RESEARCH ARTICLE

WILEY

Pedagogical stance in mentalization-based treatment

Espen J. Folmo[1] ⬤ | Tuva Langjord[2,3] | Nini C. S. Myhrvold[4] |
Erik Stänicke[3] | Majse Lind[5] | Elfrida H. Kvarstein[2,6]

[1]Department for National and Regional Functions, Division of Mental Health & Addiction, Norwegian National Advisory Unit on Personality Psychiatry, Section for Personality Psychiatry & Specialized Treatments, Oslo University Hospital, Oslo, Norway

[2]Department for National and Regional Functions, Division of Mental Health & Addiction, Section for Personality Psychiatry & Specialized Treatments, Oslo University Hospital, Oslo, Norway

[3]Department of Psychology, University of Oslo, Oslo, Norway

[4]Tunsberg Medical School, Tønsberg, Norway

[5]Department of Psychology, University of Florida, Gainesville, Florida, United States

[6]Adult Psychiatry Unit, Institute of Clinical Medicine, University of Oslo, Oslo, Norway

Correspondence
Espen J. Folmo, Department for National and Regional Functions, Division of Mental Health & Addiction, Norwegian National Advisory Unit on Personality Psychiatry, Section for Personality Psychiatry & Specialized Treatments, Oslo University Hospital, Ullevaal, PO Box 4956 Nydalen, 0424 Oslo, Norway.
Email: espenask@gmail.com;
espfol@ous-hf.no

Abstract

Background: A common aspect of evidence-based treatments for people with borderline personality disorder (BPD) is pedagogical interventions and formats. In mentalization-based treatment (MBT) the introductory course has a clear pedagogical format, but a pedagogical stance is not otherwise defined.

Methods: Treatment integrity was quantitatively assessed in a sample of 346 individual MBT sessions. Nine group sessions and 24 individual MBT sessions were qualitatively subjected to interpretative phenomenological analysis (IPA).

Results: The dominating intervention type was MBT Item 16— therapist checking own understanding (31% of the interventions). IPA unveiled the following: (1) a pervasive, but hidden/ implicit psychopedagogical agenda, (2) psychopedagogical content seemed precious for the patients, and (3) four tentative strategies for pedagogical interventions in MBT (a) independent reasoning; (b) epistemic trust; (c) mental flexibility; and (d) application of verified insights, knowledge, or strategies.

Conclusion: Development and clarification of the pedagogical stance in MBT could further improve the quality of therapists' interventions.

KEYWORDS

borderline personality disorder, clinical practice guidelines, cultural competence, education and training, evidence-based psychotherapy

1 | INTRODUCTION

Borderline personality disorder (BPD) can be characterized by an imbalance between interpersonal dependency and distrust, developmentally impeded acquisition of adaptive social skills, and unstable mentalizing capacities. Poorly functioning patients with BPD have traditionally been considered difficult to treat (Bo et al., 2017; Leichsenring et al., 2011; Luyten et al., 2020). Fortunately, several promising evidence-based treatments have been developed, with mentalization-based treatment (MBT; Karterud et al., 2020) among the four most prevalent methods (Ellison, 2020).

Fonagy and his colleagues (2015) have redefined the term "epistemic" from Aristotle (*epistémé*; Schwartz, 2011), taking it to denote the trust necessary for social communication. The generation of a process enabling epistemic trust—social learning—has been posited as crucial to the effectiveness of MBT for patients with BPD (Sharp et al., 2020). Epistemic trust seems part of the alliance in MBT (Folmo et al., 2019), and MBT therapies with good outcomes have been characterized by a positive development of therapeutic alliance (Folmo et al., 2020). Interestingly, enhancing patients' understanding of core aspects of personality disorder (psychoeducation) has also been linked to positive outcomes for BPD patients (Zanarini et al., 2018). It seems that the epistemic channel (Fonagy et al., 2015) may also be opened/stimulated by offering explicit knowledge. Consequently, integrating a "pedagogical therapeutic stance"—understood as an attempt to share knowledge—as a general therapist intervention in MBT, may be seen as a way to actively promote clinical change (MBT; Karterud et al., 2020).

