe this is a much more accurate interpretation of the results in Tables A1 and A2.

3. Relational Artefacts

This section will be divided into three subsections to counter-argue the points made by the sceptic brief regarding the possible influence of Mr Z self-presentational tendencies and of the interpersonal dynamics between the client and the interviewer (principal investigator).

a. Relational response tendencies

It has been argued in the sceptic brief that Mr Z behaves in a way that is unreliable as he hides behind a *mask* and also wishes to please the psychotherapy team.

There is convincing evidence from both change interviews and the notes of the psychotherapy team that Mr Z has difficulties in opening up and that he hides behind a mask. It is also true that he mentioned being a compulsive liar in the past. However, there is no evidence that he used this mask as a strategy to 'please' the psychotherapy team or to lie about his progress. On the contrary, Mr Z gave plenty of evidence that he was not concerned with 'pleasing' the team. He mentioned several times negative or neutral aspects regarding the team and his progress:

R: (...) are you acting in any different way or any behaviour that has changed?

P: I don't think so, no

(p.105, 6-month change interview)

P: I met [Consultant] a couple of weeks ago

R: Right

P: Um, that was fine, that was fine, I didn't think she was listening that much but (...)

P: (...) Yeah, yeah she, it didn't seem like she was fully taking on what I was saying

(p.123, 6-month change interview)

R: Okay. And what about the research? Is there any helpful aspects of being part of the research? Or is it something that's not helpful at all?

P: It's not something I've really given much thought to

R: No. What did you say, what do you think it helps you? Do you think it's something you would rather not do or?

P: Well it helps other people. I don't know if it helps me or not (R: Okay) it's not really, the therapy is helping and that's what I'm in it for as it were

R: Okay

P: Um, the research that you do and the questions that I ask, I assume would be done by any psychiatrist anyway to keep a measured check over the course of a period of time

(p.155, one-year change interview)

P: I like labels, I like departmentalising or compartmentalising, whatever you call it (R: Okay). I find that quite helpful to all of, because my mind is so like a maelstrom that I find it helpful, when I can, to be able to go, that, that, that and put and order into things. It helps to clarify in my own mind

R: And [Therapist Name] said there is no labels here

P: [Therapist Name] doesn't do labels, she doesn't refer to anybody as being depressive, bipolar, ADHD, whatever (R: Right) the many, many different things there are

(p.163, one-year change interview)

The sceptic brief also highlights the inconsistency of Mr Z's statement with the evaluation of the therapist and the psychosocial nurse. It is clear that there are some inconsistencies on Mr Z's narrative but it is plausible to assume that this is due to his disorganized thinking and avoidance strategies, both characteristics of his personality, rather than a conscious deceiving tactic. All three professionals involved (the

psychosocial nurse, the therapist and the consultant) made clear remarks on their reports regarding Mr Z's tendency to disconnect from his feelings through the use of cannabis or by missing sessions for example, which will feed into the disorganization of thought:

Your absences feed into your propensity to disconnect and therefore prevent you from carrying on thinking. This encourages the disorganization of thought (therapist 7-month progress report)

One other way to deal with relational artefacts is to use a social desirability or other quantitative validity scales (Elliott, 2002). Although such a measure was not used it is possible to make inferences from the 'negatively worded' items on the working alliance inventory (WAI-S); the consistency found between 'positively worded' and 'negatively worded' items indicate that Mr Z's responses were genuine and not a reflection of his desire to please the team.

b. The 'hello-goodbye' effect

Here the sceptic brief makes a valid argument and the words of Mr Z are very clear. However, there are a couple of problems in the sceptic position which are not given enough consideration. The 'hello goodbye' effect mentioned by Elliott (2002) states that "the client enters therapy emphasizing distress to impress the research staff to accept him or her. However, at the other end of therapy, the client emphasizes positive functioning either to express gratitude to the therapist and research staff or to justify ending therapy. (...) if therapy is going to end anyway, there is little to be gained by trying to look worse than one is (...)" (p.11, not highlighted in original version). The problem here is that the therapy is running for two years and was only half-way through at the time of the interview, which makes it unlikely that Mr Z was under the 'goodbye' effect.

The second problem in the sceptic brief argument is that the quote selected hides what is said exactly after, which can change slightly the meaning of Mr Z's statement:

R: Because of that. Okay, but do you think it's, it's really a change or are you kind of um (P: I don't know yet) saying that you have changed but you didn't really change?

P: I don't know yet, I don't know how much this is sticking. It could all fall to pieces next week. I don't know, but at the moment this is the way seems, things seem to be going for me

R: Mmm, and at the moment you feel there is a change in this area?

P: Yes

(p.150, one-year change interview)

In addition, following Bohart and Boyd (1997 as cited in Elliott, 2002: p.11) plausibility criteria to evaluate reported therapy attributions, it is possible to reject the role of self-presentational artefacts, since there are a number of *elaborated* accounts of the therapy's influence in Mr Z's narrative. The following example contains specific details about what has changed and how the change came about:

P: I mean I do have a lot of understanding that I never expected

R: Understanding

P: Yeah, now you know because obviously kept it secret, hidden for so long. Now that I'm being open about it I find that people are not judging me the way I thought they were going to and I think that might have helped

R: Mmm. So people in general or?

P: Um well friends and family (...) But yeah people in general have been quite accepting of the fact and I've found that quite surprising

R: Surprising. And do you, what do you think caused you to be more open in the first place? Or honest with those people?

P: because I was being honest in therapy. I was happy to come out with these things in therapy and sometimes it overflows and I have to, if I've got a friend round or I see my dad or something, I will talk about some of the things that I've talked about in therapy.

(pp150-151, one-year change interview)

Differentiation (Bohart and Boyd, 1997 as cited in Elliott, 2002: p.11) is also present in the interview transcripts, showing a mixture of positive, negative and neutral descriptions (see Tables C3 to C12 and the example in point 3a above).

c. Interview strategy

The interview with Mr Z was extremely complicated due to his natural avoidance tendency and difficulties in opening up. In this sense, the sceptic team makes a valid point here when stating that the interviewer has guided Mr Z in some of the questions. It appears exaggerated, however, to affirm that the interviewer was only interested in positive change and disregarded any negative accounts. Evidence that this is inaccurate can be found in the following examples:

P: it does help to know that I have got a diagnosis of this and this. To be able to go into the world and know what you are dealing with

R: So the fact that there is no labels in here you find it unhelpful, you would like to see...

P: (...) It helps to clarify in my own mind

R: And [Therapist Name] said there is no labels here

P: [Therapist Name] doesn't do labels, she doesn't refer to anybody as being depressive, bipolar, ADHD, whatever the many, many different things there are

R: Nobody here talked to you about diagnosis or labels

P: No one has really no

R: Okay and you would find that helpful

P: I would yeah, because as I've said I, I got the diagnosis of bipolar disorder. I'm not sure if that's right or not or whether any additions need to be made to that (pp.161-162, one year change interview)

In the following example, the interviewer insists in trying to find unhelpful or negative aspects of therapy despite the dismissal of Mr Z:

J: (...) In terms of problematic aspects, was there anything about the therapy that you feel was hindering to your recovery or unhelpful?

P: No, no... (...)

J: What about the program in general, anything that was unhelpful?

P: No, er not, not yet no

J: Anything that was difficult or painful but still OK to...?

In other occasions there was direct encouragement to hear negative aspects:

R: If you have something negative to say it's perfectly fine (p.162, one-year change interview)

As shown above, it was possible to rebut all of the sceptic arguments regarding relational artefacts and, in this way, caution is advised when attempting to attribute the observed changes to the interpersonal dynamics between the client and the psychotherapy and research teams.

4. Expectancy artefacts

The sceptic researcher makes two basic arguments: that Mr Z had therapeutic expectations of change that impacted on the outcome; and that these expectations were revealed through his 'scripted' accounts of the process of treatment and reliance on cultural schemas as opposed to him producing idiosyncratic and experiential narratives (Elliott, 2002: p.12).

One way of showing that Mr Z's accounts are grounded in his immediate experience, as opposed to expectation-driven, would be to find detailed, careful and self-reflective descriptions in his change interviews (Bohart and Boyd, 1997 as cited in Elliott 2002: p.12). Mr Z's accounts of therapy reveal a mixture of expectation-driven and self-reflective statements. The following example appears to be close to Mr Z's immediate experience and, therefore, more credible:

P: I didn't even realise I was doing it until... (Pause) I think a couple of weeks ago when I was out with my father shopping and he was getting annoyed and I was sort of saying to him, 'no calm down, let's just go outside and we'll take a breather' and I realised that I was doing exactly the same thing but in my own head. I was sort of going (breathes in and out audibly). And I, I sort of was staying calm in a stressful situation, I knew it was stressful because my dad was getting stressed by it

R: And you didn't even realise you were doing that?

P: I didn't realise, no and that's when I suddenly thought hang on, I'm getting a bit, you know, I would normally explode by now (p.168, one-year change interview)

In addition, when clients mention that they are surprised by a certain change, it is plausible to assume that it is not a reflection of generalized expectancies or stereotyped scripts for therapy (Elliott, 2002). Again, Mr Z shows a great variety of responses which do not allow for the development of a convincing or consistent conclusion: out of 9 changes reported, one was 'very much expected', three were 'somewhat expected', one was 'neither expected nor a surprise', two were 'somewhat surprising' and the other two were rated as 'very much a surprise'.

In conclusion, although it is not possible to completely refute the sceptic argument on this point, it is clear that the sceptic researcher has exaggerated the importance of Mr Z's expectations, not taking into account other contradictory elements.

5. Self-Correction Processes

I believe this sceptic argument supports the therapy efficacy hypothesis rather than casting doubt on it. What Mr Z says in the quote selected by the sceptic researcher is indicative of how he was starting to trust the therapy process and beginning to understand the importance of being involved.

The following argument made regarding Mr Z's self-reported changes and attributions seems incomplete at best. A closer look at both Tables C1 and C2 shows that most of the changes reported were considered to be 'very unlikely' without the therapy. The extent to which the client was surprised with the changes is also mixed; of the nine changes reported by Mr Z, the sceptic brief decided to only comment on the three that were 'somewhat expected', hiding other changes where the client was truly surprised.

Reference to self-correction efforts in the therapist process notes or the psychotherapy team reports are very scarce. Apart from a few comments on his attempt to stop smoking cannabis there is only one event that may have some relevance since it happens during a session where the PQ drops dramatically. In the therapist process notes for the 09th of November 2011 the therapist writes 'tries too hard; feels out of sorts - plays the piano and tries to exhaust himself'. This event, however, does not seem able to fully explain the client changes.

Furthermore, taking into consideration the duration of Mr Z's problems (more than 10 years) it seems very unlikely that Mr Z would be able to achieve change solely through his own effort.

6. Extra-therapy events

The sceptic researcher highlights the influence of two extra-therapy events in any changes observed: his first diagnosis prior to commencing the MBT program; and the understanding he received from his family and friends following this diagnosis.

It is evident in both the 6-months and one-year interviews that receiving a diagnosis was important for Mr Z and that he attributed some of his changes to the diagnosis and the impact this had on the understanding of his family, particularly his father. Nevertheless, during the 6-months interview, Mr Z attributes 99% of influence to the therapy programme, leaving the diagnosis and the understanding to second stage:

P: And I tried to explain what was going on in my head, he didn't believe me

J: Mm

P: He didn't have any understanding he just said that I was a waste and things. So now that I've got a diagnosis and he understands that, he's read books and

J: Mm

P: Um I can talk to him about it and that helps but it's mostly the group

J: So do you feel this, the fact that your dad understands a little bit better has helped you in achieving these changes

P: Yeah, yeah

J: OK. What else do you think was responsible for the changes (inaudible)?

P: Group therapy

J: The therapy, the group, yeah

P: Oh yeah the group has been 99% and you know the fact that I've got a bit of understanding outside of group helps

J: Yeah, so 99

(p.117, 6-months change interview; relevant passages highlighted)

The reports from the generic psychiatrists are not conclusive and could have, in the best of chances, created confusion in the patient. The patient records show several tentative and different diagnoses from the CMHT psychiatrists, some of which written with question marks: (?) Cyclothymia and (?) Borderline Personality Disorder (26th January 2011); Cyclothymia / Bipolar Spectrum Disorder and Borderline Personality Disorder (06th April 2011); Cyclothymia and Emotionally Unstable Personality Disorder (5th July 2011). Despite all the different classifications, the patient states he was given the diagnosis of “bi-polar” and this seems to be what he shared with others. The psychotherapy team, conversely, was clear about the diagnosis of personality disorder and this was explained at length to the patient, in particular during the SCID-II interviews with the team consultant. Furthermore, in the MBT adherence scale the group therapist has

consistently marked a 'yes' to the question 'diagnosis has been discussed with the patient' showing that this was not something to shy away from.

These extra-therapy events are, therefore, confusing and may also reflect the confused state of the patient and his need to cling to some label to explain his own behaviour. It is not possible, in this way, to fully attribute the changes in Mr Z to these extra-therapy events. At best, we could assume the bidirectional influence of the therapy program, receiving a diagnosis and the greater family understanding.

7. Psychobiological causes

The sceptic team seems to agree that the medication could not explain, in an unidirectional way, the changes observed in Mr Z. His medication was stable since March 2011 (7 months prior to the start of the program) and did not suffer alterations until the point of this evaluation (one-year in therapy). Not only did the medication not seem to have an impact on positive change but could even have had a negative influence, since both Mr Z and the psychosocial nurse believed he should increase it, as reported in the one-year change interview:

P: I've got to phone up [CMHT General Psychiatrist Name] and have my medication looked at

R: Right, [CMHT General Psychiatrist Name]

P: [Psychosocial Nurse Name] mentioned, the psychiatric nurse, mentioned that I may need to, it may be helpful to have a review, maybe up my meds, but I haven't done that

(p.160, one-year change interview)

Regarding the second argument made by the sceptic brief, it is undeniable that a reduction in the cannabis intake could have influenced Mr Z's well being; however, the cannabis reduction would be unlikely to have happened without the influence of therapy, as evidenced through several sources:

Realizing that cannabis is my mask not just part of it / I hadn't looked at it that way before (helpful event in the HAT form, 13th August 2012, rated as greatly helpful, Table B1)

I have cut down. I've had help with [Consultant Name] and she's got me on a sort of a plan to sort of bring me down of of that and I'm sticking to that (p144, one-year change interview)

We discussed your cannabis intake in detail and made plans for you to have small but sustainable decreases which [Psychosocial Nurse] and I will monitor and support you through (quote from 12 months MBT report by the consultant)

It is also worth noticing that the sceptic researcher uses the argument of the cannabis reduction here when in point nr.1 the researcher argued that the use of cannabis did not seem 'to have changed appreciably'.

8. Reactive effects of research

It is not possible to give credibility to the sceptic points since the evidence presented is scarce and unreliable. There is no confirmation that the 'extra' reflection provided by being part of research had an influence in the positive outcome. When asked about the

effects of the research Mr Z did not spontaneously refer to any benefits. There was also no evidence in the therapist process notes or the rest of the psychotherapy team that the research was having a positive impact.

At the one-year change interview Mr Z did not report any helpful factors about taking part in the research. He did, however, mentioned a hindering factor, the fact that the HAT forms were complicated: "sometimes they can be quite difficult" (p.147, one year change interview). This is further confirmed by the high number of forms that he returned empty or with only one or two words written.

In addition, Mr Z's comments about the research in general do not indicate that this was particularly helpful for him. In the one-year interview, for example, he comments:

R: Okay. And what about the research? Is there any helpful aspects of being part of the research? Or is it something that's not helpful at all?

P: It's not something I've really given much thought to

R: No. What did you say, what do you think it helps you? Do you think it's something you would rather not do or?

P: Well it helps other people. I don't know if it helps me or not (R: Okay) it's not really, the therapy is helping and that's what I'm in it for as it were

R: Okay

P: Um, the research that you do and the questions that I ask, I assume would be done by any psychiatrist anyway to keep a measured check over the course of a period of time

(p.155)

Mr Z seemed to take the research as more of an inconvenience than a benefit or, at best, he was neutral about his participation making it very unlikely that the research was solely responsible for the changes observed.

Conclusion

Viewed from this perspective, the arguments of the sceptic case carry little weight. We ask you to consider the following points:

1. Different sources of evidence suggest that Mr Z changed substantially. The quantitative data strongly points in the direction of positive change surpassing even the minimum criteria suggested by Elliott (2002).
2. The great majority of the quantitative measures used point in the direction of positive change which leaves no room for suspicion that statistical errors were in place.
3. There is credible evidence that Mr Z's responses were genuine and that no 'hello-goodbye' effect was in place, mostly because therapy was only half-way through. The avoidant personality traits of Mr Z may have affected the change interview but not to the extent of manipulating the data.
4. Enough evidence exists to suggest that many of Mr Z's accounts were self-reflective and credible as opposed to mainly expectation-driven. Mr Z was indeed surprised with many of his changes.
5. All of Mr Z's problems were of more than 10 years duration whilst the majority of his reported changes were considered to be 'very unlikely' without the therapy. Both these facts cast serious doubts to the possibility that self-corrections processes alone would cause any of the reported changes.

6. There is no evidence that the 'extra-therapy events' reported can fully explain the changes. At best, there is a bidirectional influence between these events and the therapy program itself.
7. No changes in medication were made during the MBT program and therefore it is not possible to make a link between the use of medication and psychosocial change. In addition, there is sufficient evidence that the reduction in cannabis was linked with the therapy program and could not by itself explain Mr Z's reported changes.
8. Mr Z seemed to take the research as more of an inconvenience than a benefit or, at best, he was neutral about his participation making it very unlikely that the research was solely responsible for the changes observed.

References

Elliott, R. (2002) Hermeneutic single case efficacy design. *Psychotherapy Research*, 12, pp.1-20.

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APPENDIX E

SCEPTIC REBUTTAL OF THE AFFIRMATIVE CASE

Note: The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

The affirmative argument asserts that Mr Z's enduring problems did change substantially during the course of therapy and that this adjustment was a result of the MBT program. This sceptic rebuttal challenges the validity of these conclusions and demonstrates the tenuous evidence and fallacies on which they are based.

1. No substantial change in stable problems

The affirmative argument asserts that a reliable and substantial drop occurs in Mr Z's PQ ratings from pre-therapy to one month, which is then sustained throughout the year. However, there are only two reliable positive changes in this indicator (Figure A1). Furthermore, there are two instances of reliable negative changes in PQ ($p < .2$): month three to month four and again from month five to month six (Figure A1 and Additional Tables); this indicates a reliable worsening of functioning for Mr Z in these instances.

In addition, a reliable negative change ($p < .05$) occurs in CORE-OM between pre-therapy and five months and also between five months and eight months (Table A1). This negative change is sustained between eight months and one year (although the difference is not reliable between these dates). Even taking into account the affirmative argument that the low pre-therapy score on CORE-OM could be due to measurement error, the remaining instances on this dimension still highlight reliable negative change. Consequently this proposes that the patient did not change substantially during the first year of the MBT program.

The WSAS (Table A1) also shows no improvement between five months and one year (with a slight unreliable worsening of symptoms), the patient's Mentalizing Capacity (Table A2) remains in the moderate range between five months and one year, whilst the GAF worsens between five months and one year (Table A2). Moreover, following one year of the MBT program Mr Z remains in the clinical range for all indicators, suggesting that there has been no substantial change in his stable problems.

The affirmative argument posits that during the three monthly reviews the Consultant Psychiatrist judged that the patient had changed. However, the Consultant Psychiatrist described the situation for Mr Z on 19th September 2012 (one year into the treatment) by writing that 'there is much work to do, which feels possible, but only with your determination for change'. This excerpt indicates that the patient has not changed substantially and that a great deal of accomplishment remains necessary for meaningful alteration to be inferred.

The therapist's three month Progress Report supplements this sense of Mr Z's resistance to change: 'As other members of the group are letting go of their addictions [Mr Z] remains resistant for the time being'; and '[Mr Z] is constantly concerned about his financial situation but continues to buy drugs as opposed to invest in the group process to make the long term changes needing to be made'. The therapist's 12 month Progress Report, one year into therapy, describes the patient as feeling 'he is so ugly he cannot imagine that anyone would see

him differently'. This illustrates the way that Mr Z has not changed substantially during the course of the MBT program; any change is trivial or negative.

In addition, the affirmative position states that some measurements were achieved when the patient was having a 'bad' day; however, in contrast, some other information was recorded when Mr Z was having a 'good' day. In the Six Month Change Interview (p.138), the patient explains his former scores by saying 'Yeah and today it would be probably a six. It was just I was having a good, a good week there', and again:

Interviewer: OK so when you've done this on, on the 12th, you were feeling very confident?

Mr Z: Yeah I was feeling very good about myself

Interviewer: Mm. So do, would you like to add this to the change list or do you think it's still a problem?

Mr Z: Oh no, no it will still be a problem

Following this, there is no evidence to convincingly suggest that Mr Z established meaningful alterations in terms of his chronic problems; any changes noted were trivial, negative or fallacious. Therefore, it can be confidently asserted that Mr Z did not experience substantial change to his stable problems during the first year of the MBT program; the sceptic position must be adopted.

2. Problems with retrospective attribution

The affirmative case argues that Mr Z attributed any alterations that he noted to the MBT program. However, this sceptic rebuttal asserts that the evidence presented by the affirmative brief is biased. Mr Z attributed a number of his changes to factors other than therapy and it is also worth remembering that the patient makes convincing statements that he does not believe he has changed at all.

The affirmative argument suggests that Mr Z attributed seven out of nine of his changes to therapy (Tables C1 and C2). However, the figures for the One Year Change Interview (Table C2) show that the patient believed that 50% of these alterations would have occurred without the MBT program or may or may not have occurred without the MBT program. Therefore, when the affirmative case quotes the One Year Change Interview (p.149) as supporting retrospective attribution, it is presenting a selective and biased view of the data.

Moreover, the Six Month Change Interview excerpt highlighted by the affirmative argument does not unequivocally attribute alterations to the MBT program since it also affirms the usefulness of the research process (Sceptic Argument, p.61) and the understanding that the patient has outside of the group (Sceptic Argument, pp.59-60). Following this, the affirmative case also posits that Mr Z rated all of his changes as 'extremely important'. However, Elliott et al (2009) argue that clients almost always indicate that their changes were 'important' in the Change Interview, suggesting that this measure has questionable validity.

In addition, the sceptic brief has already shown that Mr Z wears a 'mask' and engages in impression management techniques (Sceptic Argument, p.52). The patient was also acutely aware of what may have been 'expected' of him in therapy (Sceptic Argument, p.54). These relational artefacts, compounded by an interview strategy that included leading questions and over-reporting positive changes whilst under-reporting negative alterations, suggest that Mr Z's testimony cannot be considered to be reliable in a straightforward way. It must also

be remembered that in certain interview excerpts, Mr Z did not believe that he had changed at all ('it's just seems to be the same barrage that I've always had', One Year Change Interview, p.154).

Following this, the sceptic rebuttal asserts that the affirmative brief fails to examine the nuances of the Change Interview transcripts, leading to analytic shortcomings in the arguments it presents (Antaki et al, 2003). The information presented by the affirmative case as supporting retrospective attribution is unreliable and the sceptic assertion of merely tenuous retrospective attribution must be upheld.

3. Insubstantial process-outcome mapping

The affirmative case has attempted to map changes reported in the Six Month and One Year Change Interviews (Tables C1 and C2) to specific therapeutic events or processes thought of as being helpful by Mr Z (HAT, Table B1). However, this sceptic rebuttal argues that the mapping process undertaken is extremely tentative and requires a 'leap of faith' to be believed. In addition, there is direct evidence to show that the therapist's adherence to MBT (Table D1) and the Helpful/Hindering Aspects of Therapy (Tables B1/B2) do not co-vary reliably, suggesting that a clear process-outcome mapping is not possible.