Pedagogy can be described as the act of transferring defined learning objectives to demarcated groups (Imsen, 2011). A primary goal is to contribute to an increased reflective practice (Imsen, 2011). Applied to the MBT therapist, a pedagogical stance might imply explicit guidance on emotional and mentalizing skills. For the patient, the process should ideally result in more reflective management of emotionally complex situations.

This study investigated the use of pedagogical interventions or a pedagogical stance in MBT. Style of interventions in a large sample of MBT sessions was assessed quantitatively (346 sessions) while qualitative analyses explored the therapeutic stance (33 sessions).

1.1 | Epistemic trust at the core of MBT

When the "epistemic highway" (Fonagy et al., 2015) is opened, it facilitates accurate and flexible mentalizing to become fully available to the individual (Luyten et al., 2020, p. 91). Epistemic vigilance, freezing, or petrification is considered evolutionary protection from misinformation, whether motivated by ignorance or the intention to deceive (Sperber et al., 2010), and is, according to Fonagy et al., typical for BPD patients (Campbell et al., 2021). Luyten et al. (2020) have "redefined personality disorder as a disorder of social communication resulting in marked impairments in the sense of self-coherence and self-continuity because the individual is unable to benefit from the organizing influence of social communication and social recalibration of the mind in particular" (p. 91).

Fonagy et al. (2019) highlight the importance of the "re-emergence of social learning," which they claim is "the way in which any effective treatment is embedded in metacognitive processes about the self in relation to perceptual social reality" (p. 94). Luyten et al. (2020) state that the view regarding epistemic trust comes closest to those of Kruglanski and colleagues who argue that "epistemic freezing refers to a tendency to defend existing knowledge structures even when they are incorrect or misleading" (p. 91). However, this has important implications for the re-education seen as important in effective treatments for BPD (Spinhoven et al., 2007). According to the theory of mentalization, the establishment of epistemic trust between the teacher and the learner is essential for communication to be accepted as meaningful and relevant (Luyten et al., 2020; Wilson & Sperber, 2012). Interestingly, in a qualitative MBT study, BPD patients expressed high satisfaction with the initial psychoeducational group (Ditlefsen et al., 2020). Patients emphasized an expanded understanding and vocabulary for mental states, and that positive learning experiences facilitated their hope and trust in treatment.

1.2 | Designing a pedagogical stance

Bateman et al. (2018) propose three Communication Systems central for amending epistemic trust: Communication System 1: the teaching and learning of content; Communication System 2: the re-emergence of robust mentalizing; and Communication System 3: the re-emergence of social learning. In describing these three "aspects of the communication process that unfold in effective psychotherapeutic interventions—the way in which any effective treatment is embedded in metacognitive processes about the self in relation to perceptual social reality is explained" (Fonagy et al., 2019, p. 94). However, there is little guidance as to how to address System 1 in MBT and little knowledge about MBT processes that might facilitate such development. Sharp et al. (2020) indeed, argue that the proliferation of MBT "lags behind that of more skills-based therapies" (e.g., dialectical behavior therapy [DBT] and schema therapy [ST]) "due to a lack of concrete operationalization of its key components" (p. 1). One step in the direction of better operationalization may be to seek further understanding of how a pedagogical stance can be integrated as a dynamic therapeutic attitude within (MBT) therapies.

All traditions of psychotherapy contain some degree of psychoeducation/teaching of content, and it is generally considered important that the therapist clarifies the treatment model (Wampold & Imel, 2015). In the field of pedagogy, a "didactic stance" and an "affective—relational stance" are defined as the two main categories of pedagogical stance (D'Errico et al., 2012, p. 929). In both DBT, ST, and preparatory phases of MBT, explicit psychoeducational interventions are integrated. However, to stimulate patients' development, skills, and mentalization, therapists may more implicitly, direct patients towards the insights of social knowledge. The application of indirect pedagogical techniques may be reflective of a general pedagogical therapeutic stance.