First, the affirmative argument has only been able to map five changes out of the nine reported (45%). This figure is too low to convincingly demonstrate a connection between the therapeutic process and patient outcome. Furthermore, of these five changes that the affirmative case has attempted to map, three of them appear to be completely unconnected to the therapy. For instance, the change 'more hopeful' was reported in the Six Month Change Interview (Table C1). However, it has been mapped onto a therapeutic process occurring in August 2012, almost one year into therapy and six months after Mr Z mentioned the alteration. It is inconceivable to suggest that the change could have occurred before the therapeutic process took place and then attribute the change to that process.

Likewise, 'control a little bit more my aggression' and 'gained more control over emotions in general' were asserted in the One Year Change Interview and yet mapped onto a process that occurred in November 2011, almost a one year difference in time frame. It seems to be completely unreasonable to assert that one event in one session in November 2011 could be linked to changes reported almost one year later. This leaves the affirmative argument with only two out of nine changes mapped onto therapeutic events; the process-outcome mapping appears to be insubstantial.

Moreover, of these two changes that seem to have been mapped, the change 'I have more understanding and can focus more' was 'very much expected' by Mr Z (Table C1). This highlights the way that the patient's expectancy effects as opposed to the therapy may have been implicated in this alteration (Sceptic Argument, p.56). Elliott (2002: p.13) writes that if a patient is surprised by a change then it is more likely that it is attributable to therapy; Mr Z was not surprised by this change, which acts to invalidate the process-outcome mapping in this instance.

In addition, the mapping of this change did not reflect the PQ scores, with 'disorganised thinking' (strongly related to the possible change 'I have more understanding and can focus more') maintaining a consistently high rating of either five or six points for February, April, May and August (Additional Tables), the months in which the helpful therapeutic events were reported to have occurred. This suggests that the patient did not change significantly on this measure.

This leaves a tentative mapping of one change discussed at the Six Month Change Interview – 'more able to control impulses' – being mapped onto only one instance of a helpful therapy event that occurred in November 2011. This link is extremely fragile and would require a 'leap of faith' to be sustained. No other specific process-outcome mappings have been asserted in the affirmative brief, merely the contention that 'the link is not entirely obvious'.

Making a 'leap of faith' or asserting that 'the link is not entirely obvious' are inappropriate to the process-outcome mapping argument, which requires that 'the content of the client's post-therapy changes correspond to specific events, aspects, or processes within therapy' (Elliott, 2002: p.6). It is therefore prudent to assert that the process-outcome mapping is insubstantial and the sceptic position, that any changes that occurred are not obviously attributable to therapy, must be accepted

4. No within-therapy process-outcome correlation

The affirmative brief has found no evidence to support a relationship between in-therapy process variables and shifts in client problems. As stated by the affirmative argument: 'no correlation was found between the results in the PQ and the overall adherence to MBT'. The only correlation established was between 'framework of treatment' and the PQ results ($p < .05$). However, the category 'framework of treatment' does not specifically relate to MBT techniques and therefore provides negative evidence for the effectiveness of the MBT program in this case.

Following this, despite the high adherence that the therapist has shown to MBT principles in her self-report statements, these cannot be correlated with client changes and do not stand alone as evidence for a connection between the MBT program and the client outcome. Instead, evidence suggests that the most important aspects of the therapy were unspecific to MBT.

5. Difficulty in inferring event-shift sequences

The affirmative brief has attempted to suggest that important events in therapy led to a shift in client problems by locating event-shift sequences between the PQ score and the Helpful Aspects of Therapy (HAT, Table B1), both for the same session and for the following month(s). However, the sceptic rebuttal argues that the links made are questionable and can be explained by other factors.

a. Same session HAT and PQ links

The affirmative case seeks to establish links between the HAT and the PQ for the same session in order to infer a stable change in patient problems. This method is dubious since comparing indicators from the same session is unlikely to show that the patient has changed in a stable manner following a helpful event.

Following this, it is asserted that the Helpful Aspect of Therapy (Table B1) on 9th November 2011 – briefly regarding losing control of temper - caused a dramatic and reliable drop in the PQ score, specifically in relation to items concerning this issue. However, as mentioned above, it is likely to be too soon for an event in therapy to have affected the PQ scores so dramatically.

In addition, other dimensions on the PQ also dropped by the same amount (four points) as the indicators concerning a losing control of temper did (for example, self-loathing and negativity). Moreover, it is likely that this drop in the PQ score - measured between pre-therapy (the beginning of August) and November 2011 (the first therapy indicator) - is due to the extra-therapy events defined in the Sceptic Argument (p.59-60), specifically the diagnosis received from Mr Z's generic psychiatrist and the understanding that he received from his father as a result of this. This is especially likely to be the case since the measurement period spans around a three month gap, leading to a larger drop being expected than for the other sessions.

The affirmative argument then turns to two further reliable shifts in PQ on sessions 15th February 2012 and 11th April 2012, which it is argued correspond to HAT events in the same session. It is suggested that the Helpful Aspect of Therapy of discussing compulsive lying (15th February 2012) led to a reliable worsening of the patient's PQ scores due to it affecting his self-esteem, with the affirmative argument citing the way in which the PQ items 'not believing in myself', 'self-loathing' and 'depressive spirals' rose from three to four, three to five, and two to three points respectively.

However, the sceptic rebuttal asserts that this reliable negative drop in PQ is not due to increased insight and a subsequent lowering of self-esteem. For instance, these figures are not different from the mean scores for these items across the therapy period, with 'not believing in myself' having a mean of 4.5, 'self-loathing' having a mean of 4.2 and 'depressive spirals' having a mean of 3.8. This suggests that, taken globally, the rises in these items on the PQ following this session were not due to the HAT but were part of the broader fluctuations experienced by Mr Z in terms of his 'good' days and 'bad' days discussed previously.

In addition, the therapist's Process Notes for 15th February 2012 highlight that the patient was 'feeling normal at the moment (not that he knows what that feels like). From being manic has not gone into depression. Entered into lively conversation...' This again suggests that the therapeutic event in that session did not affect Mr Z in the negative way asserted by the affirmative brief; instead it seems that the changes in his PQ items relating to that session were within the normal range for this patient, illustrating that no event-shift sequence can be inferred.

In terms of 11th April 2012, the affirmative case suggests that a Helpful Aspect of Therapy – briefly, talking about self-hatred – led to a reliable increase in the PQ score, again due to issues of self-esteem. Nevertheless, it is more likely that the increase in the PQ score was influenced by the patient's extra-therapy predicament, as highlighted by the therapist's Process Notes (11th April 2012): 'Talked about the

terrible debt he is in, on-going, he just buries his head and hopes it will all go away, instead it starts vicious circle. Feels unbearable, feelings of hopelessness and takes dope to repress the feelings'. It is reasonable to assume that Mr Z discussing this debt led to increases in the PQ items 'not believing in myself', 'self-loathing and negativity' and 'depressive spirals'.

The affirmative case also notes a reliable shift in the PQ score on 4th July 2012 although it cannot explain this with an event-shift sequence, perhaps again suggesting the fluctuations that Mr Z experiences. In addition, the sceptic rebuttal asserts that Mr Z recorded 10 Helpful Aspects of Therapy (Table B1). However, the affirmative brief has only suggested four event-shift sequences that relate to this; therefore 60% of the helpful therapeutic events do not seem to produce corresponding changes in PQ. Likewise, there are 11 PQ mean scores and only four show reliable shifts, with one of those spanning a three month period from pre-therapy to therapy. This suggests that the patient did not change substantially and that any change cannot be connected to the MBT program.

b. Following month(s) HAT and PQ links

The affirmative case suggests that the HAT event (9th November 2011) concerning losing control of temper may be responsible for changes in the following months. However, the way that the argument is constructed is untenable since the pre-therapy PQ (3rd August 2011; baseline) is compared with the average score from November onwards. However, the pre-therapy PQ measure occurred three months before the Helpful Aspect of Therapy did, and there can therefore be no connection between these indicators in terms of a link between HAT events and PQ ratings of the following month(s). Instead, the score on 9th November must be compared with the overall average:

- Problem 2: 9th November 2011 is 3, mean is 4.2
- Problem 5: 9th November 2011 is 3, mean is 2.6

- Problem 9: 9th November 2011 is 3, mean is 3.7

This shows that there were no large changes over the following months and two of the problems got somewhat worse, with Problem 2 being reliably worse in terms of a comparison with the PQ measurement of 9th November 2011 and the overall mean. This therefore suggests that the HAT event on 9th November 2011 did not lead to a change in PQ ratings for the following months. Therefore, this challenges both the quantitative assertions and the qualitative evidence in the form of the Therapist Process Notes presented by the affirmative brief.

In relation to 11th April 2012, the drops in PQ following this session can be explained by the patient having spoken about his crippling debt in the session (Therapist Process Notes), which acted to raise his PQ profile on that date (as previously discussed). This is evident since the PQ for 'not believing in myself', 'depressive spirals' and 'self-loathing and negativity' is highest for 11th April 2012 than for any other month of the therapy, even pre-therapy.

In addition, these drops do not represent stable changes, for instance 'depressive spirals' drops from seven on 11th April 2012 to three on 14th May 2012 but then the next session (6th June 2012) it has returned to six again. Likewise, 'dark disturbing thoughts' drops from six to four but the following session it has returned to six. Consequently, no stable changes in client functioning can be inferred.

In summary, it has been shown that event-shift sequences cannot be unquestionably inferred both in terms of same session measures and subsequent indicators. Instead, a combination of measurement problems, methodological issues, extra-therapy events, Mr Z's discussion of his debt and the patient's naturally fluctuating patterns are responsible for any changes in the PQ scores. Furthermore, it has been highlighted that the majority of HAT events reported by Mr Z do not produce corresponding changes in the PQ score. Therefore,

there is great difficulty in inferring event-shift sequences and connecting changes in PQ to therapeutic processes; the sceptic position that any change cannot be attributed to therapy must be accepted.

Conclusion

The sceptic rebuttal has examined the affirmative brief in good faith and makes the following assertions:

- There was no substantial change in Mr Z's stable and chronic problems
- It is not clear that Mr Z reliably attributed any changes he experienced to the therapy
- The process-outcome mapping asserted by the affirmative brief does not accurately account for the majority of the changes reported by Mr Z
- No link was established between MBT techniques and outcomes
- Therapy events cannot be shown to have led to a stable shift in client problems.

Therefore, there is insufficient evidence to support the therapy efficacy hypothesis; competing explanations for apparent client change must be accepted.

References

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APPENDIX F

AFFIRMATIVE SUMMARY NARRATIVE

Note: The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

When Mr Z was referred to the Psychotherapy Department and Personality Disorder Service he was 45 years old; he was having difficulties since he was a little boy, describing nightmares and intrusive thoughts from an early age. His school days had been difficult and he was feeling depressed and with his emotions 'running high' since his teens. He mentioned feeling suicidal from the age of 13. In his adult life he complained of mood swings, emotional outbursts and instability in relationships. He used psychoactive substances from an early age to 'calm his nerves' and to disconnect from painful feelings. In his personal questionnaire he described a number of problems he wanted to work on in therapy, for example, 'not knowing when to stop', 'disorganized thinking', 'self-loathing and negativity' and 'dark disturbing thoughts'. All of his reported problems were long standing and bothering him for more than 10 years.

Mr Z had a number of provisional diagnoses from generic psychiatric services: cyclothymia, bi-polar disorder and borderline personality disorder. Following a period of consultation in the Specialist Personality Disorder Service the diagnosis of borderline personality disorder was confirmed; he was also considered to have a depressive personality disorder and a co-morbid dependency on cannabis. In the SCID-II questionnaire and interview he scored high on a number of other personality traits, with particular emphasis on narcissism.

With such a dramatic history and presentation the affirmative brief made a convincing argument that Mr Z changed substantially after a year of MBT and that this change was due to the therapy. Out of five different types of evidence, two were considered to be strong, 'change in stable problems' and 'retrospective attribution'. According to Elliott (2002) this would be enough to corroborate the therapy efficacy hypothesis. However, we also found some evidence for 'process-outcome mapping' and 'event-shift sequences' which give further weight to the affirmative position.

The sceptic brief attempted to refute the therapy efficacy hypothesis but enough evidence was found to disprove the sceptic position, both in the quantitative measures and in qualitative accounts of Mr Z and the MBT team.

APPENDIX G

SCEPTIC SUMMARY NARRATIVE

Note: The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

The affirmative case has sought to demonstrate that Mr Z changed meaningfully during the MBT program and that the therapy was the main cause of this change. However, the sceptic argument and rebuttal have shown convincingly that Mr Z did not change substantially; any alterations that did occur were trivial or negative in nature. Furthermore, patient change could not be shown to be reliably related to the MBT program or the therapeutic process; competing evidence has greater explanatory power in this case.

The sceptic process has illustrated that Mr Z's changes were not substantial. All of the indicators remained in the clinical range following one year of treatment and the CORE-OM shows a reliable negative change, not only from pre-therapy to five months but also between five months and eight months (Table A1). Mr Z's cannabis use and Mentalizing Capacity (Table A2) did not change appreciably between five months and one year, and his GAF score got worse. Furthermore, Mr Z himself did not believe that he has changed (One Year Change Interview, p.154). Therefore, any changes experienced by the patient are trivial or negative and the sceptic position must be accepted.

Mr Z has been shown to have strong relational response tendencies and he has the problem of 'compulsive lying'. In addition, the interview style adopted led to an over-reporting of positive changes and an under-reporting of negative changes. Likewise, Mr Z both wanted

and expected to improve in therapy, as shown by his explicit assertions and his reliance on cultural schemas as opposed to idiosyncratic details to describe his experiences of therapy. These factors influenced the patient's progress on the MBT program and in this research.

Furthermore, Mr Z was resolved to change and engaged in self-correction processes; this consideration, coupled with the understanding he received from his father and the importance of the diagnosis provided to him by his generic psychiatrist prior to commencing the MBT program, led to any improvement noted. Similarly, Mr Z openly acknowledged the beneficial effects of participating in the research process, which confounds this investigation in its attempt to establish that the MBT program was the agent behind any change observed in the patient.

Therefore, the affirmative brief is unable to convincingly demonstrate that Mr Z changed substantially over the course of the treatment and that these changes were the result of the MBT program. This has been confirmed in certain excerpts of both the Therapist's and the Consultant Psychiatrist's Reports, as discussed in the sceptic rebuttal. Instead of changing substantially, Mr Z has been shown to fluctuate in terms of both the qualitative and quantitative indicators, a fact confirmed by the patient when he spoke of his 'ebbs and flows' (Six Month Change Interview, p.126); this variation is neglected by the biased and fallacious presentation of data in the affirmative argument.

Further to this, the sceptic rebuttal has demonstrated that the affirmative case cannot convincingly establish the key elements of the therapy efficacy hypothesis. The affirmative team has been unable to satisfactorily and reasonably show any two of the following factors: substantial change to Mr Z's stable problems; retrospective attribution; process-outcome mapping; within-therapy process-outcome mapping; or event-shift sequences.

Consequently, the suggestion that the patient changed substantially and that this change was a result of the MBT program must be rejected. Mr Z did not change substantially over the course of the treatment; any change was trivial or negative in nature. Moreover, where changes may have occurred they cannot be reliably linked to the therapeutic process. The sceptic position must be reasonably accepted.

References

Elliott, R. (2002) Hermeneutic single case efficacy design. *Psychotherapy Research*, 12, pp.1-20.

APPENDIX H

CHANGE INTERVIEW TRANSCRIPTS

(This section was removed to protect the participant identity – sections of the interview are found in Tables C3 – C12 and also throughout the analysis)

APPENDIX I
ADDITIONAL TABLES

Table F1 - Monthly PQ ratings for each item

Item	09.11.11 1	14.12.11 2	11.01.12 3	15.02.12 4	12.03.12 5	11.04.12 6	14.05.12 7	06.06.12 8	04.07.12 9	13.08.12 10	26.09.12 11
1. Not believing in myself	4	2	3	4	2	7	6	6	5	4	6
2. Not knowing when to stop	3	6	5	3	5	4	3	4	5	4	5
3. Depressive spirals	5	2	2	3	2	7	3	6	4	5	3
4. Disorganized thinking	5	6	5	5	7	6	6	6	5	5	4
5. Taking things too far in relationships	3	3	3	4	3	2	2	3	2	3	1
6. Self-loathing and negativity	3	2	3	5	4	6	5	5	4	5	5
7. Poor sleep	6	5	2	6	5	4	6	6	2	6	5
8. Dark disturbing thoughts	6	3	3	4	4	6	4	6	5	5	6
9. Not knowing how to manage myself in any relationship	3	5	2	5	2	3	6	4	3	3	3
10. Financial problem	3	5	5	7	7	7	7	7	6	7	2

TABLE F2 – PQ/MBT Adherence Spearman *r* Correlations

		Correlations							
		Framework of Treatment	Mentalization	Working With Current Mental Sates	Bridging the Gaps	Affect Storms	Use of Transference	Overall Adherence	PQ results
Framework of Treatment	Pearson Correlation	1	.491	.458	.601 [*]	.154	.015	.766 ^{**}	.722 [*]
	Sig. (2-tailed)		.105	.135	.039	.633	.964	.004	.043
	N	12	12	12	12	12	12	12	8
Mentalization	Pearson Correlation	.491	1	.582 [*]	.679 [*]	-.202	.228	.622 [*]	.488
	Sig. (2-tailed)	.105		.047	.015	.530	.476	.031	.220
	N	12	12	12	12	12	12	12	8
Working With Current Mental Sates	Pearson Correlation	.458	.582 [*]	1	.903 ^{**}	.111	-.161	.684 [*]	.254
	Sig. (2-tailed)	.135	.047		.000	.732	.617	.014	.544
	N	12	12	12	12	12	12	12	8
Bridging the Gaps	Pearson Correlation	.601 [*]	.679 [*]	.903 ^{**}	1	.133	-.003	.762 ^{**}	.310
	Sig. (2-tailed)	.039	.015	.000		.681	.993	.004	.455
	N	12	12	12	12	12	12	12	8
Affect Storms	Pearson Correlation	.154	-.202	.111	.133	1	.320	.440	.032
	Sig. (2-tailed)	.633	.530	.732	.681		.311	.152	.940
	N	12	12	12	12	12	12	12	8
Use of Transference	Pearson Correlation	.015	.228	-.161	-.003	.320	1	.368	.200
	Sig. (2-tailed)	.964	.476	.617	.993	.311		.239	.635

	N	12	12	12	12	12	12	12	8
Overall Adherence	Pearson Correlation	.766**	.622*	.684*	.762**	.440	.368	1	.607
	Sig. (2-tailed)	.004	.031	.014	.004	.152	.239		.111
	N	12	12	12	12	12	12	12	8
PQ results	Pearson Correlation	.722*	.488	.254	.310	.032	.200	.607	1
	Sig. (2-tailed)	.043	.220	.544	.455	.940	.635	.111	
	N	8	8	8	8	8	8	8	8

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Table F3 – CORE-GAF Spearman *r* correlations

		Correlations					
		W	P	F	R	CORE	GAF
W	Pearson Correlation	1	.953*	.996**	.974*	.988*	-.077
	Sig. (2-tailed)		.047	.004	.026	.012	.923
	N	4	4	4	4	4	4
P	Pearson Correlation	.953*	1	.975*	.955*	.989*	.177
	Sig. (2-tailed)	.047		.025	.045	.011	.823
	N	4	4	4	4	4	4
F	Pearson Correlation	.996**	.975*	1	.970*	.997**	.012
	Sig. (2-tailed)	.004	.025		.030	.003	.988
	N	4	4	4	4	4	4
R	Pearson Correlation	.974*	.955*	.970*	1	.975*	-.118

	Sig. (2-tailed)	.026	.045	.030		.025	.882
	N	4	4	4	4	4	4
	Pearson Correlation	.988 [*]	.989 [*]	.997 ^{**}	.975 [*]	1	.057
CORE	Sig. (2-tailed)	.012	.011	.003	.025		.943
	N	4	4	4	4	4	4
	Pearson Correlation	-.077	.177	.012	-.118	.057	1
GAF	Sig. (2-tailed)	.923	.823	.988	.882	.943	
	N	4	4	4	4	4	4

*. Correlation is significant at the 0.05 level (2-tailed).

** . Correlation is significant at the 0.01 level (2-tailed).

Table F4 - Mean Scores on the Personal Questionnaire

Session	Pre-therapy	1	2	3	4	5	6	7	8	9	10	11
Date	03/08/11	09/11/11	Ave 07.12.11 and 14/12/11	Ave 11/01/11 and 16.01.11	15/02/12	12/03/12	11.04.12	14.05.12	06.06.12	04.07.12	13.08.12	26.09.1 2
Mean PQ	6.9	4.1	3.9	3.3.	4.6	4.1	5.2	4.8	5.3	4.1	4.7	4.0

APPENDIX J
ADJUDICATION

HSCED Instructions for Judges
(Adapted Version, October 2012)*

JUDGE D

Completing the adjudication process

Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.)

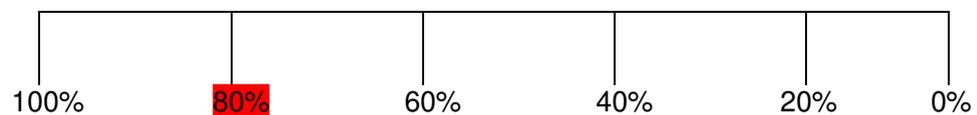
In answering the rest of the questions, please use whatever space you need in order to give a full response.

1a. To what extent do you think this patient *changed* over the course one-year of therapy?

No Slightly Moderately Considerably Substantially Completely

Change



1b. How certain are you?**1c. Please describe the basis for your judgement:**

By considering all of the information in the rich case record. There is evidence that the client did change, but this change did seemed to fluctuate. Clearly, these have been long-term problems and so I understood them to be considerable for the individual. The client reports learning to live with his problems in a different kind of way, which is why I did not choose 'completely'.

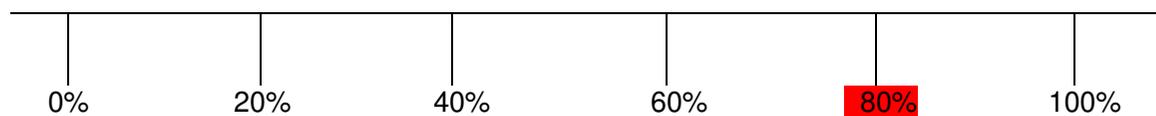
1d. How much did you weigh (take into consideration) the following case elements in evaluating *patient change* over the course of therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data						✓
b. Quantitative outcome data						✓
c. Change Interview transcript (including qualitative coding)				✓		
d. HAT data					✓	
e. Affirmative Case						✓
f. Sceptic Case						✓
g. Affirmative Rebuttal/Closing argument					✓	

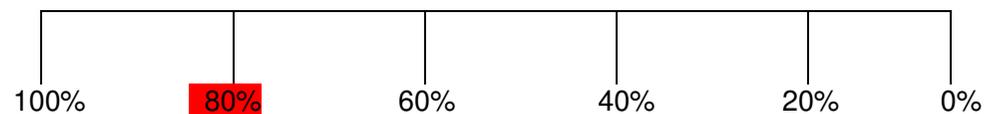
h. Sceptic Rebuttal/Closing argument					✓	
i. Other						

2a. To what extent do you think that the patient's changes were due to the therapy?