The therapeutic relationship aims to enable the patient to develop other learning relationships by acquiring a sense of how to trust (e.g., recognize) another person as a source of significant social information (Fonagy et al., 2019; Stänicke & Killingmo, 2013), that is, System 3. Basically, the capacity to trust socially transmitted information may be rooted in developmental experiences such as attachment security, childhood adversity, and the associated capacity to reflect on mental states (i.e., mentalizing) (Campbell et al., 2021, p. 2). Hence, epistemic "credulity pertains to a pronounced lack of vigilance and discrimination, signaling a general lack of clarity about one's own position and resulting in vulnerability to misinformation and potential risk of exploitation" (Campbell et al., 2021, p. 3). Consequently, mindful use of pedagogical interventions in BPD treatments seems a crucial element of treatment.

Our focus on a pedagogical stance concerns primarily the explicit communication of common sense, cultural and social knowledge, rather than more implicit conveyance, the tacit knowledge (Polanyi, 1966). The content of cultural knowledge transmission will depend on the psychotherapeutic method. In MBT, a framework exists for the initial part of the MBT program—the introductory MBT group (MBT-I). Learning processes are a central aspect of psychotherapy. Gaining explicit knowledge through psychoeducation may be experienced as acquiring new, or more valid building blocks for the mind and thus contribute to better personality functioning. For instance in DBT, another evidence-based treatment for BPD, psychopedagogical interventions constitute the core of labeling the patients' mental states, where the therapist takes an expert view (Garred & Gough, 2021; Linehan, 1993). In contrast, MBT advocates a not-knowing, reflective therapeutic stance. A not-knowing stance is indicated when fostering mentalization, but the absence of concrete knowledge may indirectly influence the capacity to mentalize. Mentalization seems more related to the process of elaborating, combining, digesting, judging, transposing, and implementing than learning explicit/concrete information. The psychopedagogic interventions in MBT would typically concern information about attachment, emotions, and social rules.

A pedagogical stance has recently been suggested as an MBT intervention (i.e., separate adherence item; Karterud et al., 2020). However, to the best of our knowledge, we have not found studies investigating the use of specific MBT interventions in clinical practice.

The primary aim of this study was to explore the use of pedagogical interventions or a pedagogical stance in MBT applying a mixed-methods design: (1) with a quantitative approach, we aimed to investigate the use of different MBT interventions in a large sample of MBT adherence/quality ratings, and (2) with a qualitative approach,

we aimed to identify if and how pedagogical interventions or a pedagogical stance could be reflected in MBT therapists' style of intervention, and (3) suggest aims for a pedagogical stance in MBT.

2 | METHODS

2.1 | The quantitative analyses

2.1.1 | Material

The quantitative material consisted of treatment integrity scores from 346 individual MBT sessions collected in the period 2014–2020 as part of a regular supervisory service for local MBT teams across Norway (Quality Lab for Psychotherapy, Norwegian National Advisory Unit on Personality Psychiatry, Oslo University Hospital, http://www.psykoterapilab.no).

For this purpose, local MBT programs deliver video recordings of therapy sessions to the lab. The lab does not receive any other patient information.

2.1.2 | Evaluation of MBT in session interventions

The integrity evaluation was based on the adherence and competence scales for individuals (Adherence and Competence Scale for Individual MBT [MBT-I-ACS]; Karterud et al., 2013) and group versions of MBT (Folmo et al., 2017).

The 17-item MBT-I-ACS identify the occurrence and quality of 17 separate MBT interventions (see Table 1). The item content and rating procedures are described by Karterud and Bateman (2010). A reliability study by Karterud et al. (2013) reported a G coefficient (G-study) of 0.84 and 0.88 with seven raters for adherence and competence, respectively. In the current material, therapy sessions were rated by one rater (45%), two raters (42%), or up to five raters (13%). The adherence and competence ratings did not have missing data, and the raters scored all items for all videos assessed. Former publications report the scale used as documentation of model fidelity in treatment studies (e.g., Beck et al., 2020; Kvarstein et al., 2019), and in process studies relating therapists' interventions to patient outcomes (Moller et al., 2017).

2.1.3 | Procedures for scoring adherence and quality

Adherence ratings represent counts of the number of interventions judged to comply with the MBT-I-ACS items, while competence/quality is assessed according to a 0–7 Likert scale. After assessing each item, the raters decide on an overall score for each specific therapy session for both adherence and competence/quality. This global assessment is not an exact arithmetic average of the 17 items but is an overall judgment of the total picture, informed by item ratings. Overall ratings of "4" or more indicate that the psychotherapeutic work performed by the therapists fulfills "good enough standards for MBT." For detailed rating procedures, refer to Karterud et al. (2013).

2.1.4 | Statistics

Quantitative analyses explored frequencies and quality of different MBT interventions and differences in occurrence for subgroups with high and low overall scores (cut-off level: 4). Descriptive statistics are reported. Comparison of subgroups was performed by independent sample T tests (continuous data).

TABLE 1 The adherence and competence scale for individual MBT (MBT-I-ACS)

Item # and name	Adherence rating	Notes for "good enough" competence
1. Engagement, interest, and warmth	This item is not rated for adherence	4: The therapist appears genuinely warm and interested. The rater gets the impression that the therapist cares. Several concrete comments communicate this positive attitude
2. Exploration, curiosity, and a not-knowing stance		4: The therapist poses appropriate questions designed to promote exploration of the patient's and others' mental states, motives, and affects and communicate a genuine interest in finding out more about them
3. Challenging unwarranted beliefs		4: The therapist confronts and challenges unwarranted opinions about oneself or others in an appropriate manner
4. Adaptation to mentalizing capacity	This item is not rated for adherence	4: The therapist seems to have adapted to the patient's mentalizing level and the interventions are for the most part short, concise, and unpretentious
5. Regulation of arousal	This item is not rated for adherence	4: The therapist plays an active role in terms of maintaining emotional arousal at an optimal level (not too high so that the patient loses his or her ability to mentalize; not too low so that the session becomes meaningless emotionally)
6. Stimulating mentalization through the process	This item is not rated for adherence	4: The aim of the interventions clearly seems to be to stimulate the mentalizing of experiences of self and others in an ongoing process and is less concerned about content and interpretation of content to promote insight
7. Acknowledging positive mentalizing		4: The therapist identifies and explores good mentalization, and this is accompanied by approving words or judicious praise
8. Pretend mode	This item is not rated for adherence	4: The therapist identifies pretend mode and intervenes to improve mentalizing capacity
9. Psychic equivalence		4: The therapist identifies psychic equivalence functioning and intervenes to improve mentalizing capacity
10. Affect focus		4: The interventions focus primarily on affects more than on behavior. The attention is directed at affects as they are expressed in the here and now, particularly in terms of the relationship between patient and therapist
11. Affect and interpersonal events		4: The therapist connects emotions and feelings to recent or immediate interpersonal events
12. Stop and rewind		4: The therapist identifies at least one incident in which the patient reacts in a maladaptive way to an interpersonal event, then tries to slow down the pace and find out about the incident step-by-step

TABLE 1 (Continued)