No Slightly Moderately Considerably Substantially Completely
Change



2b. How certain are you?



2c. Please describe the basis for your judgement:

There seem to be sufficient occasions when the client confirms this. The interviews seem to give the client the opportunity to say that therapy hasn't been helpful.

2d. How much did you weigh (take into consideration) the following case elements in evaluating the extent to which client change was due to therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data						✓
b. Quantitative outcome data						✓
c. Change Interview transcript (including qualitative coding)					✓	
d. HAT data						✓
e. Affirmative Case						✓
f. Sceptic Case						✓
g. Affirmative						✓

Rebuttal/Closing argument						
h. Sceptic Rebuttal/Closing argument						✓
i. Other						

3. Which therapy processes (mediator factors) do you feel were helpful to the client?

Sharing experiences with other people in the group.

Experiencing acceptance.

Experiencing self-disclosure.

Becoming more reflective.

Noticing when things were not as bad as he had imagined.

Feeling supported (cared for?) when 'a plan' was put together to help him reduce his cannabis intake.

4. Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled her to make best use of her therapy?

He seems able to 'hang on in there' despite the difficulties he experiences.

* adapted with permission from "unpublished research procedure, Counseling Unit, University of Strathclyde, Glasgow, UK"

HSCED Instructions for Judges
(Adapted Version, October 2012)*

JUDGE E

Completing the adjudication process

Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.)

In answering the rest of the questions, please use whatever space you need in order to give a full response.

1a. To what extent do you think this patient *changed* over the course one-year of therapy?

No Slightly Moderately **Considerably** Substantially Completely

Change



1b. How certain are you?**1c. Please describe the basis for your judgement:**

The PQ scores overall show a change from pre-therapy to one-year (at the $p < .05$ level of confidence). The change in WSAS scores also supports that there has been some change this over the same period of time. With regard to CORE scores, these indicate significant negative change ($p < .05$) from pre-therapy to 5 months, from 5 months to 8 months and from 8 months to one year, indicating a worsening of functioning between each interval. However, this still indicates change of some kind. These quantitative scores indicate the client has changed between pre-therapy and one year.

The qualitative data which supports that the client has changed is evidenced by the client's reporting of a reduction in the amount of spliffs he smokes indicating he relies less on substances. However, there is the argument that he needs less cannabis because his anti-depressant medication may be, in some sense, taking the place of cannabis. Nevertheless the client displays a change in behaviour (or at least reports to have). In addition, the client himself clearly reports positive change in all of his ten reported problems [2.9 (mean); 4 and 2

(mode); 3.5 (median)]. The consultant psychiatrist, during the three monthly reviews, also suggests that the patient has changed. More evidence which indicates the patient has changed is in the 6 month change interview (p.111 - 112) where the patient indicates that he is still the same as far as his 'sick brain' and 'emotional roller coaster' is concerned but he has more understanding of himself. Having a greater understanding of self is arguably a change.

J: So that's a little bit how you're feeling? Emotional rollercoaster?

P: I feel like that all the time

J: All the time?

P: Yeah

J: Mm

P: And it does sort of it does help when you know that it is just um you know a sick brain and that you will get over it and that other people are at different stages of that sort of rollercoaster and you see that. You see yourself in them.

J: OK. So are you telling me that it's a little worse than it was when you started?

P: No

J: It's the same?

P: It's the same. But I've got more understanding of what's going on

J: OK

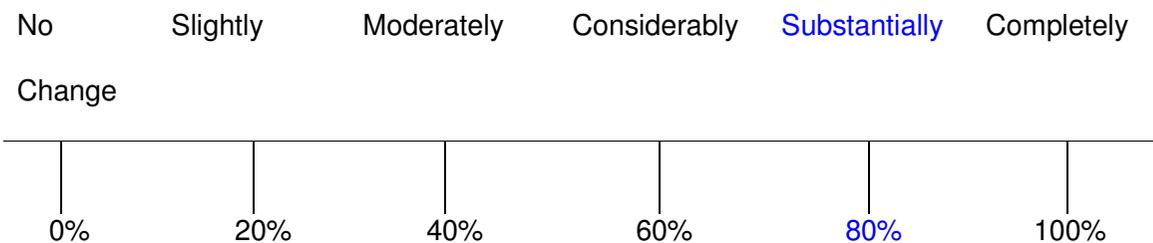
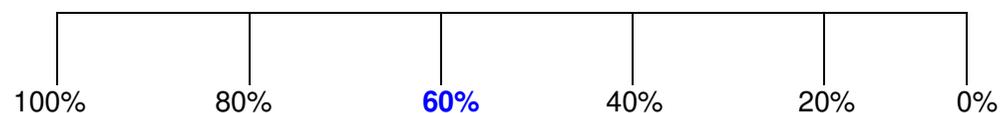
P: And I think that helps

The reason I am 60% certain is that there appears to be considerable evidence (as mentioned above) of change. The remaining 40% doubt is due to the fact that CORE scores showed significant negative change between all 4 points of assessment. In addition there negative changes in WSAS scores from five months to one year. However, these figures are unlikely to be significant and it suggests a positive change from pre-therapy to five months. The PQ also shows a negative change between five months and eight months of therapy. This quantitative data would suggest that many of the changes are trivial. However, the above excerpt from the 6-month transcript might suggest the patient's understanding of himself has changed considerably but that his symptoms have not. This might explain the inconsistencies indicated by outcome measures.

1d. How much did you weigh (take into consideration) the following case elements in evaluating *patient change* over the course of therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data				x		
b. Quantitative outcome data					x	
c. Change Interview transcript					x	

(including qualitative coding)						
d. HAT data					x	
e. Affirmative Case					x	
f. Sceptic Case					x	
g. Affirmative Rebuttal/Closing argument				x		
h. Sceptic Rebuttal/Closing argument				x		
i. Other						

2a. To what extent do you think that the patient's changes were due to the therapy?**2b. How certain are you?****2c. Please describe the basis for your judgement:**

Firstly, the patient himself reports during his change interviews, at 6 months and one-year into therapy, that seven out of the nine changes were considered to be 'very unlikely without therapy'. Secondly, in the 6-month change interview, the client attributes the changes to the 'whole' therapy program (p.116). Here, he says that the change is due to it being '99%' down to the group therapy. The reason I think the

changes are 60% due to the group are to do with the client's medication; the client's medication may have contributed a little to the client's changes. In addition the client also spoke of his dad and said that this helped albeit a small amount.

I feel I can only 60% certain that the client's changes were 80% due to therapy because the client may have underestimated or misperceived the contribution of his medication and the contribution of his father and other family members.

2d. How much did you weigh (take into consideration) the following case elements in evaluating the extent to which client change was due to therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data				x		
b. Quantitative outcome data					x	
c. Change Interview transcript (including qualitative coding)					x	
d. HAT data				x		
e. Affirmative Case				x		
f. Sceptic Case				x		
g. Affirmative			x			

Rebuttal/Closing argument						
h. Sceptic Rebuttal/Closing argument			x			
i. Other						

3. Which therapy processes (mediator factors) do you feel were helpful to the client?

Being aware of others' similar experience.

Non-judgemental aspects of therapy

Reflective stance of the therapy

Difficult interactions in group provide helpful learning

4. Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled him to make best use of his therapy?

Client's own self awareness

Awareness of his anger

Awareness of his passive aggression

Keeping a lid on his anger may have helped

Being more open in the group.

* adapted with permission from “unpublished research procedure, Counseling Unit, University of Strathclyde, Glasgow, UK”

HSCED Instructions for Judges
(Adapted Version, October 2012)*

JUDGE F

Completing the adjudication process

Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.)

In answering the rest of the questions, please use whatever space you need in order to give a full response.

1a. To what extent do you think this patient *changed* after one-year of therapy?

No Slightly Moderately Considerably Substantially Completely

Change



1b. How certain are you?**1c. Please describe the basis for your judgement:**

The arguments on which I base myself are: 1) the nature of the disturbance of the patient, 2) the results of the outcome measures, 3)

Qualitative data.

1. Nature of the patient's disorder

1.1. The patient has a serious or chronic medical condition, with a personality disorder and co-morbidity. The prognosis is very reserved and it is expected that clinical recovery is gradual and slow.

2. Outcome

2.1. Four psychological outcome measures are applied (CORE-OM, WSAS, GAF and PQ), and a measure of mixed substance use and well-being (TOP). In TOP only the items related to substance use are analysed.

2.2. In the pre-treatment, all outcome measures place the patient in the "dysfunctional range", which would be expected, given the nature of the disturbance.

2.3. There is one exception: the CORE-OM gets an average score at pre-therapy stating that the patient lies in the functional range. This result is doubtful, since both the clinical history, clinical evaluation of the professionals who conducted the screening and the results of other outcome measures, point to clinical dysfunction. We can not know the reasons why these results were obtained. On the one hand, the patient may not have answered the questions honestly. On the other hand, there may have been an error in the collection or analysis of data. Regardless of the reasons, the results of the pre-treatment CORE-OM are not reliable. Therefore, this measure should not be used to measure change pre-post treatment.

2.4. In all outcome measures, the scores to 5, 8 to 12 months continue to be in the dysfunctional range, which would be expected given the nature of the clinical case.

2.5. The comparison with the pre-tx outcome scores during treatment, indicate that in the first five months there was clinically significant improvement and that these gains were maintained at 8 and 12 months.

2.6. The PQ seems to be more sensitive to change than the WSAS: While the change in PQ is clinically significant at $p < .05$, in WSAS the change is clinically reliable at $p < .2$. The reasons for this difference are not clear. On the one hand, It can be due to reactive effects, because the PQ was administered by the therapist, which could cause the patient to report more positive results. On the other hand, it can be due to the fact that the PQ is an individualized measure, wherein the content of the items are patient-generated. Although this is a new area of research, there is evidence that PGM are more sensitive to change than standardized measures (Ashworth et al., 2007). Still, the

convergence of these two measures, which point to consistent and stable improvement at the end of 12 months, suggests that there was a small change but reliable.

2.7. The fact that this change is also small within the dysfunctional range, can explain the results of GAF and the TOP over 1 year of treatment, which remain at the pre-treatment level.

3. Qualitative data

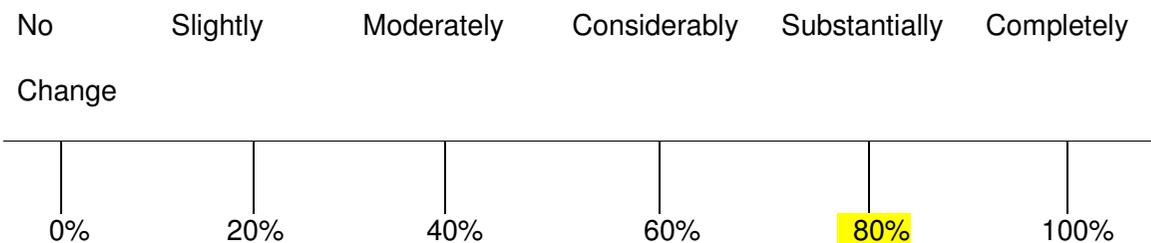
3.1. During the Change Interview, the patient says he feels in the process of change but has not changed (“I think I think the best way of describing it is changing (...) is in the process of ... I do not think anything has changed at the moment but (...) I think things are in the process of sort of coming together”, CI, 6 months). These qualitative data of retrospective change confirm the pattern found in measures of outcome: small improvement without recovery.

During the Change Interview, along with the identification of several changes the patient also points criticisms and complaints (for example, “I'm an empty shell, I'm fat I'm balding and feeling of everything I'm just a waste of space at the moment (...) I just feel as though I'm a burden to everyone”). In these circumstances, is to trust the changes described.

1d. How much did you weigh (take into consideration) the following case elements in evaluating *patient change* over the course of therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data						5
b. Quantitative outcome data						5
c. Change Interview transcript (including qualitative coding)						5
d. HAT data			2			
e. Affirmative Case			2			
f. Sceptic Case			2			
g. Affirmative Rebuttal/Closing argument			2			

h. Sceptic Rebuttal/Closing argument			2			
i. Other			2			

2a. To what extent do you think that the patient's changes were due to the therapy?**2b. How certain are you?****2c. Please describe the basis for your judgement:**

The main arguments in favour of the positive effect of therapy are the changes in chronic and stable problems immediately after the start of the program.

The retrospective attribution of the changes to the treatment program, performed during the two interviews of change, is a second strong argument. In these interviews, the patient presents open criticisms and points to changes in him that were not achieved. In parallel, he indicates clear changes and establishes a clear link between these changes and the therapeutic program. I consider this retrospective attribution reliable. In general, the Affirmative Brief and the Affirmative Rebuttal of the Sceptic Brief present solid arguments justifying the causal attribution of change to the treatment.

I believe that the effect of treatment explains 80% of the changes achieved. I Assign the remaining 20% to extra-therapeutic factors: The fact that the patient can count on the support of his father and his friends. As I indicate in the next section, (when I refer to mediators of the change process) I consider that the therapeutic program continually helps the patient to maintain hope about change, helps him to become aware of his inner workings, to experiment with new forms of verbal interaction (expression of feelings and points of view) and contributes to greater confidence in his newfound ability to self-control when communicating with others. However, these changes are enhanced and consolidated by its application in relation to his father and friends. In turn, the relational improvement attributed to its own change, enhances the hope and treatment effects. There seems to be an interaction between these factors and extra-therapeutic factors.

2d. How much did you weigh (take into consideration) the following case elements in evaluating the extent to which client change was due to therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data						5
b. Quantitative outcome data						5
c. Change Interview transcript (including qualitative coding)						5
d. HAT data						5
e. Affirmative Case						5
f. Sceptic Case						5
g. Affirmative						5

Rebuttal/Closing argument						
h. Sceptic Rebuttal/Closing argument						5
i. Other						

3. Which therapy processes (mediator factors) do you feel were helpful to the client?

I believe there are several mediating variables that are involved in therapeutic change.

First, there are variables that the patient realizes for himself which are reported by him through the HAT's and Change Interviews:

- Hope that he can improve his clinical condition
- Identification with situations experienced by group members, which were reported in therapy. They help him to realize his functioning; also serve to give him hope that he will be able to change
- Experience of relational and communication processes in the group, which are then translated into extra-therapy relationships: Being able to think before acting; being able to explain its reasoning when disagreeing with others. These same processes are then transposed in its communication with his father. The repetition of these new standards, successfully reinforces positive behavior and leads the patient to believe that he can relate to others more adequately. It consolidates itself in this way, the feeling of self-control and hope
- Increased insight, critical capacity
- Therapeutic alliance with the group therapist
- Existence of a satisfactory therapeutic contract and therapeutic alliance with the nurse, the preparation plan "as" to reduce the consumption of marijuana, the existence of a personal space to help treat specific aspects of his recovery not yet achieved, again giving him hope and a sense of control in his life.

The fact that he criticized the services during the Change Interview, pointing out some events that displeased him, lend credibility to the mediating variables identified by the patient.

On the other hand, increasing the capacity of mentalization during the process can indicate the involvement of this variable on the process of change. However, any conclusion about the mediating effect of mentalization requires the contrast to cases where a relationship is established between this and the outcome variable, or other mediating variables in the process (eg insight).

4. Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled her to make best use of her therapy?

- Motivation for treatment
- Ability to insight
- Presence and continuous availability of the father
- Quality of the relationship with the father
- Continued support of friends

* adapted with permission from “unpublished research procedure, Counseling Unit, University of Strathclyde, Glasgow, UK”

REFERENCE USED IN THE ARGUMENT:

Ashworth M, Robinson S, Evans C, Shepherd M, Conolly A, Rowlands G. What does an idiographic measure (PSYCHLOPS) tell us about the spectrum of psychological issues and scores on a nomothetic measure (CORE-OM)? *Primary Care and Community Psychiatry*, 2007;12:7-16.

APPENDIX G
Full Analysis of Mr X

‘What Works in Mentalization Based Treatment: systematic case studies in personality disorder and addiction’

Hermeneutic Single Case Efficacy Design for the case of ‘Mr X’

Sub-Appendices

Appendix A: Rich Case Record

Appendix B: Affirmative Brief

Appendix C: Sceptic Brief

Appendix D: Affirmative Rebuttal of the Sceptic Brief

Appendix E: Sceptic Rebuttal of the Affirmative Brief

Appendix F: Affirmative Brief Summary

Appendix G: Sceptic Brief Summary

Appendix H: Interview Transcripts

Appendix I: Additional Tables

Appendix J: Adjudication

APPENDIX A
RICH CASE RECORD

The Patient

Mr X was referred by IAPT in May 2011 and he was 33 years old at the time of referral. He suffered from anxiety, panic attacks, mood swings and depression. He has been feeling low for 20 years and has relied on alcohol for most of this period, with evidence of physical dependence and withdrawal symptoms. He managed to stop drinking 6 months prior to his referral to the psychotherapy/complex needs department and, when the MBT program started, he was alcohol free for 10 months. He has been smoking cannabis since his teens, then stopped between the ages of 24 – 28 and has been smoking daily for the last four years, 10-15 joints per day, buying 19 grams every week. He described issues from his childhood that were still affecting him. He can be very tearful and sometimes is taken over by his accumulated anger; he mainly hits out at the wall. He talked about putting up a false front and that he has always hidden his feelings of humiliation. He said that when his anxiety hits him hard he just has to go home, regardless of where he is.

He took an overdose at 14 as he felt hopeless at school but again it was not taken seriously. He mentioned that he had suicidal thoughts on a daily basis.

Mr X had a son when he was 16; he has brought him up on his own with difficulty. At the time of referral his son was having trouble in school, with the police and had recently been released from prison for stealing. It appears that this period in prison has changed his son and since then he has engaged in college.

Mr X had terrible debts and had recently heard that he has been made redundant following 14 weeks off work. He feels he has fallen down a hole. He complained about difficulties in relationships and his inability to trust others.

He spoke about his mother leaving him when he was 16, just at the time his son was born. There is a real sense of abandonment overall and, despite not remembering anything specifically happening to him when he was younger, he felt misunderstood in his pain and anxiety which he accumulated over the years.

The MBT program started on the 9th of October 2011; in the beginning sessions he agreed to focus on issues from his childhood and how these have negatively impacted on his life. He reacts badly to issues of rejection, isolation and anger. He wants to understand his aggression, paranoia, over analysing and his difficulties with relationships.

Psychopharmacological Medication Record (April 2012 – 6 months into MBT program)

<u>Medication Name</u>	<u>For What Symptoms</u>	<u>Dose / Frequency</u>	<u>How Long / Since When</u>	<u>Last Adjustment</u>
Acamprosate	alcohol anti-craving	333mg	Unknown	Reduction from 666 mg on April 2011
Paroxetine	Depression	40 mg	1 Year	From 30mg to 40mg (Unknown date, prior to Dec 2011)
Risperidone	Anti-psychotic ('to help me give up smoking	2 mg	Started in Dec 2011 with 0.5 mg and then adjusted	March 2012 – up to 2 mg

	weed')		to 1mg in Jan 2012	
Zopiclone	Sleep deprivation	7.5 mg on prn basis at night	Start date unknown but over 6 months ago	Date unknown

Mr X decided to stop all medication apart from Paroxetine on June 2012 and went back to smoking cannabis daily. During the 1 Year change interview he stated that he was now ready to stop the cannabis and go back to the medication.

Psychopharmacological Medication Record (September 2012 – 12 months into MBT program)

<u>Medication Name</u>	<u>For What Symptoms</u>	<u>Dose/Frequency</u>	<u>How Long / Since When</u>	<u>Last Adjustment</u>
Paroxetine	Depression	40 mg once daily	18 months	Date unknown
Aripiprazole	Anti-psychotic	10 mg once daily	Started on 23 rd May 2012	23 rd May 2012 (to replace Risperidone)
Zopiclone	Sleep Deprivation	7.5 mg on prn basis at night	Start date unknown but longer than 1 year ago	Date unknown but over a year ago

NOTE. Mr X decided to stop all the above medication (apart from Paroxetine) in June 2012 and went back to smoke cannabis.

Pre-Therapy

- Initial consultation with MBT therapist in May 2011; name was put to complex needs service
- 3 appointments with MBT Consultant for the application of the SCID-II and other questionnaires
- Second consultation with MBT therapist in August 2011
- Consultation with MBT therapist in September 2011 and with Principal Investigator for consent form

Results of SCID-II and DSM-IV-TR Diagnostic Hypothesis**DSM-IV-TR Axis II / SCID-II Results**

Mr X met the diagnostic criteria for several simultaneous personality disorder types: borderline, depressive, paranoid and antisocial. He also demonstrated traits of several other disorders but not enough for a diagnosis.

Diagnosis:

- Borderline Personality Disorder (main focus of clinical attention); Depressive Personality Disorder; Paranoid Personality Disorder; Antisocial Personality Disorder.

Traits:

- Avoidant; Passive-Aggressive; Schizotypal; Narcissistic; Histrionic

Substance Abuse Disorder

Mr X met the DSM-IV-TR diagnostic criteria for Cannabis dependency and abuse; during a brief period (February to May 2012) he also met the DSM-IV-TR criteria for cocaine and ecstasy abuse.

In addition, Mr X met the criteria for Moderate Alcohol Dependence, with some evidence of withdrawal symptoms. This disorder was in total remission (maintained).

DSM-IV-TR Multi-axial Diagnosis (at pre-therapy)

Axis I	304.30	Cannabis Dependence
	305.60	Cocaine and Ecstasy Abuse
	303.90	Moderate Alcohol Dependency, with some evidence of withdrawal symptoms - In total remission (maintained).
Axis II	301.83	Borderline Personality Disorder (main focus of clinical attention)
	301.9	Depressive Personality Disorder
	301.0	Paranoid Personality Disorder
	301.7	Antisocial Personality Disorder
Axis III		None
Axis IV		Inadequate finances; Difficulties disciplining his son
Axis V	GAF = 45 (current)	

Outcome Data

The research protocol called for patients to complete a battery of quantitative outcome measures at assessment, during each three-monthly review with the consultant and at the end of therapy. This battery comprised the Work and Social Adjustment Scale (WSAS), CORE-OM, Checklist of Mentalizing Capacity, Global Assessment of Functioning (GAF) Scale, Treatment Outcome Profile for Substance Misuse (TOP), Working Alliance Inventory (WAI-S), and a Risk Assessment Tool. During assessment the SCID-II for DSM-IV-TR Axis II was used; The Simplified Personal Questionnaire (PQ) (Wagner and Elliott, 2001) was constructed with the patient during the assessment phase. The PQ was then used monthly as a measure of Mr X's complaints. These measures were used to provide a quantitative account of Mr X's change process over the course of therapy.

Three of these instruments (PQ; CORE-OM and WSAS) were evaluated using clinical significance methods for determining whether Mr X shows clinically significant change between pre and post-therapy assessments (Jacobson and Truax, 1991). The other measures (WAI-S; TOP; Mentalizing Capacity and GAF) were used to provide additional information only but no clinical significance methods were used.

Cut-off values represent the point beyond which the client can be considered to be in the clinical range on each outcome measure. Scores that fall within the clinical range are highlighted in bold.

TABLE A1 – Mr X Outcome Data (analysed with clinical significance methods)

Instruments	Cut-off	RCI Min (p<.2)	RCI Min (p<.05)	Pre-therapy	5 Months	8 Months	1 Year
Personal Questionnaire	≥3	1.0 (↓)	1.5 (↓)	6.8	5.4 * (+)	3.8 ** (+)	3.9 ** (+)
CORE-OM	≥1.25	0.43 (↓)	0.66 (↓)	2.45	2.18 (=)	2.39 (=)	1.62 ** (+)
WSAS	≥10	7.2 (↓)	10.9 (↓)	28	18 * (+)	28 (=)	20 * (+)

Notes. Pre-therapy measures were taken 1 month before the start of MBT. Values in bold fall within the clinical range; *p<.2; **p<.05; ↓= decreased score indicates positive change; (+) = reliable positive change in relation to first available score; (=) = no change in relation to first available score; (-) = reliable negative change in relation to first available score.