Item # and name	Adherence rating	Notes for "good enough" competence
13. Validation of emotional reactions		4: The therapist expresses a normative view on the warranted nature of the patient's emotional reaction(s) after these are sufficiently investigated and understood
14. Transference and the relation to the therapist		4: The therapist comments on and attempts to explore—together with the patient—how the patient relates to the therapist during the session and stimulates reflections on alternative perspectives whenever appropriate
15. Use of countertransference		4: The therapist actively utilizes his/her own feelings and thoughts about the relationship to the patient and attempts by this to stimulate an exploration of the relationship between them
16. Monitoring own understanding and correcting misunderstanding		4: The therapist checks out his/her understanding of the patient's state of mind and to what extent this corresponds with the patient's understanding. Then he/she lets his/her own understanding be influenced by the patient's understanding and openly admits to any misunderstanding whenever they occur
17. Integrating experiences from concurrent group therapy		4: The therapist stimulates exploration of the patient's experiences from the group therapy sessions and helps to integrate the material so that the treatment as a whole is coherent

Note: The MBT-I-ACS with anchor points (Level 4 rating). Adherence and competence are rated on a scale from 0 to 7, and the rater's basic assumption when grading competence should be that the therapist is average (score of 4).

Abbreviation: MBT-I-ACS, Adherence and Competence Scale for Individual mentalization-based treatment.

2.1.5 | The qualitative analyses

The initial scoring of therapy sessions (346 MBT-I-ACS ratings) indicated that the MBT intervention concerning the therapist checking and/or correcting own understanding (Item 16; Karterud et al., 2013) was especially frequent. Long sequences scored as Item 16 seemed to also reflect an attempt of conveying the therapist's knowledge and/or own understanding (e.g., communicate common-sense knowledge or demonstrate good mentalizing). These initial observations raised several questions and hypotheses well-suited for an in-depth qualitative analysis.

2.1.6 | Material

As we were searching for an unspecified pedagogical intervention, we included all available transcribed MBT sessions in our IPA analysis, from altogether 9 MBT group sessions and 24 MBT individual sessions. The sessions were collected in the period 2014–2020 and included MBT sessions from Oslo University Hospital. Sessions were transcribed and translated by the first author. The anonymized transcripts were part of other research projects (Folmo et al., 2017, 2019). The data material in the qualitative analysis included only anonymized transcripts of MBT sessions (altered, anonymized personal data, i.e., names of friends and relatives, workplaces, toponyms). There was no additional specific information on the individual patient or therapist characteristics (apart from gender) for each scored session.

2.1.7 | The treatment context

The participating MBT unit was an outpatient clinic on a specialist mental health service level for poorly functioning patients aged 18–30 years with a diagnose or subthreshold diagnosis of BPD. Sociodemographic and diagnostic characteristics of patients admitted to this MBT program, in general, are presented in a former publication (Kvarstein et al., 2015).

2.1.8 | Treatment

The MBT unit was an outpatient clinic on a specialist mental health service level. The MBT program had three components: (1) individual therapy, (2) group therapy, and (3) psychoeducational group (12 times at the onset of MBT). The unit aimed to provide MBT in accordance with the available MBT manuals in the Norwegian language (Karterud, 2011, 2012; Karterud & Bateman, 2010). The first year included weekly sessions of individual and group therapy and a psychoeducational group (12 sessions). Frequencies of individual therapy were gradually reduced in the second and third years, while group sessions continued throughout treatment. Treatment had an upper time limitation of 36 months. All groups were slow-open (i.e., as patients terminated treatment and left the MBT group, new group members were included). For a detailed description of the program and the patients, see Kvarstein et al. (2019).

2.1.9 | Therapists

In the period of data collection, 14 therapists (M age = 53 years, SD = 10.4 years, range 27–69 years, 57% females), all regular employees at the MBT unit, participated with video-recorded therapy sessions from the regular MBT program—performed as part of their ordinary workload. Twelve were experienced clinicians and group analysts (certified by the *Institute of Group Analysis, Norway*). By profession, therapists included five psychiatrists, one psychiatric resident, two clinical psychologists, one social worker, one student of psychology, one physiotherapist, and three psychiatric nurses. Each group had two therapists (therapist couple). All therapists, except the student and the psychiatric resident, had been trained in MBT when the department changed from delivering psychodynamic group-based psychotherapy in a day hospital treatment format to an outpatient MBT program. All therapists in the MBT program attended weekly, 45-min video-based supervision groups for MBT individual and 2MBT group.

2.1.10 | Treatment integrity

For the 24 individual MBT sessions, overall quality was 4.7 (SD = 1.1), and adherence 5.2 (SD = 1.1). Item 16 ("Monitoring own understanding and correcting misunderstanding") accounted for 33%, and Item 2 ("Exploration, curiosity and a not-knowing stance") for 19%, of the interventions. For the nine group sessions, overall adherence was six and quality was five.

2.1.11 | Qualitative methods—revised version of interpretative phenomenological analysis (IPA)

The 33 sessions were analyzed by a revised framework provided by IPA (Eatough & Smith, 2008; Smith et al., 2009; Walker, 2018). This adoption allows us to examine therapy transcripts unlike the more conventional use of interview material in IPA.

IPA has rapidly become one of the better-known and most used qualitative methodologies in psychology, employed in a number of papers in clinical and counseling psychology (e.g., Ostlie et al., 2018), and is specifically relevant/suited for building theories. According to IPA, without a standpoint, one would not be able to find meaning in what one examines. Consequently, concepts such as reliability and validity are replaced with reflexivity/transparency (e.g., Morken et al., 2019). IPA allows researchers to try to inhabit the lived experience of the participants. The method was therefore appropriate in the current study—aiming to interpret therapist interventions and patient experience.

The transcripts were searched for relevant excerpts to describe, exemplify, and illuminate macro- and micro-processes where therapists employed pedagogical strategies. Our epistemological stance to the present data is founded in philosophical hermeneutics (Schwandt, 2000) in which meaning is negotiated and seen as interpretations colored by current biases and prejudices. The transcripts were analyzed according to the IPA framework (Smith et al., 2009) in six steps:

(1) The first author (E. J. F.) had detailed knowledge of the transcripts, and the 346 rated sessions. From this study, E. J. F. had several hypotheses and biases concerning pedagogical interventions and stance in MBT but attempted to approach the transcripts as unbiased as possible. E. J. F. put forward the following main hypothesis/bias: Pedagogical interventions in MBT were usually absent but also observed in an indirect manner, and typically suboptimal, performed within Item 16—"Monitoring own understanding and correcting misunderstanding."

(2) The next process involved discussing viewpoints with the second (T. L.) and third (N. C. S. M.) author for whom the material was new. At this stage, the 33 MBT sessions were studied in detail by E. J. F., T. L., and N. C. S. M. and included as many different viewpoints as possible (listening perspective, linguistic perspective, psychopedagogical themes, specific content, alliance, etc.). It included reading and rereading the interview transcripts to identify important interventions. At this point, we considered investigating group and individual therapy separately, in case the group members (other patients) also performed pedagogical interventions. However, the results showed that pedagogical interventions were primarily provided by the therapists—in a similar manner in individual and group therapy. The hypothesis/biases put forward by E. J. F. were independently confirmed by T. L. and N. C. S. M. The toolkit at this stage was identification and labeling of major and minor themes. Very few examples of explicit teaching/transmission of mental content were found, but sequences, where the patient(s) agreed based on their "own understanding" brought about by the therapist performing systematic questioning (Item 2 and 16), were frequent. When this occurred, the most skilled therapists were good at validating (Item 13) and acknowledging positive mentalizing (Item 7) in a way that was indirectly pedagogical (not an exclusive pedagogical intervention): It seemed as if most MBT therapists avoided interpretations and sharing of explicit knowledge (psychopedagogical interventions). Further, they typically used Item 16 ("Monitoring understanding") more than "not-knowing stance" (Item 2) when attempting to teach the patient content (i.e., "Communication System 1"; (A. Bateman et al., 2018). Item 16 was the most frequent intervention (around 33%) in the 33 sessions. A pedagogical stance channeled through Item 2 was less directive, and open-ended (e.g., therapist demonstrating curiosity, mental playfulness, and hierarchy of focus), than when expressed through Item 16, which is closer to interpretations.