TABLE A2 – Mr X Outcome Data (additional measures)

Instruments	Pre-therapy	5 Months	8 Months	1 Year
Working Alliance Inventory (WAI-S)	N/A	52	56	63

TOP	10-15 spliffs cannabis per day (19g per week)	2g cocaine 1x or 2x per week	Ecstasy once Cannabis once	10-15 spliffs cannabis per day (19g per week)
Mentalizing Capacity	0 (poor)	3 (moderate)	4(moderate)	5 (moderate)
GAF	45 (serious symptoms)	41 (serious symptoms)	51 (moderate symptoms)	50 (serious symptoms)

Notes. WAI-S scores range from 12 (very weak working alliance) to 84 (very strong working alliance); TOP amounts are the average of a 28 day period; Mentalizing Capacity ranges from 0 (poor) to 12 (very high); GAF scores range from 0 (persistent and very severe impairment) to 100 (superior functioning); N/A = Non Applicable.

Personal Questionnaire Data

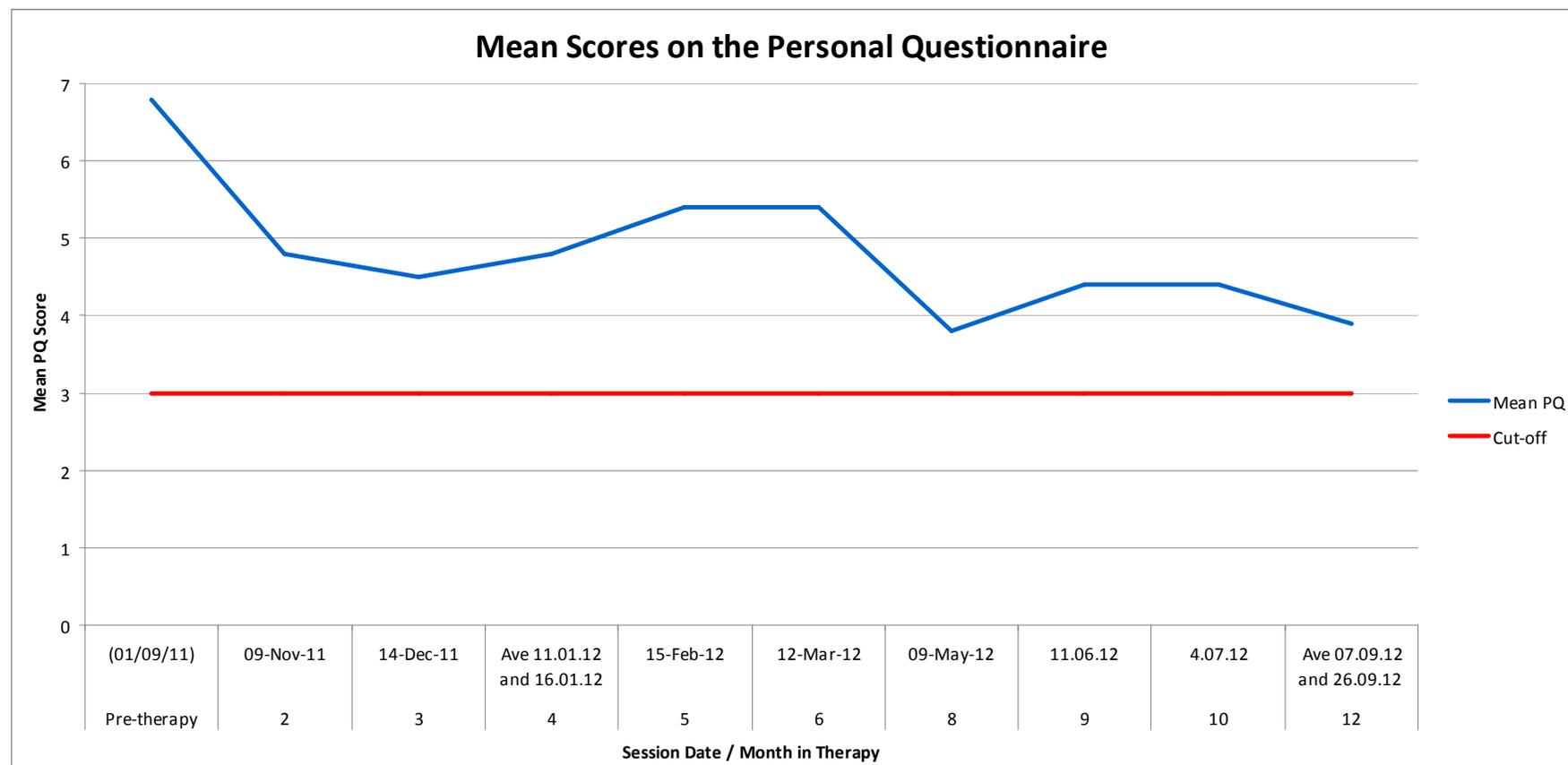
A simplified Personal Questionnaire (Wagner and Elliott, 2001) was used during screening to identify the key difficulties that each patient wished to address in therapy and to provide a rating of the extent to which they remained troubled by each difficulty as therapy progressed. The patients were also asked to state the duration of each item across their lifetime. Once a month the patients were asked to rate each item on the extent to which it had troubled them over the last week. Items were rated on a 7-point scale, from 1 (not at all) to 7 (maximum possible). Table A3 indicates the duration of each item across Mr X's lifetime, and summarises item ratings at pre-therapy, 6 months and one-year into therapy. Figure A1 illustrates Mr X's mean PQ scores across therapy

TABLE A3 – Mr X PQ Ratings and Duration

Item	Duration of the Problem	Pre-therapy (Sep 2011)	6 Months (March 12)	One-Year (Average 07.09.12 and 26.09.12)
1. Angry and aggressive	more than 10 years	7	7	4.5
2. Paranoid and worry all the time	more than 10 years	7	6	4.5
3. Over analysing and complicating	more than 10 years	7	6	4.5
5. I have no support	more than 10 years	6	5	3
6. Not managing relationships	more than 10 years	7	4	3.5
7. Violent, erratic, mood swings	more than 10 years	7	7	5
8. Having a life	more than 10 years	6	7	4
9. Impulsive (testing)	more than 10 years	7	1	3
10. Always frustrated	More than 10 years	7	6	2.5

Notes. Instructions: Please rate each of the following problems according to how much it has bothered you during the past seven days, including today. Anchors: Maximum possible (7), very considerably (6), considerably (5), moderately (4), little (3), very little (2), not at all (1).

FIGURE A1 – Mr X's Mean PQ Scores Across Therapy



Qualitative Data

Client's View of Helpful Aspects of Therapy

The Helpful Aspects of Therapy (HAT) measure (Llewelyn, 1988) was completed by each patient once a month in order to document the aspects of therapy that were especially meaningful to their therapeutic process. The HAT was completed together with the PQ and referring to the same session. Patients were asked to note the most helpful aspect or aspects of that session and to apply a helpfulness rating to that aspect on a 9-point scale from 9 (extremely helpful) to 1 (extremely hindering).

TABLE B1 – Mr X's view of Helpful Aspects of Therapy

Month	Helpful Aspect / What made it helpful	Helpfulness Rating (min 1 – max 9)
09 th November 2011	I came in the group feeling like my best friend had crossed the line with owing me money / When I discussed it with the group and they shared their opinions with me I realized that I hadn't listened to my friend properly and overreacted	8
14 th December 2011	I take a lot out of the group but can't think of just anything this time	
11 th January 2012	On Monday I was saying now that I've given up smoking weed I was gonna give up fags and [Group Member A] said why do it all over night and she was right	
16 th January 2012	I was going to give up fags but had already given up weed and the group said to me why would I want to put that much pressure on myself / They made me realize that I would possibly relapse and when I went home I know they were right as I wasn't thinking straight	9
16 th January 2012	[therapist] had a chat about my concerns and that the support is there	8
12 th March 2012	(rated a helpful event with 8 but left the form blank)	8
09 th May 2012	The fact that the group understand I'm in a bad place doing ecstasy and ended up smoking a joint and how it's affected me / the fact they do things and use them as crutches	8
11 th June 2012	Nothing / Nothing	2
07 September 2012	Being truthful all the time / because it will help me get better	9
26 September 2012	Talking to [therapist] as I really aint feeling well but come in as I always worry that [therapist] would think I was lying and think I was working or couldn't be bothered to attend group therapy / it was helpful and important as [therapist] reassured me that she knows I'm not lying and she believed me	9
26 September 2012	I told [therapist] I know now I need to start reducing my weed ready for me to quit	8

Note. 9 = extremely helpful, 8 = greatly helpful, 7 = moderately helpful

The Helpful Aspects of therapy form also asked the patients to note any aspect of the session which they experienced as hindering or unhelpful. They were asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering. Mr X only recorded one hindering aspect during the first year of MBT.

TABLE B2 – Mr X's view of Hindering Aspects of Therapy Sessions

Month	Hindering Aspect	How Hindering
11 June 2012	Just don't know who to trust up there and haven't felt so low about it as do now	2

Note. Mr X was asked to apply a hindrance rating to each noted aspect on a 4-point scale, where 4 = slightly hindering and 1 = extremely hindering.

Change Interview Data

Each patient engaged in two Change Interviews (Elliott, Slatick and Urman, 2001); one six months into therapy (following the 40th session) and one after one year. This process involved asking the patients to reflect on the therapeutic process and to note the specific changes experienced in themselves over the course of therapy. At each Change Interview they were asked to identify key changes that had taken place, and to make attributions regarding these changes (see Tables C1 and C2). The 6 month interview was not transcribed and it is not included in the data record apart from the table below; it is also worth noting that the 6 month interview had to be done twice because Mr X was very frustrated and verbally abusive in the first attempt stating that this was 'all a waste of time'.

TABLE C1 – Summary of Mr X's Changes – At 6 Months

Positive Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. Stopped impulsive texts	Somewhat surprised by it	Very unlikely	Extremely important
2. Calmed down (since stopping the weed)	Very much expected it	Very unlikely	Extremely important
3. I can listen more in the group and outside	Very much expected it	Very unlikely	Extremely important
4. I have more money (since stopping the weed)	Very much expected it	Very unlikely	Extremely important

Notes:

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

Negative Change	How expected/surprising the change was*	How unlikely/likely change would Have been without therapy**	The importance of the change***
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1. More lethargic than at the beginning	Somewhat expected it	Neither likely nor unlikely	Not at all important
2. Impulsiveness for other drugs	Very much surprised by it	Very unlikely	Not at all important

Notes:

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

TABLE C2 – Summary of Mr X's Changes – At 1 Year

Change	How expected/surprising the change was*	How unlikely/likely change would have been without therapy**	The importance of the change***
1. Back at work (part-time)	Somewhat surprising	somewhat unlikely	very important
2. Texting got a lot better	very much expected	somewhat unlikely	very important
3. Thinking differently, more positive thinking	somewhat expected	somewhat unlikely	very important
4. Greater awareness of what's is happening to me	very much expected	very unlikely	extremely important
5. Less angry and aggressive	somewhat expected	somewhat unlikely	extremely important
6. Not paranoid and worried all the time	somewhat surprising	somewhat unlikely	extremely important
7. Not always frustrated	very much surprising	very much unlikely	extremely important

* The rating is on a scale from 1 to 5; 1 = very much expected, 3 = neither, 5 = very surprising

** The rating is on a scale from 1 to 5; 1 = very unlikely, 3 = neither, 5 = very likely

*** The rating is on a scale from 1 to 5; 1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely

Summary of Key Descriptions in Change Interview at 1-Year

The following tables provide a summary of the key descriptions that Mr X offered during his change interview at 1-Year.

TABLE C3 – Helpful Therapy Processes

Taking on board what is said and ‘digesting’ it

Yeah it definitely helps. I don't care what anyone else says. I think with our problems you've either got to carry on burring your head in the sand and like not take on what's been said to you or you got to take it all on board... (R: Mmm) ...and whether you got to go home and digest it and think about it and think about what's been said

Therapy helped building a ‘helicopter view’ of himself and developing a more integrated perspective of good and bad self/object parts

I have my ups and downs like everyone else, but I've started to learn to cope with it a lot more than I was before

Therapy has stimulated mentalizing

(R: Right, just curious to know if you, if you've always think like the way you're thinking now or if you're just realising...) Starting to realise it more now

(R: Right, okay) Like what thing, like what drugs is doing to me and like (R: How it affects other people?) Yeah and, and yeah, and how I portray myself and come across to other people.

It's, it's helping me in as far as because when I come in with certain problems then we all chat about it and people will give out their opinions and obviously when you take on other people's opinions it could just be something simple like, 'but maybe they didn't mean it like that and they meant it like this', and then once you hear that and you sit back and you take it and you like digesting it. You actually think well, yeah maybe they were right and I have actually totally like, flipped it over this but maybe they did mean it like that. So then I'd go away and talk to the person and they'd go 'yeah that is what I did mean. I didn't mean it as inoffensive'. Like I did mean, you know, so in that respect opinions of other people that are in your mindset definitely helps you

(...) my thinking's definitely started to change since I've been in group therapy

Therapy paved the way to the 'depressive position' (Klein, 1948) where the locus of control is not just external but also internal

(...) you know, there's fifty percent work that still needs to be done but fifty percent of me is starting to feel and see the other side, do you know what I mean, like I'm starting to realise that there's certain things I've got to do for myself as well as the group therapy to get better

(referring to the possibility of stopping the cannabis abuse): (...) I feel that I can do it and I know that it'll be for the best of my interest whereas before I think I done it thinking that it was gonna be a... (pause) hundred percent cure (R: Right) Um, you know, I'll come of the cannabis oh I'm going to be a better and it's not going to be as easy as that. Um... (Coughs) it's still going to be a lot of work that I've got

to put in um, but I know that.

Therapy facilitated insight and helped to understand his problems which then opened the possibility of change

(R: what do you think has caused all this changes? What would you say is the cause for this?) Just finding out what your problem is, what the problems all about and understanding it (R: And was this through therapy?) Yeah coz I never knew what I had. I didn't know what was going on um, and now I know what like I'm dealing with you know. And, you know, that's important really coz then you can start making changes. Um, to support it and help yourself. Where if I hadn't come to group therapy I would never have known. I would have just been left in the wilderness you know like, just thinking this must be normal like you know. Um...

(...) at the time your brain just goes totally blank and you, it's only when you maybe sitting at home three days later (R: That something comes up) That you think 'oh god you know that was quite f*** helpful' (R: Oh right) Or a situation might occur where someone else has had (R: Right) And, and you think 'oh f*** hell yeah'

The structure of treatment and the 'system' increases his motivation to change

The system's helping me, gets me out of the house so its gives you motivation

Mr X trusts the team and their knowledge

Everyone's polite you know and they all know what they are talking about

Seeing the consultant who sets up goals in treatment

(...) they know like, trying to help you set out goals to achieve and you know. But... (R: ...that is an important aspect that people set up goals?) Yeah (...) obviously I'm not saying everyone goes away and does it because we are real, but I think everyone definitely takes on board what's being said even if they don't act on it straight away. Its food for thought. Um, and yeah you know and it all helps, do you know what I mean. Everything that you're getting told does help you know, you take it on board and listen to it. Go away, digest it and think yeah actually what they're saying makes sense

Being listened to and believed in a one-to-one with MBT therapist

When I had a one to one with [therapist] um, few weeks ago when I weren't well and I popped up just to say look I'm really ill and I had a big thing of like, um, I just felt like [therapist] didn't believe me you know like, she thought I was just having the time off couldn't be bothered to come (R: Ah yeah) Um, and she convinced me that I shouldn't be thinking like that and that she knows that I'm not well, otherwise I would turn up to group and that made me feel really positive when I left that I didn't have that worry of thinking I'm really ill at home and I've got people thinking that I'm just taking the mick like, not coming in.

The feedback from other group members about himself

(...) that helped me a lot and another thing a few weeks ago [Group Member B] said in the group that she thinks that since I've been smok... back smoking the cannabis it's made me revert back to the person I was at the start of the group (R: Yeah) And obviously I've

digested that and took that on board (R: Yeah) And that's made me realise I need to give it up

I take a lot in here (...) from what people say

TABLE C4: Helpful factors in Mr X's Life Situation

Mr X is back at work

Um, I've been working (R: You've been working?) Yeah (...) I'm doing, doing building work as well up in London (R: Right) Um, and I've been doing ok (...)

Others (e.g. family) are pleased with him

(...) everyone is really pleased with me and what I'm doing

(...) Yeah like my family coz obviously I've gone back to work you know, and they can see that there's changes in me for the better, do you know what I mean, um... (R: What did they tell you? Anything that they tell you that you can...) No just that they are pleased that I'm working and you know, and that everyone that I've worked for has been really pleased with what I've done you know. That I'm a hard worker and things like that you know, like they're the positives that peoples have said you know

People at work understand his problem and are helping

These people that I work for and that understand my problem and they relate to me that I need the help and that rather than just being like 'oh f*** hell what do you mean you gotta have Monday and Wednesday off' and stuff you know, so it's not a full time job.

TABLE C5: Mr X's personal attributes/resources that may have helped him use therapy

Motivation to work hard and to contribute

what you put in is what you get out (...) If you're putting a lot in then it makes you feel better when you leave and it makes you feel better in yourself, you know, that you've... that you have participated properly in the group, you know and that you've put valuable points across and you took valuable points in.

TABLE C6: Difficult but potentially beneficial processes (in and out of therapy)

Discussing painful issues in the group and hearing the opinion of others has helped change his perspective

Yeah, when, when I spoke about my mate [name said] who is my best mate and I told the group that I love her and, you know, that I'd love to be with her and that but its never gonna happen you know, and that was painful (R: Yeah) And listened to everything they all had to say you know and I took all bits a pieces out of it and sorted myself out you know, through being able to discuss it and take in their different opinions on, on you know, obsession and not being obsessed and you know, so and so forth. It's worked itself out for me, do you know what I mean?

(R: So you came here to the group and you shared?) Yeah (...) (...) (R: And how did it change your relationship with your friend?) Well it didn't it just made it better. It just made me, made me see things from different points of view you know, rather than just being gun ho. You know an all or nothing it made me realise that well, maybe just coz we ain't gonna go out we'll still be the best of friends and that's not changed anything from where we were at the time, so you know. Um, yeah it, it helped

TABLE C7: Helpful aspects of taking part in the research

Realizing that the research is an attempt of understanding his progress and that it helps him avoid the habitual pattern of running away

But I know that you have three different views to do the your job properly coz if it only went by [therapist], [consultant] wouldn't know if she is doing the right for us or wrong for us. You wouldn't know but you got three different perspectives, so when you put it all together to collect your information you can see that you know, 'oh look there's a pattern' or 'there's this' or 'there's that'. So I do understand that more now where at first I was a bit like, 'f*** in hell going three meetings all about the same f*** thing' like'. Just a little bits changed what the hell's going on?' It's only that I realised speaking to someone out of the group that you only reason you gotta to that is coz how would you ever know if I'm getting better (R: Mmm) Just off of one person saying oh he's better now he can go (...) But you might pick up on something that [therapist]'s not picked up on just by your information that you are taking in and what [therapist]'s taking in and what [consultant]'s taking in (...) You know so I've realised that, that it's not, although yeah it can be a bit of a pain up the bum and you

think oh it's a long day, you know. But its gotta be done if you wanna get better you gotta just sit with it and go with it coz (...) No point hiding away or running away, you're never gonna get any better and I've done it all my life

TABLE C8: Hindering factors in Mr X's life situation

Sleep Deprivation

(...) sleep deprivation is a killer and I suffer with it so bad

Being 'stoned' prevents him from making a connection with the therapy

(...) I take on board a lot more when I'm not stoned than when I am stoned

Being ill for over three weeks in November 2012

(...) and like anything I've just been ill for the last three weeks like you've seen. I've been on two lots of antibiotics (...) it's only been the last three weeks that have been a bit woo, do you know what I mean, coz I haven't actually been well you know, I've been trying to do

what I can do and I just haven't been well enough to do it

Mr X attributes the majority of his problems to smoking cannabis

You know and I know and I'm a big believer that it is due to the cannabis that it's... not all my problems (R: Yeah but) But a majority

TABLE C9: Mr X's personal attributes that may have hindered him in therapy

Interpersonal difficulties and emotional dysregulation can get in the way

When I'm aggy and I've got the hump people don't wanna be around me (...) Coz I'm vicious (...) I'm vicious with words and I haa... can lose it, you know.

(...) I can be a right horrible f**er, you know

P: ...but it builds up like a big cloud, like a big storm cloud you know, and it's just gathering pace and all gathering together and all of a sudden it's like a big explosion in the brain. Um, it gives me headaches you know, when I get raged up I get the worse headaches that you could imagine. All pains down the back of my head and in my head and on the side of my head and where I've just got myself so wild. Um...

Seeing things as all bad

(...) The negativity only comes from me when I'm down.

TABLE C10: Hindering aspects of taking part in the research

During the first 6/7 months of MBT he could not see the point of doing the research

You come to group therapy and the group it and you know and then you go to another meeting and its like, you feel like it's the same thing

Mr X uses the research forms to communicate his anger with the team (not necessarily a hindering aspect)

One of em's really shit you probably want to throw it away coz I was having a bad day and I just put 'nothing' I think coz I had the right bum ache

TABLE C11: Missing aspects of therapy

It would help to have one-to-one meetings with MBT therapist and hearing more feedback from her

Maybe if there was an opinion, maybe now and again it would be nice to have a half an hour one-to-one with just your key worker. You know, just [therapist] (...) You know, um... (Pause) just to discuss things that, not that you can't bring up in the group, but maybe you just want to find out how she thinks your treatments going, um, you know (R: So some feedback from...) Yeah, coz I know we get our letters from [therapist], you know, and from [consultant] but maybe you know, it would be nice to hear you know and just discuss how you're feeling and you know on a one-to-one level

Therapist's adherence to MBT principles

To assess whether the therapist was adhering to MBT principles a self-rating scale was completed by the therapist every time a HAT and/or PQ was completed by the patient.

TABLE D1 – Therapist self-rating of MBT adherence

Session Date	Framework of Treatment	Mentalization	Working With Current Mental States	Bridging the Gaps	Affect Storms	Use of Transference	Overall Adherence
09.11.11	94 %	81 %	100 %	86 %	100 %	60 %	86 %
07.12.11	66 %	69 %	80 %	43 %	87 %	90 %	70 %
11.01.12	55 %	87 %	100 %	86 %	87 %	80 %	77 %
08.02.12	100 %	100 %	100 %	100 %	100 %	100 %	100 %
12.03.12	100 %	88 %	100 %	100 %	100 %	80 %	94 %
11.04.12	100 %	100 %	100 %	100 %	88 %	80 %	89 %
09.05.12	83 %	100 %	100 %	100 %	100 %	100 %	94 %
14.05.12	89 %	88 %	100 %	86 %	88 %	80 %	88 %
11.06.12	77 %	81 %	100 %	86 %	88 %	70 %	86 %
13.06.12	89 %	75 %	100 %	100 %	100 %	90 %	89 %
04.07.12	94 %	100 %	100 %	100 %	63 %	70 %	84 %
13.08.12	94 %	94 %	100 %	86 %	88 %	100 %	94 %
26.09.12	88 %	81 %	100 %	86 %	88 %	90 %	84 %

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APPENDIX B

AFFIRMATIVE BRIEF

Note. The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

The job of Researcher 1 (Principal Investigator) was to find corroborated, positive evidence pointing to therapy as a major cause of patient change. The search for evidence was divided into five different sections. To make a reasonable case for the causal role of therapy in patient change, HSCED requires that at least two different kinds of evidence support the therapy-change link (Elliott et al, 2009).