(3) The first three authors produced a summary table of the themes (instructive/illustrative interventions were identified). We rejected themes that were not well represented. Emergent themes seemed to be that MBT therapists did not perform explicit pedagogical interventions, but rather used long sequences of "Monitoring understanding" (Item 16) and sometimes "Use of countertransference" (Item 15: "Use of countertransference") to convey their knowledge, which (in the best case) seemed to be an implicit pedagogical strategy. Another theme was that pedagogical content, such as references to the psychoeducational MBT teachings (MBT-I), seemed to strengthen the alliance (when performed adequately). From our observations, we identified several instances where pedagogical interventions seemed indicated, but such opportunities were missed.

(4) All authors except the fifth author (M. L.), were engaged in conversations on the construction of a cohesive narrative. At this stage, different theories, and concepts (e.g., alliance, common factors, strategic competence,

MBT, psychoanalytic theory, attachment theory) were used to illuminate the perceived patterns. Several theories were employed, including the use of metaphors (Muran & Digiuseppe, 1990), a listening perspective (Hedges, 1983), mentalizing theory (Fonagy, 2002), object relations theory (Fairbairn, 1954; Guntrip, 1973), theories of learning (Bion, 1994), of pedagogy (D'Errico et al., 2012), and the manuals/theories for different evidence-based treatments for BPD (e.g., A. Bateman & Fonagy, 2016; Beck et al., 2015; Karterud, 2015; Kernberg & Caligor, 1996; Linehan, 2014; Young, 1999; Young et al., 2006).

(5) The three first authors then went back to the transcripts, and read and reread to "inhabit" the therapies from different perspectives, with particular concern about what the patient(s) might be missing, and how pedagogical interventions could have been framed. In the group therapies, we also tried to envision what the therapists could have done to foster epistemic trust between the members. Trying to build bridges of shared knowledge between members, connecting them to a larger tree of knowledge, which is shared across different situations or individuals, seemed potent. In this phase, the three first authors checked again for differences between the group and the individual MBT—that is, to what degree the other group members performed "pedagogical interventions." The transcripts were re-examined to check if the interpretation seemed to fit with the individual cases.

(6) At last, all authors agreed on a coherent narrative of the nature of pedagogical interventions in the observed sessions.

2.2 | Reflexivity

It is important to be transparent about our possible biases in, and process of, interpretations (Finlay & Gough, 2008). The first (E. J. F.) and second (T. L.) authors were most involved in the analyses of transcripts and were joined by the third author (N. C. S. M.) in the subsequent steps of the IPA. The fourth (E. S.), fifth (M. L.), and last (E. H. K.) authors were part of the later analysis and the overall manuscript development. Four of the authors (T. L., N. C. S. M., E. S., and M. L.) are not in the field of MBT, while E. H. K. and E. J. F. have formal MBT training and clinical MBT experience. E. H. K. is also a trained group analyst. E. J. F. also has some training in DBT. E. J. F. has substantial former rating experience from the PROCMAP project headed by Leigh McCullough. E. J. F. was strongly influenced by McCullough, but his psychodynamic orientation is perhaps closest to object relations theory (e.g., Bion, Kohut, Fairbairn, Winnicott, and Guntrip) and Eastern philosophy traditions (especially Buddhism). This would have influenced his preference for a highly open-ended approach (e.g., listening before talking and being nonjudgmental and accepting) with well-timed, and tailored, transference of knowledge. T. L. would have similar preferences. She is a psychodynamic psychologist, and also holds a Master's degree in the literature linking the Buddhist philosopher Nagarjuna, and T. S. Eliot. Hence, she may have preferred a therapeutic style teaching the art of how to learn, rather than the teaching of content. E. S. shares many of the same preferences and is trained as a psychoanalyst, being most interested in the fundamental mechanisms of change in psychotherapy. N. C. S. M. has worked as a social worker with severely traumatized teens and has used MBT in this setting. Her preference is that therapy is tailored (confrontations), but also that the therapist should work with themselves to avoid (acting out) countertransference, she may be biased toward enlightening young minds with educative knowledge. M. L. is a researcher on narrative identity, and her background may have biased her towards viewing therapy as changing core narratives (e.g., autobiographical reasoning). This would imply the teaching of process, not content. Hence, it challenged many of our assumptions that MBT was inhabited by not promoting pedagogical interventions (in the model adhered to in the observed sessions).