1. Change in stable problems

A change in long-standing or chronic psychological difficulties during therapy is thought to be indicative of therapy efficacy (Kazdin, 1981). In his Personal Questionnaire, Mr X identified ten significant problems that he wanted to work on in therapy. He rated all of these problems as long-standing (ten years or more). After 5 months of MBT it is possible to observe a reliable and substantial drop in the PQ (Table A1); this score continues to drop at 8 months and is sustained at the one-year mark ($p < .05$). As Table A3 shows, Mr X reported positive change in all of his ten reported problems [2.85 (mean); 2 and 2.5 (mode); 2.5 (median)].

The change in the PQ is also corroborated by several other measures. After one year of treatment Mr X shows improvement in all the three indicators analyzed for clinical significance (Table A1). The improvement is significant at $p < .05$ for the PQ and CORE-OM and at $p < .2$ for the WSAS; this goes beyond what Elliott (2002) recommends as evidence that change was not due to chance or measurement error.

The judgement of the Consultant Psychiatrist in Psychotherapy during the three monthly reviews also suggests that the patient has changed. Although not analysed for clinical significance it is possible to observe an improvement in the patient's functioning and mentalizing capacity (Table A2). The level of substance abuse fluctuates along the year and the patient relapses into similar levels of use at the one-year mark. However, as it will be observed further along in the qualitative indicators, the patient's level of awareness and readiness to change (Prochaska and Di Clemente, 1986) seems to have improved. Consistent with other research findings (Horvath and Symonds, 1991), the working alliance seems to improve gradually along the year correlating positively with the outcome.

Taking into consideration the duration and consistency of Mr X's problems it is unlikely that the changes observed (Tables A1, A2, A3 and Figure A1) would have occurred without the influence of therapy.

2. Retrospective Attribution

In HSCED the patient is at the centre of the discussion; for that reason, we explored Mr X's opinions about the changes he experienced and how he attributed those changes.

Clear support for the therapy efficacy hypothesis was found in Mr X's 'likelihood without therapy' ratings and his descriptions of the role therapy played in achieving these changes. During his change interviews at 6 months and one-year into therapy, Mr X described eleven

positive changes. Five of these were considered to be 'somewhat unlikely' without therapy whilst six were considered 'very unlikely' without the influence of therapy. All of these changes were rated by Mr X as either 'very important' or 'extremely important'.

During his change interview (one-year mark) Mr X attributes a causal role to the MBT program:

R: (...) So I know you told me a little bit about this, you think the group, what people say to you, their opinions, but in general including things outside the therapy anything that happen In your life, what do you think has caused all these changes? What would you say is the cause for this?

P: Just finding out what your problem is, what the problems all about and understanding it

R: And was this through therapy?

P: Yeah coz I never knew what I had. I didn't know what was going on um, and now I know what like I'm dealing with you know. And, you know, that's important really coz then you can start making changes. Um, to support it and help yourself. Where if I hadn't come to group therapy I would never have known. I would have just been left in the wilderness you know like, just thinking this must be normal like you know. Um...

Mr X also commented how group therapy changed his thinking:

P: (...) my thinking's definitely started to change since I've been in group therapy

When talking about his positive changes Mr X noted:

P: I don't think I could have done it without therapy, any of it (...)

Mr X has reported a number of other helpful aspects of therapy. These can be found in more detail on Tables B1 and C3.

The fact that the changes reported are specific and idiosyncratic to Mr X gives greater weight and credibility to the retrospective attribution argument (Bohart, 2008).

3. Process-outcome mapping

HSCED also makes an attempt to link the content of the patient's post-therapy changes to specific events, aspects, or processes within therapy.

Of the twelve HAT forms requested (one each month) Mr X completed and returned ten. He rated five therapeutic events as 'greatly helpful' and three as 'extremely helpful'. He left two helpful events unrated (Table B1). The events described as helpful seem to relate to a number of core themes 1) the understanding and supportive attitude of the therapist and group members 2) listening to different perspectives 3) observing similar maladaptive patterns in other group members 4) and being able to talk in confidence to the therapist. Most of these aspects seem to relate to realizations and connections he made about himself and the way he relates to others, how he understands his impulsive behaviour, in particular the use of cannabis and the compulsive texting, and the way he usually copes in certain situations; all of these can be put under a mentalizing and affect regulation umbrella.

The above process is exemplified in the two following tables. In the first one it is possible to observe a link between psychotherapy processes (Mr X's HAT forms, Table B1) and the changes he later reported in the Change Interviews (see Table C1 and C2).

TABLE E1 - Link between HAT forms and outcome

Example of Process (HAT form)	Related Outcome
I came in the group feeling like my best friend had crossed the line with owing me money / When I discussed it with the group and they shared their opinions with me I realized that I hadn't listened to my friend properly and overreacted	<ul style="list-style-type: none"> - I can listen more in the group and outside - Thinking differently, more positive thinking - Greater awareness of what's is happening to me
<p>On Monday I was saying now that I've given up smoking weed I was gonna give up fags and [Group Member A] said why do it all over night and she was right</p> <p>I was going to give up fags but had already given up weed and the group said to me why would I want to put that much pressure on myself / They made me realize that I would possibly relapse and when I went home I know they were right as I wasn't thinking straight</p>	<ul style="list-style-type: none"> - I can listen more in the group and outside - Greater awareness of what's is happening to me
The fact that the group understand I'm in a bad place doing ecstasy and ended up smoking a joint and how it's affected me /	<ul style="list-style-type: none"> - Greater awareness of what's is happening to me

the fact they do things and use them as crutches	
Talking to [therapist] as I really aint feeling well but come in as I always worry that [therapist] would think I was lying and think I was working or couldn't be bothered to attend group therapy / it was helpful and important as [therapist] reassured me that she knows I'm not lying and she believed me	- Not paranoid and worried all the time

In addition, an analysis of the Change Interviews can provide further cues about the link between process and outcome.

TABLE E2 - Other process/outcome links

Example of Process (Quotes from Mr X in the Change Interview)
<p>Taking on board what is said and 'digesting' it</p> <p>(...) I think with our problems you've either got to carry on burring your head in the sand and like not take on what's been said to you or you got to take it all on board... (R: Mmm) ...and whether you got to go home and digest it and think about it and think about what's been said</p>

Stimulated Mentalizing

(...) when I come in with certain problems then we all chat about it and people will give out their opinions and obviously when you take on other people's opinions it could just be something simple like, 'but maybe they didn't mean it like that and they meant it like this', and then once you hear that and you sit back and you take it and you like digesting it. You actually think well, yeah maybe they were right and I have actually totally like, flipped it over this but maybe they did mean it like that. So then I'd go away and talk to the person and they'd go 'yeah that is what I did mean. I didn't mean it as inoffensive'. Like I did mean, you know, so in that respect opinions of other people that are in your mindset definitely helps you

Therapy facilitated insight and helped to understand his problems which then opened the possibility of change

(...) Just finding out what your problem is, what the problems all about and understanding it (R: And was this through therapy?) Yeah coz I never knew what I had. I didn't know what was going on um, and now I know what like I'm dealing with you know. And, you know, that's important really coz then you can start making changes. Um, to support it and help yourself. Where if I hadn't come to group therapy I would never have known.

(...) at the time your brain just goes totally blank and you, it's only when you maybe sitting at home three days later (R: That something comes up) That you think 'oh god you know that was quite f*** helpful' (R: Oh right) Or a situation might occur where someone else has had (R: Right) And, and you think 'oh f*** hell yeah'

Being listened to and believed in a one-to-one with MBT therapist

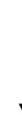
When I had a one to one with [therapist] um, few weeks ago when I weren't well and I popped up just to say look I'm really ill and I had a big thing of like, um, I just felt like [therapist] didn't believe me you know like, she thought I was just having the time off couldn't be bothered to come (R: Ah

yeah) Um, and she convinced me that I shouldn't be thinking like that and that she knows that I'm not well, otherwise I would turn up to group and that made me feel really positive when I left that I didn't have that worry of thinking I'm really ill at home and I've got people thinking that I'm just taking the mick like, not coming in.

The feedback from other group members about himself

(...) that helped me a lot and another thing a few weeks ago [Group Member B] said in the group that she thinks that since I've been smok... back smoking the cannabis it's made me revert back to the person I was at the start of the group (R: Yeah) And obviously I've digested that and took that on board (R: Yeah) And that's made me realise I need to give it up

I take a lot in here (...) from what people say



Therapist Interventions and Views of the Process + Links with Theory

Mentalizing Interventions

'He is more able to recognize his tendency to grab hold of anything that will rid him of his internal and unresolved panic. Mr X is attempting to understand this recurring pattern of finding a quick fix and be more expansive in his thinking' (quote from therapist 10

month report)

'(...) I wondered what he was actually worried about – how did that connect to himself, attempting to make the implicit more explicit'

(therapist supervision notes at month 6)

'(...) trying to help him slow down, helping him to pause and rewind. Stopping him from talking relentlessly and helping him to understand the meaning of his action' (quote therapist 10 month report)

'(...) try and regulate the internal chaos so he can begin to bridge the two extremes of behaviour with thinking in order to moderate his different states' (quote from therapist 12 month report)

'The repetition, the stopping and re-winding is enabling Mr X to stop, think and reflect rather than race with his thoughts' (quote from therapist 12 month report)

'Challenging and stopping Mr X is a difficult task but I feel that the forced interruption has enabled him to be more thoughtful and not as reactive' (quote from therapist 12 month report)

Corrective Emotional Experiences (Alexander, French, et al,1946)

'Your initial response was explosive and you were on the verge of packing the whole thing in when a different experience of being heard and understood in the group allowed you to see how the rejection is immediately converted into fury' (quote from therapist 8 month report)

'(...) but usually recovers once he has been heard and understood, a new experience for him' (quote from therapist 12 month report)

'Encouraging him to ring when he is not going to be able to make the group has helped him to understand what it feels like to be taken seriously. Demonstrating that the group and the team are concerned for him has begun to create an attachment to the group (...)' (quote from therapist 12 month report)



Related Outcome

Self-reported Changes from Change Interview

(Impulsive) Texting got a lot better

Thinking differently, more positive thinking

Greater awareness of what's is happening to me

Less angry and aggressive

Not paranoid and worried all the time

Not always frustrated

Other Changes – With Quotes from Change Interview

Therapy helped building a 'helicopter view' of himself and developing a more integrated perspective of good and bad self/object parts -

"I have my ups and downs like everyone else, but I've started to learn to cope with it a lot more than I was before"

Therapy has stimulated mentalizing -

Starting to realise it more now (...) like what drugs is doing to me (...) and how I portray myself and come across to other people.

4. Within-therapy process-outcome correlation

In addition, theoretically central in-therapy process variables (e.g. adherence to treatment principles) may be found to covary with month-to-month shifts in patient problems.

A correlation matrix was run to evaluate the link between the PQ results and the MBT principles evaluated in the adherence scale. No correlation was found. This may be due to the inefficiency of the measure used, which is a self-rated questionnaire (Bateman and Fonagy, 2006), and the possible desire of the therapist to perform well vis-à-vis the consultant (who is also her supervisor) and the principal investigator. Despite this fact it is possible to observe the consistent high self-ratings of the therapist regarding 'working with current mental states', which seems to go accordingly to her three monthly progress reports. In her reports the therapist highlights the importance of working relationally in the here-and-now for the positive outcome of therapy: "we have moved from the stage of pretend mode where stage

of protection for themselves and for one another to daring to take risks and explore how the other perceives the other to be” (taken from therapist 6-month progress report).

5. Event-shift sequences

Elliott (2002: p.7) mentions that ‘an important therapy event may immediately precede a stable shift in client problems, particularly if the nature of the therapy processes and the change are logically related to one another (e.g. therapeutic exploration of an issue followed the next week by change on that issue)’. Since the ratings for the present study were only undertaken monthly, the connection between the ‘event’ and the PQ shift may be harder to establish. However, giving that both forms (PQ and HAT) were completed once a month at the end of the group session we also looked for immediate links between these two instruments. In addition, we used the therapist session notes for that same session and the one immediately before to help us identify processes that may be linked to a shift in the PQ score.

Link between HAT ‘events’ and PQ rating for the same session

At the end of the 09.11.11 session Mr X rated a therapeutic event as ‘greatly helpful’ (‘I came in the group feeling like my best friend had crossed the line with owing me money / When I discussed it with the group and they shared their opinions with me I realized that I hadn’t listened to my friend properly and overreacted’). His mean PQ score for the same session shows a significant and reliable ($p < .05$) drop of 2 points in his personal problems (Figure A1). One of these problems is highly related to the helpful event ‘feel people are always lying to me’ and, despite not changing in this session, it shows reliable drops over the following months. Other related problems are ‘angry and aggressive’ and ‘not managing relationships’. The first one shows a reliable drop from 7 to 5 in this session and then 4 in the following

month. The second problem drops dramatically in this session from 7 to 1 and then remains at a lower score over the following months, despite some fluctuations (see additional tables).

In the 09th of May 2012 session Mr X rated a therapeutic event as 'greatly helpful' - 'The fact that the group understand I'm in a bad place doing ecstasy and ended up smoking a joint and how it's affected me / the fact they do things and use them as crutches' (Table B1). The PQ mean score for this session shows a reliable drop ($p < .05$) of 1.6 points in personal problems (Figure A1). His sense of being supported by the group may have influenced the alteration of his score on the individual item 'I have no support' from 5 in the previous rating to 4 in the 09th of May rating (see additional tables).

Link between Hat 'events' and PQ ratings of the following month(s)

The helpful event described by Mr X on the 09th of November 2011 ('I came in the group feeling like my best friend had crossed the line with owing me money / When I discussed it with the group and they shared their opinions with me I realized that I hadn't listened to my friend properly and overreacted') seems to be related with suspicions and paranoia, angry and/or aggressive reactions, listening to the perspective of others, and the overall mistrust of other people. This seems to relate with some of the changes mentioned by Mr X during the 6 month Change Interview: 'calmed down' and 'I can listen more in the group and outside'. The themes of this helpful event seem to be explored a number of times during therapy (see interview transcripts and/or coding tables) and may also, in this way, be related to some of the outcomes mentioned during the one-year Change Interview: 'greater awareness of what is happening to me' and 'less angry and aggressive'.

The average score of individual items related to this helpful event also show a reliable drop:

- Angry and aggressive, from 7 at pre-therapy to an average of 4.8 over the following months
- Paranoid and worried all the time, from 7 at pre-therapy to 5 over the following months
- Feel people are always lying to me, from 7 at pre-therapy to 5.2 over the following months
- Not managing relationships, from 7 at baseline to an average of 3.5 over the following months

The helpful event described for the 09th of May 2012 session was rated as 'greatly helpful' - 'The fact that the group understand I'm in a bad place doing ecstasy and ended up smoking a joint and how it's affected me / the fact they do things and use them as crutches' (Table B1). This event seems to be related with the overall experience of being understood and supported and of feeling less alone since other group members go through similar experiences. These processes have been described by the therapist as 'corrective experiences' and seem to be related with some of the outcomes (see table E2 in point nr3).

The individual item 'I have no support', related with the helpful event, shows a reliable drop ($p < .2$) from 5 points in the March 2012 rating to an average of 4 in the months following the event.

'Backup' evidence from therapist session notes relating to the same session of the PQ ratings and/or the session immediately before

- PQ reliable shift 09th November 2011. No relevant notes were found.

- PQ reliable shift 09th of May. The notes from the session immediately before (02.05) show that Mr X was 'not as angry and more thoughtful but needing to talk a lot'. Notes from the same session (09.05) show that Mr X was sharing difficult experiences of drug taking with the group. This sharing of experiences show an increased trust in the group process which seems to corroborate the links made above between feeling more supported by the group, and the drop in the PQ mean score and related individual items.

Conclusion

The affirmative brief provides compelling evidence that:

- Substantial changes have occurred in Mr X stable and chronic problems
- Mr X clearly attributes these changes to the influence of therapy

The affirmative brief also suggested, based on evidence, that:

- The process of therapy in general is linked to the positive outcomes
- Significant therapy 'events' have helped to reduce the severity of the patient's problems

No evidence was found for point number 4 (within-therapy process-outcome correlation).

According to Elliott (2002) two pieces of evidence would be enough to support the therapy efficacy hypothesis. Since it was possible to find evidence in four out of five steps followed, very clearly and strongly in steps 1 and 2, we can confidently assume that the client has changed substantially and that the change was caused, to a great extent, by the experience of therapy.

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APPENDIX C

SCEPTIC BRIEF

Note. The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

Competing explanations for apparent patient change

1. Trivial or negative change

This argument posits that any change found was trivial or negative. An assessment of Mr X's Outcome Data (Table A1) - PQ, CORE-OM and WSAS - highlights that all of these measures persisted in the clinical range from pre-therapy up to one year. Although some of these outcome measures show significant positive change, it would be anticipated that substantial and meaningful therapeutic change would move the patient out of the clinical range after one year on at least some of the indicators. The fact that this did not occur suggests that, following Jacobson and Truax's (1991) definition of clinically significant change, any alteration was trivial as opposed to substantial. In addition, there is considerable variation within the Outcome Data. The PQ shows significant reliable positive change at five months, eight months and one year in relation to the pre-therapy measure; however, the change between eight months and one year is not reliable. The CORE-OM shows no significant change at five months or eight months; and the WSAS only displays significant change at five months and one year, with the eight month measure highlighting a reliable worsening of symptoms.

Table A2 suggests that whilst WAI-S and Mentalizing Capacity have steadily improved, at one year the GAF suggests serious symptoms (the same category, although a more positive score, as at pre-therapy). Furthermore, Mr X is taking the same amount of cannabis - 19g per week - at one year as he was pre-therapy. This cannabis intake is significant to Mr X and his self-report in the One Year Change Interview suggests that it reverses his progress in therapy:

Mr X: When I give the cannabis up I'd say that I started listening; I was able to listen to people in the group. Um, and take on a lot more what people was saying

Interviewer: Yeah

Mr X: Since I've gone back to cannabis I'd say that I've reverted back to when I first started. In as far as, like I say, the erratic mood swings, when I'm pissed off I will let everyone know that I'm pissed off. You know, like a naughty school boy stamping his feet, you know I want that attention... I want people to know that I'm fucked off

Taken together these mixed results suggest that substantial change is unlikely to have occurred for Mr X within the first year of treatment; any change can be said to be trivial or negative in nature.

This is further supported by examining the PQ data (Table A3 and Additional Tables). At six months 60% of the PQ scores have either not changed or only changed by one point with one of these changes ('Having a life') representing a worsening in functioning. At the one year point, Table A3 suggests a much larger reduction in symptoms according to the PQ score. However, the Sceptic Case argues that this reduction is misleading since it is a conflation of two sets of very different data, one taken on 7th September 2012 and the other on 26th September 2012.

Whilst it is understandable that these figures have been combined for ease of analysis, this amalgamation disguises the fact that the average score for 7th September 2012 was 3.2, whereas for 26th September 2012 it was 4.7. Returning to Table A1, this score of 4.7 actually represents a reliable worsening of patient functioning compared to the PQ score at eight months and also compared to the score achieved on 7th September 2012. Following this, the overall picture presented by the data is that Mr X did not change substantially during the first year of the MBT program; any change can be said to be trivial or negative in nature.

2. Statistical artefacts

There is a possibility that statistical errors exist within the quantitative data. One difficulty is that the PQ data are missing for April (Month 7) and August (Month 11), and two scores are conflated for both January (Month 4) and September (Month 12), which as discussed in the first argument provides a distorted picture of patient change. Therefore, the PQ data do not accurately represent the course of therapy.

In addition, the PQ may be exhibiting a problem described by Elliot (2002, p.10) as 'regression to the mean by outliers', which occurs when the pre-treatment score is artificially high (for example, because the patient wants to be put forward for therapy). Since Mr X scored the maximum score in 80% of his pre-therapy PQ items (Table A3) it is possible that the significant results achieved on the PQ thereafter (Table A1) are an artefact of this situation. The same may be the case for the CORE-OM and the WSAS. To attempt to overcome this, a second pre-test measurement could have been taken to search for inconsistencies in the scores; however, this was not performed in this case and therefore the data must be treated with caution.

This assertion for the PQ can be examined by comparing the quantitative and the qualitative data. Table A3 shows a reliable positive change in patient functioning from pre-therapy to one year on all PQ items. However, at the One Year Change Interview, Mr X stated that 'Not managing relationships', 'Violent, erratic mood swings', 'Having a life', 'I have no support', and 'Feel people are always lying to me' were the same and had not changed since the pre-therapy measure. This contradiction suggests that the significant quantitative results shown for the PQ (Table A1) are a product of 'regression to the mean by outliers' and must be treated with caution.

Moreover, as described in the first argument herein, the quantitative data are variable and contain inconsistencies (see Point 1 above); this suggests that experiment-wise statistical errors may be present, which reflect apparent reliable differences having occurred by chance alone. Elliott (2002) asserts that the solution to experiment-wise error is to require reliable change on two of the three quantitative measures or on one measure at the $p < .05$ level of significance, leading to 'global reliable change'. At first glance (Table A1), it appears that the conditions for global reliable change have been satisfied at five months and one year (although not at eight months). However, taking into account the potential problem of regression to the mean by outliers discussed previously, it is not necessarily possible to read this quantitative information at face-value.

This is also supported by Mr X's consumption of cannabis, which remains the same at one year and pre-therapy, questioning the fact that meaningful change has occurred for the patient. Therefore, the Sceptic Case asserts that substantial change in Mr X cannot be inferred from the quantitative data alone since they provide at best a mixed picture of patient alteration and are at worst a product of statistical artefacts.

3. Relational artefacts

This section presents the argument that the self-presentational tendencies of the patient and interpersonal dynamics between the patient and the research team confound the data.

a. The plausibility of reported therapy attributions

According to Elliott (2002: p11), discursive accounts of therapy must be examined carefully for nuances and style in order to determine their credibility. Mr X reported 10 Helpful Aspects of Therapy (Table B1) and only one Hindering Aspect of Therapy (Table B2), suggesting a possible relational style of wanting to please the research team due to his descriptions, therefore suggesting that his accounts of therapy lack Bohart and Boyd's (1997 as cited in Elliott, 2002: p11) credibility criterion of differentiation. Likewise, Mr X did not describe any unhelpful aspects of therapy in the Change Interviews (Tables C3 to C11), again suggesting a lack of differentiation in his reports and a reduction of their reliability.

In addition, the plausibility of reported therapy attributions can be questioned for Mr X since he had taken cannabis the night before the interview and stated 'I still feel pretty stoned from yesterday' (One Year Change Interview). Likewise, the patient had 'ended up falling asleep about half six this morning' (One Year Change Interview) and felt that he 'can't cope with not having enough sleep' (One Year Change Interview). This suggests that the accounts provided by Mr X may be significantly distorted and he may not be a reliable observer of his own change on this occasion.

b. Relational response tendencies

Mr X exhibited certain relational response tendencies and was described as someone who hid his emotions and put up a 'false front' (see Patient Information). For instance, at both the Six Month and One Year Change Interviews, Mr X did not report any hindering aspects of taking part in the research other than to say 'you feel like it's the same thing' when discussing the therapy group followed by a research meeting (Table C10). However, one previous attempt at the Six Month Change Interview had to be postponed following Mr X's abusive stance towards the interviewer and him stating the research 'was all a waste of time'. In addition, the therapist's Process Notes (2nd April 2012) show that the patient:

'Had research meeting, was up in arms in a state about being used as a guinea pig; he wants to be told how he is doing, not asked if he has improved ... spoke about the amount of weapons he has at home to keep him safe – clearly frightened and threatened by outside world'.

This suggests that Mr X adopted certain relational response tendencies in the Change Interviews that led to him being unable to reveal his true feelings about the research; it appears that Mr X was, in fact, feeling frustrated and possibly threatened by the investigative process of the research. He was unable to disclose the true nature of these emotions in the Change Interviews, possibly due to his deference to the interviewer - an apparently successful male authority figure of approximately the patient's age – or due to the difficulties he has with expressing his emotions in ways that are not aggressive or abusive. Following this it can be argued that relational artefacts confound the data, which do not present a valid depiction of the patient; therefore any changes reported cannot be reliably attributed to the therapeutic program.

4. Expectancy artefacts

This argument shows how the patient's personal or cultural expectations of change account for the progress he reported. Elliott (2002: p12) suggests that expectations and experiences are distinguishable in terms of the language that patients use, with expectations reflected by 'scripted' accounts and actual experiences involving more idiosyncratic descriptions.

A careful examination of the One Year Change Interview reveals a combination of both scripted, intellectualised discussion and also personal, idiosyncratic talk. For example, many of Mr X's accounts of his progress revealed an intellectualised and self-convincing quality; at the One Year Change Interview Mr X stated that: 'and I'm still smoking cannabis. But I'm gonna try and give it back up this week and go back on the new medication they've given me'. Mr X made a number of such statements, which suggests a speculative and self-persuasive speech strategy that may be expectation-driven.

Furthermore, from the 11 positive changes identified by Mr X (Tables C1 and C2) only one was considered to be 'very much surprising' and only three were 'somewhat surprising'. Elliott (2002: p13) writes that 'if a client reports being surprised by a change it is unlikely to reflect generalised expectancies or stereotyped scripts for therapy'. The fact that Mr X was only surprised or very surprised by four out of 11 changes suggests that expectancy artefacts are operating in his accounts of therapy at least some of the time. For this reason, it is not necessarily the case that the cause of any apparent change was the MBT program since the results may be confounded by expectancy artefacts influencing the way that Mr X reported and presented his progress.

5. Self-Correction Processes

This argument posits that self-correction processes and not therapy were responsible for any changes observed. Although the duration of Mr X's problems of more than 10 years (Table A3) makes self-correction an unlikely explanation for any changes observed, Mr X did show certain self-help tendencies. Mr X had been alcohol dependent for many years but had stopped drinking alcohol six months before being referred to the psychotherapy department and at the beginning of the MBT program he had not consumed alcohol for 10 months. In addition, Mr X had been able to stop taking cannabis between the ages of 24 and 28 and then again for a number of months during the therapy.

Mr X had also experienced therapy previously since he was referred by IAPT and, at the time of his referral, Mr X was able to identify that problems from his childhood were affecting him and he understood that he hid his feelings and put up a 'false front'. Mr X had also found work during the MBT program (although he later quit this job), which suggests self-help and motivational tendencies. Furthermore, Mr X raised a son from a young age as a single parent, indicating a degree of personal resolve.

This level of motivation and resolve is corroborated by Mr X in the One Year Change Interview:

'What you put in is what you get out ... If you're putting a lot in then it makes you feel better when you leave and it makes you feel better in yourself, you know, that you've... that you have participated properly in the group, you know and that you've put valuable points across and you took valuable points in'.

Taken together, this suggests that Mr X is a person who draws on self-correction processes and that this was in operation prior to his commencement of the MBT program; it is therefore unlikely that the therapy alone can account for any changes experienced by the patient.

6. Extra-therapy events

Mr X felt that many of the changes he reported (Tables C1 and C2) would have been unlikely without therapy (although he also expected many of them to occur). Nevertheless, it is essential to recognise that a number of very significant extra-therapy events occurred in the patient's life during the treatment period and to be mindful to their potential effects, both positive and negative.

Importantly, Mr X found work during the MBT program, which was very meaningful for the patient since he was previously made redundant following a long absence from work, was struggling with a large amount of debt and experiencing difficulties with the state benefits system (Therapist Process Notes). It is not clear from the Case Record at what point during the MBT program Mr X returned to work, although the Therapist Process Notes mention this for the first time on 28th August 2012. The One Year Change Interview highlights the importance of work for Mr X and also the understanding that he felt he had from his colleagues:

Mr X: Um, you know, only doing like, you know, like part-time, you know, cash in hand coz obviously, you know like, I can't take full time job on because I could just... ..anything could happen. These people that I work for and that understand my problem and they relate to me that I need the help and that rather than just being like 'oh fucking hell what do you mean you got to have Monday and Wednesday off' and stuff you know, so it's not a full time job.

The significance of this work for Mr X's functioning is revealed in the following discussion at the One Year Change Interview:

Interviewer: Any, any other change that you've noticed in the way you, the things that you do or um, the way you feel about yourself?

Mr X: (Sighs) Well when I'm working and I'm not around the house I feel like a lot better...

Interviewer: Hmm

Mr X: You know, it's nice, and then when I get home it just feels like I'm just back, you know, I'm just back to where I, where I am you know like...

Um ... (Pause) and...

Therefore, work is very important for Mr X and it may be this that is related to any change in his functioning rather than the MBT program. This is reflected in the PQ scores, which are significantly lower for the measurements taken on 7th September 2012 than those recorded from previous dates (see Additional Tables), demonstrating the significance of economic activity for Mr X's well-being. The One Year Change Interview also highlights the way that working impacted upon Mr X's relationship with his family and his self-image:

Interviewer: OK... (Pause) And in terms of other people noticing changes in you, is there anyone that's, that pointed out anything or...?

Mr X: Yeah like my family coz obviously I've gone back to work you know, and they can see that there's changes in me for the better, do you know what I mean, um...

Interviewer: What did they tell you? Anything that they tell you that you can...?

Mr X: No just that they are pleased that I'm working and you know, and that everyone that I've worked for has been really pleased with what I've done you know. That I'm a hard worker and things like that you know, like they're the positives that peoples have said you know...

This information shows how Mr X's job was central to his functioning. The connection between his employment and a reduction in his PQ scores for 7th September 2012 suggests that it was this activity as opposed to therapy that is responsible for any patient change

observed. Another important extra-therapy situation for Mr X is his profound relationship with his female friend and Mr X used this friend as a source of support and strength throughout therapy.

For instance, the therapist Process Notes highlight:

'So much more thoughtful. Had spoken to [friend] before group, must talk about it being a problem. It is as if he has taken her strength for him' (9th November 2011).

Following that session, Mr X's PQ scores for 'I have no support', 'Not managing relationships', 'Having a life' and 'Always frustrated' dropped dramatically and reliably (see Additional Tables), perhaps reflecting the significance of this extra-therapeutic relationship for the patient.

Mr X's friend also persuaded him to go to the group when he did not want to go (therapist Process Notes 22nd February 2011) and their relationship is repeatedly mentioned in his notes throughout the year of therapy. Following this, it seems that Mr X was very dependent on the relationship with his female friend and it had considerable ability to affect his functioning in both positive and negative ways. This shows how extra-therapy events impacted significantly upon Mr X; the MBT program alone cannot account for any changes recorded.

7. Psychobiological causes

There were a number of alterations to Mr X's prescribed medications throughout the first year of the MBT program and, in addition, Mr X made a variety of changes to his intake of other drugs such as cannabis, ecstasy and cocaine. It is likely that such psychobiological fluctuation would have had a significant impact on Mr X's functioning and could account for any changes observed in the patient.

In December 2011, during the MBT program, Mr X was prescribed Risperidone and the dose was increased in March 2012. Mr X was not smoking cannabis regularly during this period (although he still smoked occasionally, therapist Process Notes 9th May 2012) but he used ecstasy and cocaine. In June 2012, Mr X stopped taking all prescribed medication, with the exception of Paroxetine for depression, and began to take cannabis again, perhaps as a reaction following his feeling he had been let down by his psychiatrist (Therapist Process Notes, 18th June 2012).

This information suggests that Mr X feels highly dependent on drugs as a means of 'escape' from his problems (Therapist Process Notes, 9th May 2012). The increase in Mr X's Risperidone in March 2012 could account for the drop in the PQ score between March 2012 and May 2012 (the measurement for April 2012 is missing). Following this it is likely that psychobiological factors confound any psychotherapeutic causes of alterations in Mr X, suggesting that change cannot be attributed substantially to the MBT program.

8. Reactive effects of research

Mr X participated in the research in an extremely self-conscious way, at times deploring it and on other occasions seemingly deferring to it (see point 3b above). Nevertheless, despite this challenging relationship with it there is also a sense that Mr X may have viewed the investigation as part of his potential improvement; it appears that he felt it was important 'if you want to get better'. The One Year Change Interview highlights this:

Mr X: But you might pick up on something that [therapist's] not picked up on just by your information that you are taking in and what [therapist's] taking in and what [consultant's] taking in

Interviewer: So I think you are putting it in very well, I'd say that's exactly what we need to...

Mr X: You know so I've realised that, that it's not, although yeah it can be a bit of a pain up the bum and you think 'oh it's a long day', you know.

But it's got to be done if you want to get better you got to just sit with it and go with it coz...

Interviewer: Yeah

Mr X: No point hiding away or running away, you're never gonna get any better and I've done it all my life...

Each month the patient was required to reflect on and complete the PQ and the HAT. Furthermore, a Change Interview was undertaken six months into therapy and again after one year. These procedures provided Mr X with a great deal of opportunity to reflect on the process of therapy and his personal change. Therefore, it is impossible to separate whether any changes in the patient were due to therapy, research, or a combination of therapy and the research; it is unreasonable to assert that any patient change noted can be due to the MBT program alone.

Conclusion

This sceptic argument has established compelling evidence that competing explanations explain the data presented. In particular, it is asserted that:

- Mr X did not change substantially during the first year of the MBT program and any changes observed are trivial or negative in nature
- The possibility of statistical artefacts limits the ability to infer positive changes from this data
- The self-presentational tendencies of Mr X and the interpersonal dynamics between the patient and the research team confound the data

- The patient's expectation-driven narrative of change accounts for any progress he reported
- Mr X engaged in self-correction processes both prior to and during therapy; this reduces the likelihood of the MBT program being responsible for any changes recorded
- Important extra-therapy events occurred in Mr X's life during the treatment period which have been shown to have influenced the patient significantly
- Psychobiological causes cannot be eliminated as an explanation for patient change
- The reactive effects of taking part in the research process may be contributing to any possible improvements observed

Following this, the Sceptic Case has demonstrated that Mr X did not change substantially during the MBT program. Any changes observed have been shown to be due to competing explanations.

References

Elliot, R. (2002) Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research* 12:1, 1-21.

Jacobson, N., S. and Truax, P. (1991) Clinical Significance: a Statistical Approach to Defining Meaningful Change in Psychotherapy Research. *Journal of Consulting and Clinical Psychology*, 59:1, 12-19.

APPENDIX D

AFFIRMATIVE REBUTTAL OF THE SCEPTIC CASE

Note. The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

The purpose of this rebuttal is to challenge the arguments put forward in the sceptic brief that Mr X changed little during therapy and that evidence exists to support alternative explanations for Mr X's changes. A refutation is presented for all the eight arguments made by the sceptic researcher.

1. Mr X's apparent changes were trivial or negative; substantial therapeutic change cannot be established

The first argument made in the sceptic brief to support the trivial change hypothesis was that the client did not move to the non-clinical range in the three outcome measures (Table A1) analysed for clinical significance (RCI) and therefore that change was not substantial. Whilst it would be ideal that Mr X would be in the non-clinical range after one year of therapy, the changes observed are still substantial and remarkable if we take in consideration the severity and duration of Mr X's problems (over 10 years). The sceptic brief then substantiates the trivial change argument by suggesting that the change did not meet the criteria established by Jacobson and Truax (1991) for clinical significance. This argument is incorrect and could mislead the judges' interpretation of the data. In Table A1, it is clear that all three instruments (PQ, CORE-OM and WSAS) dropped by more than the Reliable Change Index (RCI) calculated for each instrument using Jacobson and Truax (1991) formulas. Two of these instruments show clinically significant change at the $p < .05$ level of confidence and one at

$p < .2$. According to Elliott (2002), change at the $p < .05$ level in one out of three measures is enough to assume that global reliable change has occurred and that change was not due to chance or measurement error. However, in this case we can observe reliable change at the $p < .05$ level in two measures and also in a third one at the $p < .2$ level (see Table A1). This extra assurance leaves no doubt that change has occurred and was substantial.

Following this the sceptic team argues that, despite the clinically significant change observed in the PQ in all three reviews (5 months, 8 months and one-year), significant change was not observed from 8 months to 1-year. There are two problems with this argument: first, for the analysis to be meaningful the scores must be contrasted with a baseline (i.e. pre-therapy scores) and not with each other; second, what is observed from 8 months to 1-year is the maintenance of the changes previously achieved which were already significant.

The sceptic researcher then continues to highlight possible contradictions in the data and suggests that, at 8 months, the WSAS shows a worsening of the symptoms. Again, this statement can be misleading since the scores must be compared with the baseline and not with each other. At 8 months the score in the WSAS (Table A1) returns to pre-therapy values, but only temporarily. This shows no worsening or improvement, rather than a negative change as suggested in the sceptic brief. In addition, it is important to remember that these types of fluctuations are normal in patients with severe personality disorder; despite the expected fluctuations it is possible to observe a consistent and steady lowering of symptoms observed in all the indicators and this should be sufficient assurance that the change is reliable.

Continuing further, the sceptic brief argues that the GAF (Table A2) still shows serious symptoms at the one-year mark. This is indeed the case, however, there is a slight improvement in this measure compared to baseline levels and the improvement is also evident in the other additional instruments (Table A2). Regarding the fact that Mr X was smoking cannabis again, the sceptic researcher is not taking into account other factors such as the learning and the increase in self-awareness that Mr X evidences regarding his cannabis intake (see

interview transcript). The quote highlighted by the sceptic researcher is indeed a good example of this, showing significant awareness of the negative effects, which seems to contribute for the necessary state of ambivalence that precedes change (Prochaska and Di Clemente, 1986). The quote below (taken from the 1-year change interview) shows the different attitude of Mr X regarding his cannabis smoking which predicts a better outcome in a future attempt of stopping:

I feel that I can do it and I know that it'll be for the best of my interest whereas before I think I done it thinking that it was gonna be a... (pause) hundred percent cure (R: Right) Um, you know, I'll come off the cannabis oh I'm going to be a better and it's not going to be as easy as that. Um... (Coughs) it's still going to be a lot of work that I've got to put in um, but I know that.

The sceptic researcher then highlights potential problems when interpreting Table A3, in particular the conflation of two sets of data, one taken on 7th September 2012 and the other on 26th September 2012. The affirmative brief counter argues and explains why this is not a problem: the PQ was only measured once per month, however, on some occasions the therapist measured it twice; on those occasions a running median was undertaken to 'smooth out the noise' caused by fluctuations; this is a method recommended by Elliott (2010) and was not deliberately undertaken to mislead the judges or the sceptic researcher. In any case, even if we take the two sets of data independently (mean of 3.2 and 4.7 respectively), there would still be a reliable improvement comparing to both pre-therapy and 6 months measurements (6.8 and 5.4 respectively). The sceptic researcher goes further in her attempts and gives an incorrect analysis, stating that the September score of 4.7 represents a reliable worsening compared to the 8-month mark of 3.8. This is not the case as the difference of 0.9 is below the Reliable Change Index purposed (see Table A1).

As evidenced above, the sceptic brief makes several mistakes in the analysis of the data and the arguments presented should not be taken into consideration. When in doubt, Elliott (2002) suggests a number of strategies; one of those strategies is to ask the client to rate the importance of the changes reported. Mr X rated all his changes as either 'very important' or 'extremely important'; this extra assurance leaves no doubt that change occurred and was substantial.

2. Statistical Artefacts

The sceptic brief starts by highlighting potential problems with the PQ, particularly the conflated scores for both January (Month 4) and September (Month 12). The reason for this procedure was already explained in point one above and is one that is recommended by Elliott (2010) to 'smooth out the noise' of possible fluctuations in the data. The conclusion of the sceptic team that the PQ data do not accurately represent the course of therapy due to the conflation stated above seems to be a radical and strange conclusion, which is not based on credible arguments.

The second argument put forward by the sceptic team regarding 'regression to the mean by outliers' and the lack of a second pre-test measure is a valid argument and indeed a limitation of the study. However, it is possible to overcome these difficulties using the following examples: 1) if we use the mean of the pre-therapy and the 5 months scores as the baseline measurement a significant improvement would still be found from 5 months to 1-year in the PQ and CORE (two out of three); 2) If we calculate the mean of the first two PQ scores (pre-therapy and 09.11) and use that score, 5.8, as the baseline we would still observe clinically significant improvement in this indicator at both the 8-month and the 1-year mark. Elliott (2002) also suggests that if the client's problems are of chronic nature and present for a long time (over 10 years in Mr X) the changes observed are not probably a function of regression to the mean.

The sceptic brief then argues that ‘experimentwise error’ may be in place (Elliott, 2002); however the sceptic team rapidly reaches the conclusion that more than the minimum criteria to avoid experimentwise error were met, raising again the ‘regression to the mean’ problem and the relapse into cannabis smoking as potential problems. These arguments were already refuted in the example above and in point nr1. The above evidence suggests that, contrary to the claim of the sceptic brief, statistical artefacts were not operating.

3. Relational Artefacts

This section presents counter arguments for the suggestion that Mr X’s self-presentational tendencies and the interpersonal dynamics between the patient and the research team confound the data:

a. the plausibility of reported therapy attributions

The affirmative brief argues that it is possible to observe *differentiation* (Bohart and Boyd’s, 1997 as cited in Elliott 2002: p11) in Mr X’s arguments. It is true that Mr X only reported one hindering event in Table B1. However, that event - reported 9 months into therapy - is very negative and rated as ‘greatly hindering’ demonstrating that Mr X is not concerned with pleasing the researcher or the therapy team.

Just don't know who to trust up there and haven't felt so low about it as do now (HAT Form, 11th June 2012)

Also, contrary to the sceptic brief’s suggestion, Mr X has indeed mentioned two negative changes during the 6-month change interview. He also did not hesitate to mention missing aspects of therapy during the one-year change interview. All of the above are aspects that show differentiation and, in this way, increase the reliability of his claims.

Then the sceptic team argues that Mr X's interview was not reliable because he admitted to have taken cannabis the night before and was still feeling stoned. The affirmative brief can understand this argument to some extent but it seems an exaggeration from the sceptic team; cannabis intoxication does not severely impair judgements and the duration of the effects range from 2 up to 6 hours; even if Mr X stated 'I still feel pretty stoned from yesterday' this is likely to be the 'hangover' effects of cannabis rather than an acute state of intoxication; despite his agitation and pressure of speech, the interviewer did not notice any gross incoherence in his narrative suggesting that Mr X was in his 'normal' state of consciousness.

b. relational response tendencies

In here the sceptic team suggests that Mr X's criticisms of the research process, including the need to reschedule the 6-month interview due to his abusive comments, were actually part of Mr X's defensive style and his inability to reveal his true feelings. This conclusion seems slightly odd since Mr X's comments are very clearly a criticism of the research process showing that he is not preoccupied with the effects of his words on other people.

4. Expectancy artefacts

The sceptic team starts by arguing that some of Mr X's accounts of his progress revealed an intellectualised and self-convincing quality; then an example is given regarding his use of cannabis. Once again the affirmative team highlights and counter-argues that in fact what this may indicate is that he circulated the cycle of change again (Prochaska and Di Clemente, 1986) and that this time he seems more authentic and realistic (e.g. he is now aware that it will not be easy and that not all will be good suddenly). The following quote confirms this:

I feel that I can do it and I know that it'll be for the best of my interest whereas before I think I done it thinking that it was gonna be a... (pause) hundred percent cure (R: Right) Um, you know, I'll come of the cannabis oh I'm going to be a better and it's not going to be as easy as that. Um... (Coughs) it's still going to be a lot of work that I've got to put in um, but I know that.

This shows self-reflection, one of the criteria recommended by Elliott (2002) as helping to distinguish expectation driven statements from statements that come from the client's immediate experience.

The following argument is accepted and it is true that only in about 40% of his changes Mr X reveals being surprised. This means that he expected some of the changes to happen and that this may have, to some degree, affected the results.

5. Self-Correction Processes

The fact, raised by the sceptic team, that Mr X had stopped taking cannabis during the MBT program, a habit he had since his teenage years with only one interruption between the ages of 24-28, shows that therapy is likely to have propelled this change. This demonstrates that this self-effort was not independent from therapy and cannot be taken, therefore, as an alternative explanation for the changes observed.

The argument that he had been in therapy before and that his capacity for self-observation derived from there is also a flawed argument and cannot be presented as a cause of the present changes. If that was the case, Mr X would not have been assessed as in extreme difficulties at the beginning of the program.

As stated in the sceptic brief, Mr X's levels of motivation and resolve could have been, in some way, a moderator factor. However, it can be argued that the persistence and patience of the therapist was an important factor in keeping Mr X engaged:

Encouraging him to ring when he is not going to be able to make the group has helped him to understand what it feels like to be taken seriously. Demonstrating that the group and the team are concerned for him has begun to create an attachment to the group. Although he is capable of severing the attachment, I believe that the fact that we are always there for him, whatever his behaviour is like is what is beginning to allow for a real sense of connection (quote from therapist 12-month report).

Elliott (2002) suggests a number of strategies that evaluate non-therapy explanations such as self-correction efforts. One of those strategies is to ask the client what has caused the changes. In the following quote Mr X attributes the changes to the influence of therapy:

R: what do you think has caused all this changes? What would you say is the cause for this?

P: Just finding out what your problem is, what the problems all about and understanding it

R: And was this through therapy?

P: Yeah coz I never knew what I had. I didn't know what was going on um, and now I know what like I'm dealing with you know. And, you know, that's important really coz then you can start making changes. Um, to support it and help yourself. Where if I hadn't come to group therapy I would never have known. I would have just been left in the wilderness you know like, just thinking this must be normal like you know. Um...

Another strategy is to assess how likely the client feels the change would have been without the therapy. All of the changes reported by Mr X were considered to have been unlikely without the therapy, even if in different degrees (see Tables C1 and C2).

The long duration of Mr X's problems (over 10 years) also makes it very unlikely that self-corrections efforts could explain the observed changes. For the above reasons, the sceptic argument should not be taken into consideration as valid.

6. Extra-therapy events

The sceptic brief starts by mentioning the importance of having started work in influencing the results. It appears to be true that finding work was a self-generated effort and an important extra-therapy event. There is mention on the therapist notes to the link between being at work and feeling better, for example:

Much calmer – has gone back to work part-time (therapist process notes, 19.09.12)

Despite the above, when asked what brought about the changes Mr X did not spontaneously refer to the work situation which casts doubt on the weight of this extra-therapy event. It seems to be an extremely exaggerated statement from the sceptic brief to affirm that work, and not the MBT program, was responsible for any changes observed. It is also not clear when Mr X started working but it appears that this only happened from the 28th of August which could not account for the changes observed in the previous 11 months of therapy. In fact this may demonstrate the bi-directional influence of therapy and having found work in the final results.

The sceptic team then tries to corroborate the work hypothesis by making a link with the PQ results from the 7th of September, supposedly the first measurement following the start of the job. Whilst this was a low score in mean terms, it is not true that these were the lowest scores in all items (for example, items nr.6, nr.8 and nr.9 do increase comparing to other previous months; also, item nr.8 'having a life' which would appear to be related with the satisfaction of having a job was, nonetheless, rated as being worse than in previous months). Another counter-argument can be made by looking at the following PQ scores (on the 26th of September). Mr X was still working by this date; however, many of the individual items have been rated as being worse in the PQ measurement. The fact that approximately a week

later, as seen in the quote used by the sceptic team, Mr X had quit his job and was texting aggressive messages also suggests that work was a temporary self-effort but with no real impact on the 'global reliable change' observed.

The next extra-therapy event suggested was the relationship with his female friend. However significant this relationship may have been it is highly unlikely that this alone could explain the patient changes, particularly because Mr X has known her for many years. If this relationship was the cause for the changes observed why would the changes happen only now, precisely during the MBT program?

P: No, no she's just my best friend. She is just my best friend, you know, um and obviously I'd, you know I have felled in love with her, do you know what I mean

R: Okay

P: Um, over the years, but it will only ever be a love of a sister. You know it's never really gonna mater... it's never going to materialise, do you know what I mean. So we only will ever be best friends and do what we can for each other

There is also evidence that the therapy has helped him understand certain aspects of this relationship. This would suggest that it was not the relationship itself that caused the positive outcomes but the clarification that the therapy program provided to certain important aspects of this long term relationship; this could have solved some pending issues for Mr X such as his belief, at certain points, that this friendship could become a romantic relationship:

R: So you came here to the group and you shared?

P: Yeah

R: What was happening?

P: Yeah

R: And it was helpful to hear?

P: Yeah

R: Okay

P: Yeah, definitely

R: And how did it change your relationship with your friend?

P: Well it didn't it just made it better. It just made me, made me see things from different points of view you know, rather than just being gun ho. You know an all or nothing it made me realise that well, maybe just coz we ain't gonna go out we'll still be the best of friends and that's not changed anything from where we were at the time, so you know. Um, yeah it, it helped (One year change interview, p....)

One final comment to consolidate this rebuttal is to use the same method suggested in the point above which looks at the estimates given by Mr X regarding the likelihood of the changes having occurred without the therapy. As stated above all of the changes reported by Mr X were considered to have been unlikely without the therapy, even if in different degrees (see Tables C1 and C2). This fact, together with the counter-arguments presented above leaves no doubt that the extra-therapy events could not, by themselves, have caused the changes.

7. Psychobiological causes

The majority of the medication taken by Mr X was started prior to the MBT program; this did not prevent him, however, from being extremely unwell at the start of the program as the majority of the assessment indicators suggest, including the subjective opinion of the

therapist and the consultant. The only medication that was started during the MBT program was the Risperidone; however, this has been replaced by Aripiprazole and then discontinued by Mr X who replaced it with cannabis.

It is undeniable that Mr X's erratic use of medication plus the use of illicit psychotropic drugs has had some sort of impact on Mr X's mental state and well being. However, it seems unlikely that the medication would have caused the positive changes unidirectionally. The unreliable way in which Mr X used the medication would, at best, cause more instability rather than improvement

8. Reactive effects of research

The sceptic brief points out the potential benefits of taking part in the research; the extra opportunity for self-reflection was viewed as a helpful factor, influencing the changes observed. Despite the fact that Mr X seems to have concluded that there are certain benefits in taking part, he has been extremely resistant to the research process and even showing aggressive and paranoid features at times. As pointed out in the reach case record, the 6-month change interview had to be done twice because Mr X was verbally abusive in the first attempt and could not see the purpose of replying to the researcher's questions.

The following statement taken from the therapist's Process Notes (2nd April 2012) is indicative of his antagonistic attitude:

'Had research meeting, was up in arms in a state about being used as a guinea pig; he wants to be told how he is doing, not asked if he has improved ... spoke about the amount of weapons he has at home to keep him safe – clearly frightened and threatened by outside world'.

Also, has highlighted in Table C10 Mr X did not see any benefits in taking part for at least the first 6/7 months of treatment:

You come to group therapy and the group it and you know and then you go to another meeting and its like, you feel like it's the same thing.

Other times he used the research forms to communicate his anger and disappointment with the team:

One of em's really shit you probably want to throw it away coz I was having a bad day and I just put 'nothing' I think coz I had the right bum ache

Another important aspect to consider is that Mr X did not spontaneously refer to the research when asked what caused the changes.

With so many contradictions it is not possible to affirm that client outcome was affected mostly as a function of being in research.

Conclusion

Viewed from this perspective, the arguments of the sceptic case carry little weight. We ask you to consider the following points:

9. Different sources of evidence suggest that Mr X changed substantially. The quantitative data strongly points in the direction of positive change surpassing even the minimum criteria suggested by Elliott (2002).
10. The great majority of the quantitative measures used point in the direction of positive change which leaves no room for suspicion that statistical errors, such as 'regression to the mean by outliers' or 'experimentwise error', were in place.

11. There is enough evidence to assume that Mr X's attributions are plausible and that his responses were not performative utterances to please the researcher or the MBT team.
12. Mr X was surprised by some (but not all) of his changes which may indicate some expectancy artefacts. However, enough evidence exists to suggest that many of Mr X's accounts were self-reflective and credible as opposed to mainly expectation-driven.
13. All of Mr X's problems were of more than 10 years duration whilst all of his reported changes were considered to be unlikely without the therapy. Both these facts, together with both the therapist and his own statements regarding the direct influence of therapy, cast serious doubts to the possibility that self-corrections processes alone would cause any of the reported changes.
14. There is no evidence that the 'extra-therapy events' reported can fully explain the changes. At best, there is a bidirectional influence between these events and the therapy program itself.
15. It seems unlikely that the medication would have caused, unidirectionally, the positive changes observed. The unreliable way in which Mr X used the medication would, at best, cause more instability rather than improvement.
16. There is enough evidence pointing to Mr X's resistance to the research process for at least the first 6-7 months of the programme. Even if he was starting to understand the purpose of it all towards the one-year mark there are too many contradictions and it is not possible to affirm that client outcome was affected mostly as a function of being in research

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APPENDIX E

SCEPTIC REBUTTAL OF THE AFFIRMATIVE CASE

Note. The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

The affirmative brief argues that Mr X's stable and chronic problems changed substantially during the MBT program and that the therapy was the cause of this change. This sceptic rebuttal challenges the validity of these conclusions and argues that the patient did not make meaningful alterations during the course of therapy; any changes observed were trivial, negative or due to factors other than the MBT program.

1. No clear and substantial change in stable problems

The affirmative brief cites the duration and severity of Mr X's self-reported problems at the beginning of therapy (Table A3). It then attempts to show how the quantitative indicators (Table A1), the judgement of the Consultant Psychiatrist in Psychotherapy (Table A2) and the Working Alliance Inventory (Table A2) corroborate the hypothesis that substantial change occurred for Mr X during the first year of the MBT program.

However, the sceptic rebuttal disputes this argument on four grounds: first, Mr X's baseline measures may be artificially inflated; second, there are problems with the quantitative data, especially the presentation of the PQ results; third, towards the end of the year Mr X

appears to be experiencing a worsening of symptoms; and fourth, at the end of the first year of therapy Mr X still remains in the clinical range on all of the indicators. These arguments are now discussed in turn.

In terms of Mr X's baseline measures being artificially inflated, the initial sceptic argument has already shown how pre-therapy indicators can produce elevated results, for example because the patient would like to be put forward for therapy. This then produces the misleading impression of significant therapeutic change occurring in later indicators. Elliott (2002) suggests that this problem can be overcome by taking a second pre-test measurement, which was not performed in this instance. Therefore, the statistically significant change asserted by the affirmative argument must be treated with caution.

The affirmative brief also asserts a reliable and substantial drop in the PQ Items as evidence for meaningful change in Mr X. However, as highlighted by the initial sceptic argument in point number 1, the final mean PQ score (26th September 2012) is 4.7, which represents a reliable worsening of symptoms compared to the score achieved on 7th September 2012, which was 3.2. This evidence suggests that whilst the affirmative brief argues that Mr X consistently improves, his progress fluctuated much more than has been allowed for and it may actually have been worsening towards the end of the first year of therapy.

The 12 Month Therapist Progress Report substantiates the oscillating and highly nuanced way that Mr X experienced therapy: 'I feel [Mr X] remains unstable but fluctuates from being on course for recovery and then sabotages the development and retreats back into a volatile state ... He continues to speak his unmodified thoughts aloud rather than take stock and digest the material'. Mr X also confirms this in his One Year Change Interview, where he discusses returning to his pre-therapy consumption levels of cannabis: 'Since I've gone back to cannabis I'd say that I've reverted back to when I first started' and he asserts two negative changes in the Six Month Change Interview -

lethargy and impulsiveness for other drugs – the latter which he attributed to the therapy (Table C1). Taken as a whole, this material suggests that Mr X has not changed substantially during the course of therapy.

Furthermore, following one year of therapy the patient remains in the clinical range on all indicators and only some of these measures show a significant positive change. In summary it appears that Mr X cannot be said to have changed substantially during the first year of the MBT program; the affirmative argument cannot sustain the case for substantial or clear change in Mr X's long standing problems.

2. Difficulties with retrospective attribution

The affirmative argument suggests that Mr X clearly attributed any changes in his functioning to the MBT program. However, the sceptic rebuttal asserts that, due to a number of factors such as expectancy effects and relational artefacts, the patient's claims cannot be taken at face value and must be examined more deeply to reveal the conditions underlying their construction.

Mr X identified 11 positive (and two negative) changes resulting from therapy (Tables C1 and C2). Of these 11 positive changes, all of them were considered to be either very unlikely or somewhat unlikely without therapy, suggesting that Mr X attributed his changes to therapy. However, Mr X also considered seven of these positive changes to be very much or somewhat expected. Following Elliott (2002), if a patient is not surprised by changes then it is likely that expectancy effects are operating and the validity of the therapy attributions are reduced. This potential lack of validity highlights the way in which Mr X's evidence cannot be taken at face value.

The initial sceptic argument (point 3a) has already shown that Mr X had smoked cannabis the night before the One Year Change Interview – 'I still feel pretty stoned from yesterday' (One Year Change Interview) – and had not slept well, which Mr X described as affecting him very negatively. This suggests that any retrospective attributions made by Mr X must be treated with extreme caution. Furthermore, Mr X

puts up a 'false front' and he experienced challenges in revealing his true feelings concerning the research process to the interviewer, either becoming abusive or deferent in attempts to do so (sceptic argument point 3b). This demonstrates that Mr X cannot be considered to be a reliable witness to his own change and so his retrospective attributions must be thoughtfully examined.

In addition, a number of factors have been identified that could convincingly contribute to any changes observed in Mr X other than the MBT program. For instance, Mr X returned to work at the end of August 2012 according to the Therapist's Process Notes (28th August 2012). This change in Mr X's circumstances occurred prior to him achieving the lowest mean score for the PQ during his year of therapy (3.2 on 7th September 2012), which then rose to 4.7 by 26th September 2012, shortly before Mr X stopped working again (Therapist's Process Notes 10th October 2012). This suggests that it was employment as opposed to the MBT program that created the conditions for potential patient change.

Relating to this, the qualitative reports from the One Year Change Interview also highlight the importance of work for Mr X (sceptic argument point 6). Similarly, the sceptic argument (point 6) has shown how Mr X's emotional well-being appears to fluctuate according to the circumstances of his relationship with his female friend. These extra-therapy events can both be related to a reduction in the relevant PQ scores (initial sceptic argument, point 6), which suggests that factors other than the MBT program were importantly involved in any changes noted in patient functioning.

Furthermore, the affirmative argument is, at times, drawing on highly selective evidence to suggest retrospective attribution. For example, the affirmative brief quotes Mr X saying 'I don't think I could have done it without therapy, any of it' in the One Year Change Interview without placing this excerpt in context. In fact, when Mr X says this he is not referring to his experiences of therapy as a whole but merely to one change 'Not paranoid and worried all the time' (Table C2). The implication that this statement refers to his global change is

therefore fallacious. There is also evidence that Mr X did not find therapy to be beneficial: on 30th April 2012 Mr X 'spoke in a contemptuous tone, rubbishing the group' (Therapist Process Notes).

In summary it can be argued that there are a number of conditions present in the construction of Mr X's qualitative reports of his own change that make it necessary to treat them with caution. In addition, extra-therapy events appear to relate to Mr X's PQ scores and the patient spoke disparagingly of group therapy. This evidence, plus the selective reporting of information used by the affirmative brief, suggests that retrospective attribution cannot be inferred imprudently.

3. Insubstantial process-outcome mapping

The affirmative argument attempts to map therapy outcomes reported by Mr X in the Change Interviews to therapeutic processes or events described in the HAT forms (Table B1). However, the sceptic rebuttal seeks to show that there is no clear process-outcome mapping and that the evidence cited by the affirmative brief is insubstantial. Furthermore, the patient experienced considerable challenges in completing the HAT forms, which renders this source of data open to question.

As mentioned above, one problem with any attempt at process-outcome mapping is the great difficulty that Mr X experienced filling out the HAT forms, confirmed by the One Year Change Interview (Interviewer: I know you, you've been having some difficulties with those forms ... Mr X: Yeah). Reflecting this difficulty, the patient only completed 10 out of 12 forms, he did not rate two helpful events that he described and he wrote 'Nothing' on one form, rating it as two (see Table B1). This inconsistency in completion means that out of 12 forms only seven were correctly finished, leading to problems of reliability when using this measure as evidence to support the therapy efficacy hypothesis.

Furthermore, of the 13 positive and negative outcomes from therapy that Mr X reported in the Change Interviews (Tables C1 and C2), the affirmative brief has only been able to map four of these onto specific therapeutic processes or events described in the HAT forms; this leaves nine outcomes as appearing to be unconnected to therapeutic processes or events.

In addition, it is important to remember that not all of the positive changes (Tables C1 and C2) reported by Mr X have been sustained. For instance 'I can listen more in the group and outside', discussed by the patient in the Six Month Change Interview (Table C1) and mapped by the affirmative argument onto two HATs (9th November 2011 and 11th January 2012), appears to be no longer the case for Mr X according to the One Year Change Interview:

Mr X: When I give the cannabis up I'd say that I started listening; I was able to listen to people in the group. Um, and take on a lot more what people was saying

Interviewer: Yeah

Mr X: Since I've gone back to cannabis I'd say that I've reverted back to when I first started

Following this it appears that the outcome 'I can listen more in the group and outside' was considered by Mr X to be connected to his cannabis intake as opposed to any specific therapeutic processes or events from participating in the MBT program. This renders the affirmative brief's process-outcome mapping problematic in this instance.

The affirmative argument has mapped the outcome 'Not paranoid and worried all the time' (Table C2) onto the HAT on 26th September 2012, when the patient felt understood by the therapist, suggesting a causal link. However, the patient's PQ rating for 'Paranoid

and worried all the time' was 6 on the same date (26th September 2012), mirroring its levels of the previous year. This suggests that the therapeutic event had not helped the patient to reduce this PQ item and that it is therefore unlikely to be related to the outcome.

In terms of the outcome 'Thinking differently, more positive' (Table C2), this has been mapped onto one therapeutic event on 9th November 2011, although it was not mentioned by the patient until the One Year Change Interview. It seems to be a leap of faith to suggest that one event in therapy at the end of 2011 could affect the patient almost a year later. Furthermore, the PQ ratings on 26th September for items that could correspond with 'Thinking differently, more positive', such as 'Overanalysing and complicating', 'Violent and erratic mood swings', and 'Paranoid and worry all the time' are all scored at 6, which suggests that substantial and sustained change has not occurred on this indicator.

Furthermore, 'Greater awareness of what is happening to me' (Table C2) has been mapped by the affirmative argument onto four therapeutic events (9th November 2011, 11th January 2012, 16th January 2012 and 9th May 2012, Table B1). However, this outcome was 'very much expected' by Mr X, suggesting that expectancy artefacts and not therapy may be influencing his self-reports. It is also worth noting that two of these therapeutic events (11th and 16th January 2012) did not lead to any reliable reduction in the mean PQ score (Additional Tables) on that session. The remaining two events (9th November 2012 and 9th May 2012) show reliable reductions in the corresponding mean PQ scores but the validity of this must be questioned since the first measurement follows the pre-therapy indicator (see sceptic argument point 1) and the second measurement follows a missing score for April.

In addition, Mr X may have a greater awareness, as suggested by the Consultant Psychiatrist in Psychotherapy in her ratings of his Mentalizing Capacity (Table A2); nevertheless, it is unlikely that this alone can lead to the assertion of substantial change when other processes and behaviours – such as aggression or smoking cannabis – remain unchanged. This suggests that although there may be some

alterations in Mr X they are not substantial or meaningful and they do not map clearly onto therapeutic processes or events; therefore other factors, such as expectancy effects or extra-therapy events, may be more causally significant for Mr X.

The affirmative brief also presents Table E2, which proposes indirect process-outcome links; however there is no explicit evidence here to support clear process-outcome mapping. In addition, some of the outcomes asserted do not appear to be sustained for Mr X, for instance, the idea that the patient is less angry and aggressive and is no longer impulsively sending text messages is challenged by the Therapist Process Notes (10th October 2012), which state that: 'he has quit gardening job, has been texting very aggressive messages which he read out'. This disputes the notion that therapeutic events and processes had a significantly positive impact for Mr X.

In summary, no substantial process-outcome mapping has been demonstrated. It is likely to be more prudent to accept the sceptic position that there are no obvious connections between patient outcome and events in the MBT program; this is especially convincing given the difficulty that Mr X had with completing the HAT forms and the evidence for alternative explanations of possible patient change that have already been put forward.

4. No within-therapy process-outcome correlation

The affirmative brief has found no evidence to support a relationship between the therapist's adherence to MBT principles (Table D1) and shifts in the patient's PQ scores. Therefore, despite the high adherence that the therapist has shown to MBT principles in her self-report statements, these cannot be correlated with patient changes and they do not stand alone as evidence for a connection between the therapy and the outcome for Mr X.

5. Difficulty in inferring event-shift sequences

The affirmative brief has attempted to suggest that specific therapy events led to a stable shift in patient problems. The sceptic rebuttal argues that other explanations account more persuasively for any shifts observed. What follows is divided into two sections, reflecting the presentation of the affirmative argument.

a. Link between HAT events and PQ ratings for the same session

The affirmative argument suggests that a HAT on 9th November 2011 relating to Mr X's reaction to his best friend owing him money (Table B1) had led to significant changes in the patient's PQ scores for personal problems in additional sessions, with particular focus on Item 4 'Feel people are always lying to me' (Additional Tables). However, there are a number of problems with this assertion.

First, the affirmative argument is attempting to establish a link between HAT events and PQ ratings for the same session but it then states that the PQ item 'Feel people are always lying to me' did not drop in that session. In addition, it is not elaborated by Mr X in the HAT form that the patient felt that his best friend was actually lying to him, just that she or he owed him money; the link made by the affirmative argument between the patient being owed money and the patient feeling that people are lying to him appears to have no evidential grounds and the sceptic argument disputes the validity of this connection.

Furthermore, an alternative explanation for the reduction in the PQ score following this session can be found in the Therapist's Process Notes, as already highlighted in the initial sceptic argument (point 6): '[Mr X is] so much more thoughtful – had spoken to [friend] before group – must talk about it being a problem. It is as if he has taken her strength for him'. Given the extreme importance that Mr X's relationship with his female friend had for him, this explanation appears to offer a more direct account of the related reductions in PQ items

for personal problems. In addition, such a large reduction can be observed because the pre-therapy score (September) is being compared with a score taken in November; it might be expected that some change would occur during this period.

The affirmative case then suggests that the HAT on 9th May where Mr X discussed drug use and reported feeling understood (Table B1) could account for the reliable drop in PQ for that month. However, the sceptic rebuttal asserts that this contention is confounded since the data are missing for April 2012 and it might be expected that there would be a significant change between March 2012 and May 2012 (either positive or negative) due to the time span between the measurements. In addition, the PQ rating 'I have no support' was 5 in March, then 4 in May as stated by the affirmative argument, and then it reverted to 5 in June (the next measurement), suggesting that any changes on this item were not sustained.

Furthermore, an alternative explanation for the reliable drop in PQ for May 2012 is the increase in Mr X's Risperidone in March 2012 (Medication Record), which could explain the reduction in the PQ score between March 2012 and May 2012 (the measurement for April 2012 is missing). In summary there are no clear links between HAT events and PQ scores for the same session and any connections forwarded by the affirmative brief have alternative explanations.

b. Link between HAT events and PQ ratings for the following months

In terms of the link between the HAT events and PQ ratings over the following months, the affirmative brief has only managed to link two HAT events to such changes: Mr X discussing his friend owing him money on 9th November 2011 and the group understanding his drug use and identifying with it on 9th May 2012. Importantly, 10 HAT events (Table B1) have not been linked to PQ ratings for the following months, highlighting only a very tenuous connection at best.

In terms of the first HAT event that has been linked to PQ scores (9th November 2011), it is suggested that this is related to changes mentioned during the Six Month Change Interview, such as 'calmed down' and 'listening more'. However, the change of 'calmed down' was specifically related by the patient to stopping cannabis during this period (Table C1) and so it is unlikely to be related to the HAT on 9th November 2011. It has also been shown that the outcome of 'listening more' was not sustained by Mr X (sceptic rebuttal point 3).

The affirmative argument also links this HAT event of 9th November 2011 with changes between the pre-therapy measurement and the mean PQ scores for: 'Angry and aggressive'; 'Paranoid and worried all the time'; 'Feel people are always lying to me'; and 'Not managing relationships'. However, the sceptic argument (point 2) has already shown how the initial pre-therapy score may be artificially inflated.

Likewise, the PQ scores do not always coincide with the qualitative evidence. For instance, in terms of 'Angry and aggressive' the PQ reveals an improvement in functioning but other sources of information suggest sustained issues with this item: 'continues to have outbursts of anger' (Therapist 3 Month Progress Report) or 'has been texting very aggressive messages' (Therapist Process Notes 10th October 2012). This material supports the notion that therapeutic process did not lead to substantial changes for Mr X.

The second HAT event that the affirmative brief linked to PQ scores occurred on 9th May 2012 and involved the group understanding Mr X's drug use (Table B1). The affirmative argument connects this to a reduction in the PQ for 'I have no support' (Additional Tables). However, as previously stated, this PQ item went from 5 in March to 4 in May when the HAT occurred (a space of two months) but then went back to 5 for both June and July, suggesting that no lasting impact was made by the HAT.

In addition, even if the patient were feeling more supported this can be alternatively explained by his close relationship with his female friend, particularly since Mr X does not attribute this support to the group, as discussed previously (see point 2 'difficulties with retrospective attribution' above). Likewise, any changes in PQ that occurred between March and May could be due to psychobiological

factors since this is the period during which Mr X's Risperdone was increased; the fact that his psychiatrist was willing to do this could also have led to Mr X feeling more generally supported.

In summary, implying that specific events in therapy led to a stable shift in patient problems in terms of the PQ ratings is extremely challenging both for same session shifts and shifts during the following months. The sceptic rebuttal has shown that the evidence for such shifts is insubstantial and has asserted alternative explanations for any changes in the PQ results.

Conclusion

The sceptic rebuttal has examined the affirmative argument in good faith and makes the following assertions:

- The affirmative argument cannot sustain the case for substantial or clear change in Mr X's long standing problems
- The case for retrospective attribution advanced by the affirmative brief is unreliable
- There are no obvious connections between patient outcome and events that occurred during the MBT program
- No correlations between therapist MBT adherence and PQ ratings have been established
- Therapeutic events cannot be convincingly shown to have led to a stable shift in client patterns.

Therefore, there is insufficient evidence to support the therapy efficacy hypothesis; any changes in Mr X's functioning can be considered to be trivial or negative in nature and competing explanations for apparent patient change must be accepted.

References

Elliot, R., 2002. Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*, 12:1, pp.1-21.

Jacobson, N., S. and Truax, P., 1991. Clinical Significance: a statistical Approach to Defining Meaningful Change in Psychotherapy Research. *Journal of Consulting and Clinical Psychology*, 59:1, pp.12-19.

APPENDIX F
AFFIRMATIVE SUMMARY NARRATIVE

Note: The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

Mr X came to the psychotherapy department and personality disorder service with a long history of chronic problems, all with over 10 years duration. After one year of MBT the affirmative brief found enough evidence to suggest that Mr X changed substantially and that the changes were substantially due to the effects of MBT. The quantitative data (Tables A1, A2 and A3 and Figure A1) show unequivocally a reliable and sustainable change. At the same time, Mr X has plausibly attributed the changes to the therapy program. The judgement of both the therapist and the consultant also point to the same conclusion. A number of links were established showing the influence of the therapeutic process in the final results. The helpful aspects of therapy were put into four core themes 1) the understanding and supportive attitude of the therapist and group members 2) listening to different perspectives 3) observing similar maladaptive patterns in other group members 4) and being able to talk in confidence to the therapist. These helpful aspects were linked with particular 'mentalizing' interventions from the therapist and 'corrective emotional experiences' during the MBT program that seem to have had some connection with the resulting outcomes. The affirmative brief also attempted to demonstrate that a number of isolated therapeutic 'events' have helped to reduce the severity of the patient's problems.

In summary, out of five pieces of evidence, the affirmative brief found evidence to support the therapy efficacy hypothesis in four of them and in two very strongly and unequivocally. This surpasses Elliott's (2002) suggestions that two pieces of evidence would be enough to support the therapy efficacy hypothesis.

The sceptic brief has raised a number of problems and contradictions in the data, suggesting that the therapy did not cause significant changes and that factors other than therapy were responsible for the changes observed. The affirmative rebuttal, however, was capable of demonstrating that the majority of the sceptic arguments carried little weight and were not able to disconfirm the therapy efficacy hypothesis.

The affirmative brief concluded, following a critical reflection and dialectical process, and having in mind the severity and duration of Mr X's problems, that Mr X changed substantially during the first year of MBT and that the changes were substantially due to the therapy program.

APPENDIX G

SCEPTIC SUMMARY NARRATIVE

Note: The following arguments do not necessarily represent the views of the author but are presented in good faith to facilitate the analysis of the data through the proposition of alternative views.

The affirmative case has sought to highlight that Mr X changed substantially during the MBT program and that the therapy was the cause of this change. However, the sceptic argument and rebuttal have demonstrated convincingly that Mr X did not change meaningfully during the therapy and that any alterations that were present were trivial in nature. In addition, competing evidence for any changes that did occur has been shown to have a potentially greater explanatory power than that gained from considering the MBT program alone.

The sceptic case has illustrated that Mr X's changes were not substantial. This conclusion is confirmed by various sources of evidence: the quantitative data persists in the clinical range following one year of treatment; Mr X returned to cannabis use at his pre-therapy levels; qualitative self-report statements made by Mr X suggest that he has reverted back to his pre-therapy functioning; and the Therapist 12 Month Progress Report argues the patient remains unstable and continually sabotages his own progress. Therefore, any changes made by Mr X must be prudently viewed as insubstantial in nature at this point in time.

In addition, there are a number of important competing explanations for possible patient change. Mr X had taken drugs the night before the One Year Change Interview and the sceptic argument has shown that he presented a 'false front' and had difficulty making sense of his true feelings; both of these issues confound the qualitative data. Mr X expected to change and also engaged in self-correction processes (such as stopping alcohol prior to the beginning of the MBT program).

These helpful strategies were additionally aided by extra-therapy events that occurred in the patient's life during the course of therapy, such as his employment and his examination of his relationship with his female friend. Psychobiological factors and research effects have also been demonstrated to be interwoven with the therapeutic program, eluding any attempt to isolate causation. Taken together, these factors suggest that the MBT program cannot be readily viewed as the source of any change in Mr X.

Supporting this assertion, the sceptic argument and rebuttal have shown how any changes in Mr X's PQ scores can be explained by extra-therapy events, questioning the ability of the affirmative case to pinpoint the MBT program as the catalyst for patient change.

Following this, the affirmative researcher is unable to conclusively demonstrate that Mr X changed substantially during therapy and that the MBT program was the cause of this change; the therapy efficacy hypothesis cannot be assuredly accepted.

APPENDIX H
INTERVIEW TRANSCRIPTS

(This section was removed to protect the participant identity – sections of the interview can be found in Tables C3 – C12 and also throughout the analysis)

APPENDIX I
ADDITIONAL TABLES

Monthly PQ ratings for each item

Item	Pre-therapy (Sep 11)	09 November 2011	14 December 2011	11 January 2012	16 January 2012	15 February 2012	12 March 2012	09 May 2012	11 June 2012	04 July 2012	07 September 2012	26 September 2012
1. Angry and aggressive	7	5	4	6	4	6	7	4	5	4	4	5
2. Paranoid and worry all the time	7	6	6	6	5	5	6	5	4	4	3	6
3. Over analysing and complicating	7	6	6	6	5	6	6	5	5	5	3	6
4. Feel people are always lying to me	7	7	6	4	4	6	5	5	5	5	4	6
5. I have no support	6	3	4	4	4	6	5	4	5	5	3	3
6. Not managing relationships	7	1	4	1	5	4	4	3	6	4	4	3
7. Violent, erratic, mood swings	7	7	6	5	4	6	7	4	6	5	4	6
8. Having a life	6	2	4	5	4	5	7	3	1	5	4	4
9. Impulsive (texting)	7	7	5	3	4	1	1	1	1	2	1	5
10. Always frustrated	7	4	6	5	6	6	6	4	6	5	2	3

Mean Scores on the Personal Questionnaire

Session	Pre-	2	3	4	5	6	8	9	10	12
Date	therapy	09/11/11	14/12/11	Ave	15/02/12	12/03/12	09/05/12	11.06.12	4.07.12	Ave
	(01/09/11)			11.01.12						07.09.12
				and						and
				16.01.12						26.09.12
Mean PQ	6.8	4.8	4.5	4.8	5.4	5.4	3.8	4.4	4.4	3.9

APPENDIX J
ADJUDICATION

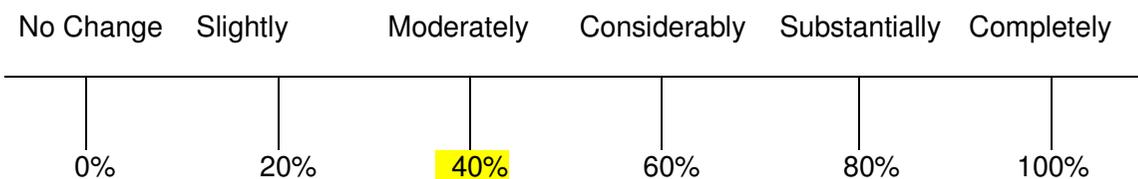
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JUDGE G

Completing the adjudication process

Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.) In answering the rest of the questions, please use whatever space you need in order to give a full response.

1a. To what extent do you think this patient *changed* over the course one-year of therapy?



1b. How certain are you?**1c. Please describe the basis for your judgement:**

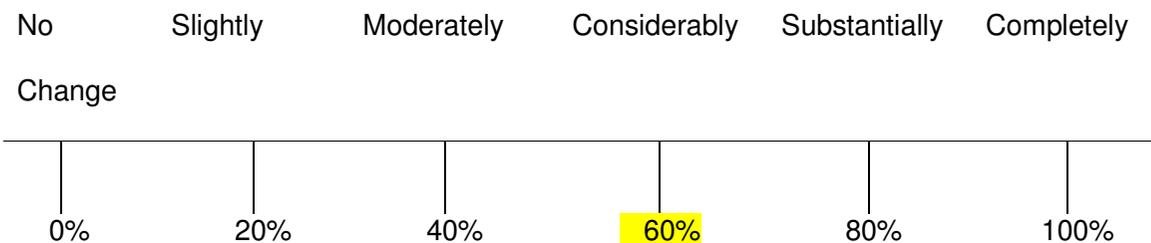
- The global reliable change in quantitative measures provide strong evidence for change. While the participant did not move to below clinical cut-off for any measures, the positive change in scores across all measures was substantial and significant.
- No quantitative measures showed any worsening of client problems
- Further to this, the client's identified problems had been present for more than ten years, so changes of such weight over the one year period of therapy are certainly of importance
- There are some potential statistical issues with the quantitative data which resulted in my judgement of 80% certainty of the change rather than 100%, but the positive change on a number of outcome measures seems to provide valid justification for the claim of global reliable change.
- Change is rated as only moderate (40%) as there are some aspects that appear to not have changed for the client, or that have reverted to a similar position as they were a baseline, for instance, his cannabis use. On this it would seem the client had not

sustained change in the one year period. However, the difficulty in maintaining such a change should not be under-estimated, and perhaps of greater value here, is the individual's awareness of the problem and the effort that may be required in eventually achieving abstinence. From the qualitative data, it would seem that this aspect of his understanding and self-awareness had certainly changed significantly, and this is an essential pre-requisite to behavioural change.

1d. How much did you weigh (take into consideration) the following case elements in evaluating *patient change* over the course of therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data				X		
b. Quantitative outcome data					X	
c. Change Interview transcript (including qualitative coding)					X	
d. HAT data				X		
e. Affirmative Case					X	
f. Sceptic Case				X		
g. Affirmative Rebuttal/Closing argument					X	
h. Sceptic Rebuttal/Closing argument					X	

i. Other						
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2a. To what extent do you think that the patient's changes were due to the therapy?**2b. How certain are you?****2c. Please describe the basis for your judgement:**

- The client's attributions for the reported changes are important here – in the interviews, he describes how therapy has helped him to change and manage particular problems that he described at the start. These are idiosyncratic and specific to him – e.g. being heard

by the group, gaining increased understanding for his relationship with his best friend – and there is a clear link made by the participant as to how therapy helped with these things.

- Furthermore, the change record ratings show that the client viewed all of the changes as unlikely to have occurred without therapy. While these changes may have been somewhat expected in some cases, the argument for expectancy artefacts does not seem sufficient to justify the strong statements the client makes as to how he perceives the changes.
- The client rates most Helpful events on the HAT forms as 8/9 and identifies particular realisations for him that occurred as a result of hearing other group members views; he also clearly identified the support from the group and the trust given by the therapist as particularly helpful to him, and this seems to be suitably correlated with particular event-shifts on the PQ ratings in following sessions.
- The difficulties identified with process-outcome mapping and specific event –shift sequences are understandable in the context of the therapeutic process where client changes are not always connected to therapeutic processes in a linear fashion. Research literature has identified the difficulty of such correlations, and pointed to the lack of a dose-response relationship in terms of improvement. It may be much more likely that long-term participation in the group process (and a continued attendance by the participant despite difficulties at times) would bring about changes gradually and in a non-linear manner. Hence, the qualitative statements by the participant as to how they understood the changes seem to carry more importance.
- Additionally, the severity and length of the participant's difficulties would make it unrealistic to expect that changes would have dropped below clinical cut-off or that problems (such as interpersonal relationships) could be easily attributed to singular therapy events, rather than the entire therapeutic encounter.

- While extra-therapy events did occur (finding work, improvements in relationships), it seems unlikely that these changes were unrelated to the therapy process, and even less likely that they could solely account for the changes observed/reported without therapy having any effect. The qualitative data (participant interview and therapist notes taken together) would suggest that it is more likely that the positive experience of the therapy group, the increased awareness the participant developed as a result, made it possible for these extra-therapy events to occur.

2d. How much did you weigh (take into consideration) the following case elements in evaluating the extent to which client change was due to therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data				X		
b. Quantitative outcome data				X		
c. Change Interview transcript (including qualitative coding)						X
d. HAT data					X	
e. Affirmative Case					X	
f. Sceptic Case				X		

g. Affirmative Rebuttal/Closing argument					X	
h. Sceptic Rebuttal/Closing argument					X	
i. Other						

2. Which therapy processes (mediator factors) do you feel were helpful to the client?

- The support provided by the group appears to have been very important for the client. A number of helpful aspects on the HAT forms and statements made in the change interview show that the client gained a great deal of self-awareness from being able to share with the group the difficulties he was having.
- The experience of hearing other people's views about his difficulties within this supportive environment also seem to have been very helpful to the participant in coming to a realisation about his negative behaviours and difficult interpersonal relationships.
- Increased resilience and willing to persevere with difficult changes appear more likely since the group shows empathy and understanding (e.g. not quitting cannabis and cigarettes all at once), and this seems to give the participant a greater understanding and compassion for himself and his problems
- Of particular note, the therapist's and the group's commitment to showing Mr X that he is trusted and that people do not think he is lying, seems to have an impact on his willingness to attend, his ability to share his feelings in the group, and this has subsequent positive impacts in his behaviours outside the group.
- It is notable that as a result of the above therapeutic experiences, his most improved scores on the PQ at the end of 12 months relate to his problems of "having no support" and "not managing relationships"

4. Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled him to make best use of her therapy?

- Readiness to change – Mr X shows a cycle through the trans-theoretical model of change, and it seems that his willingness to take action (e.g. attend the group, make the most of the experience, and quit cannabis) are facilitated by his increased awareness of the problem (gained through the therapy experience) and the subsequent willingness to make some changes.
- Background information indicates a resilience and resolve on the part of the client – raising his son as a single parent, stopping and maintaining abstinence from alcohol, and a previous period of quitting cannabis. The severity of his difficulties would suggest that achieving significant changes on his own may be too difficult, but having this personal strength and self-directedness would appear to facilitate the changes then occurring in therapy.
- Perseverance – it is evident that the client finds his difficulties very problematic at times, and he can feel hopeless about these at times. However, despite relapses in his behavioural and interpersonal changes, he nevertheless returns to a position of wanting to make changes, and is able to gain greater awareness into the difficulties involved.

* adapted with permission from “unpublished research procedure, Counseling Unit, University of Strathclyde, Glasgow, UK”

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JUDGE H

Completing the adjudication process

Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.) In answering the rest of the questions, please use whatever space you need in order to give a full response.

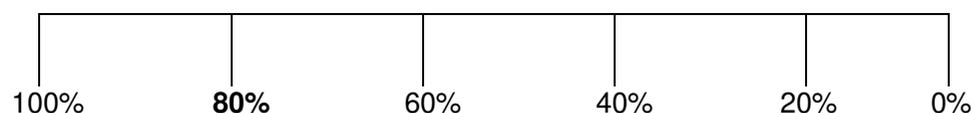
1a. To what extent do you think this patient *changed* over the course one-year of therapy?

No Slightly **Moderately** Considerably Substantially Completely

Change



1b. How certain are you?



1c. Please describe the basis for your judgement:

He changed but not in all domains. More are needed.

Nevertheless, he also presents behaviours of some resistance and I'm not certain that he was psychologically prepared to change more than he did.

I'm certain 80% because he had to control the medication and the drugs and alcohol abuse, but he also scored some changes in the scales.

This showed me that he feels different but with resistances in changing behaviour.

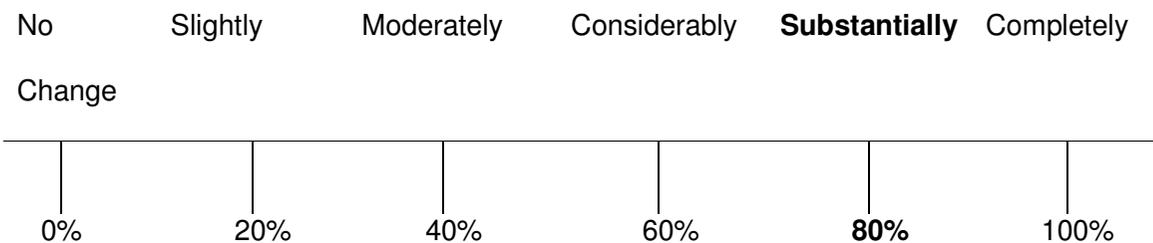
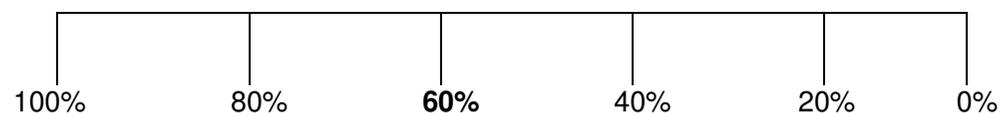
He scored less clinical distress at one year (CORE-OM changes $p < 0.05$), in spite of a possible artefact at pre-therapy moment. Other interpretations can be taken from these observations: He learned to neglect his issues or there are movements within the patient towards a release cannabis (the patients may feel less distressed to give up cannabis).

Social and family are important and patient is dependent on these, however this will always be present since this patient has an addition – he depends on cannabis.

1d. How much did you weigh (take into consideration) the following case elements in evaluating *patient change* over the course of therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data					X	
b. Quantitative outcome data					X	
c. Change Interview transcript (including qualitative coding)					X	
d. HAT data				X		
e. Affirmative Case				X		
f. Sceptic Case				X		
g. Affirmative Rebuttal/Closing argument					X	
h. Sceptic Rebuttal/Closing argument					X	

i. Other (Summary)			X			
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2a. To what extent do you think that the patient's changes were due to the therapy?**2b. How certain are you?****2c. Please describe the basis for your judgement:**

He did not change due to medication. From his history, he tried to control the medication and stopped some of that in spite of the importance in taking it.

He tried to control therapy. This made him feel less clinically distressed and he could think on his behaviour and possible changes (forward of backward)

2d. How much did you weigh (take into consideration) the following case elements in evaluating the extent to which client change was due to therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data			X			
b. Quantitative outcome data					X	
c. Change Interview transcript (including qualitative coding)					X	
d. HAT data					X	
e. Affirmative Case				X		
f. Sceptic Case				X		
g. Affirmative Rebuttal/Closing argument					X	

h. Sceptic Rebuttal/Closing argument					X	
i. Other (Summary)			X			

3. Which therapy processes (mediator factors) do you feel were helpful to the client?

The feedback from other elements from his group could be percept as “someone” taking care of him. And this seems to be important for the client.

4. Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled him to make best use of her therapy?

His ability to ear others and rely on them, in spite of his “paranoid” traits.

* adapted with permission from “unpublished research procedure, Counseling Unit, University of Strathclyde, Glasgow, UK”

HSCED Instructions for Judges
(Adapted Version, October 2012)*

JUDGE I

Completing the adjudication process

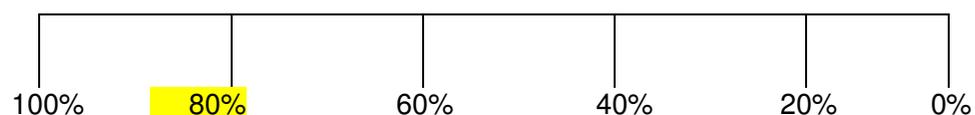
Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.) In answering the rest of the questions, please use whatever space you need in order to give a full response.

1a. To what extent do you think this patient *changed* over the course one-year of therapy?

No Slightly Moderately Considerably **Substantially** Completely

Change



1b. How certain are you?**1c. Please describe the basis for your judgement:**

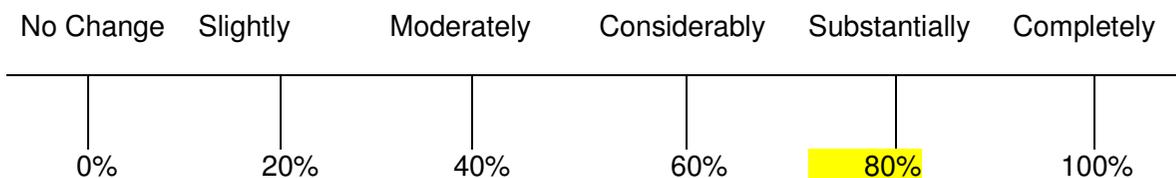
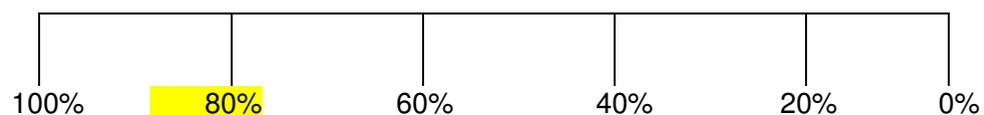
The patient made several changes – the more obvious two being that he returned to work, after struggling to maintain a job because of his anxiety whenever he was out of the house. He also previously struggled with forming and maintaining relationships and reported being paranoid, yet he managed to establish a strong working alliance, use the group as a support system (both of which require trust) and start a romantic relationship.

The patient also made “psychological” changes – he has increased awareness and reflexivity into his own process.

1d. How much did you weigh (take into consideration) the following case elements in evaluating *patient change* over the course of therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data						+
b. Quantitative outcome data					+	
c. Change Interview transcript (including qualitative coding)					+	
d. HAT data					+	
e. Affirmative Case					+	
f. Sceptic Case					+	
g. Affirmative Rebuttal/Closing argument					+	

h. Sceptic Rebuttal/Closing argument					+	
i. Other – (Personal views on what is patient change)					+	

2a. To what extent do you think that the patient's changes were due to the therapy?**2b. How certain are you?****2c. Please describe the basis for your judgement:**

It is impossible to accurately quantify to what extent the patient changed, and even more so to find a direct "causal link" with any one factor. The effect of the medication, as well as other external factors is unknown. For example, although gaining employment may have led to changes, this is a change in itself that may have been facilitated by therapy. Furthermore, given the duration of the patient's problems, and

that no changes were made in the 20 years *prior* to therapy, it seems highly likely that changes that occurred during the one year of therapy are likely to be due to this.

The patient himself attributes the changes to therapy.

The therapeutic relationship is highly regarded as being an important factor in facilitating change (Clarkson, 1995). It is interesting to note that the patient made changes specifically within the realm of relationships, therefore it seems likely that therapy may have served as safe environment from which he could learn and apply this to new settings.

Although the patient did not change on *all* measures (such as substance abuse), this does not negate the effects of therapy on other aspects. Furthermore, the main focus of therapy was the BPD traits, and not the substance abuse.

2d. How much did you weigh (take into consideration) the following case elements in evaluating the extent to which client change was due to therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data						+
b. Quantitative outcome data					+	
c. Change Interview transcript (including qualitative coding)					+	
d. HAT data					+	
e. Affirmative Case					+	
f. Sceptic Case					+	
g. Affirmative Rebuttal/Closing argument					+	

h. Sceptic Rebuttal/Closing argument					+	
i. Other						

3. Which therapy processes (mediator factors) do you feel were helpful to the client?

Building trust

- Structure of therapy (routine – seems relevant as patient was struggling with getting out of the house. Therapy would have been an opportunity to face this anxiety and learn that he could endure being out of the house for a length of time without getting panic attacks)
- Receiving feedback
- Opportunity to reflect

4. Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled him to make best use of her therapy?

- Willingness to change (Motivated)
- Perseverant
- Honest (for example, would be open about being under the influence of substances)

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