2.3 | Ethics

Qualitative material: All patients and therapists had given their written consent for research participation by procedures approved by the privacy ombudsman at Oslo University Hospital. The study is based on anonymous transcripts.

Quantitative material: The use of the numerical ratings from Quality Lab for Psychotherapy at Oslo University and all procedures involved were approved by the privacy ombudsman at Oslo University Hospital.

3 | RESULTS

3.1 | Quantitative data

Adherence and quality scores for the 17 MBT interventions based on 346 individual MBT sessions are displayed in Table 2. In this sample, the average score levels for overall adherence and quality were above the MBT cut-off level (adherence score > 4: 71%, quality score > 4: 72%). For sessions with a global quality score > 4, the mean global quality score level was 4.5 (SD 0.6), and for sessions with quality score < 4, mean level was 2.8 (SD 0.8) ($p < 0.001$).

Mean quality ratings for all specific MBT interventions (17 items) ranged from 3.6 to 4.4 (Table 2). Scores were significantly higher in sessions with global quality scores > 4 ($p < 0.001$). In the total sample, the highest quality was found for Items 4 ("Adaptation to mentalizing capacity"), 5 ("Regulation of arousal"), 6 ("Stimulating mentalization through the process"), 10 ("Affect focus"), and 16 ("Monitoring understanding"). Poorest quality was found for Items 3 (Challenging unwarranted beliefs), 9 ("Psychic equivalence"), 12 ("Stop and rewind"), and 15 ("Counter-transference") (Table 2).

The total number of identified MBT interventions per session was significantly higher in sessions with high global adherence ratings (adherence score > 4: mean number of MBT interventions 75 (SD 14), versus adherence score < 4: mean number of MBT interventions 40 (SD 6), $p < 0.001$). The number of MBT interventions was also higher in sessions with high global quality ratings (quality score > 4: mean number of MBT interventions 72 (SD 15), versus quality score < 4: mean number of MBT interventions 42 (SD 7), $p < 0.001$). Table 2 demonstrates MBT adherence in subgroups with different MBT quality ratings.

The most frequently used MBT intervention was Item 16 ("Monitoring understanding") which represented 31% of all identified MBT interventions, most frequent in highly adherent MBT (global adherence score > 4: Item 16 mean number, 23 (SD 5), versus global adherence score < 4: Item 16 mean number 12 (SD 5), $p < 0.001$). Item 2 ("not-knowing stance") was also highly prevalent, represented 20% of all MBT interventions, and more frequent in highly rated MBT (global adherence score > 4: Item 2 mean number 15 (SD 4), versus global adherence score < 4: Item 2 mean number 5(SD 4), $p < 0.001$). Item 10 ("Affect focus") represented 15% of all interventions, more in highly rated MBT, but differences were smaller (global adherence score > 4: Item 10 mean number 10 (SD 3), versus global adherence score < 4: Item 10 mean number 8 (SD 3), $p < 0.001$). Items 11, 13, and 14, represented 7%–8%, and the remaining items 3% or less. The least frequent interventions in this sample were Items 9 ("Psychic equivalence") and 12 ("Stop and rewind") (Table 2).

3.2 | Qualitative results

The IPA revealed three themes: (1) The pervasive hidden psychopedagogical agenda in MBT sessions, (2) that psychopedagogical content seemed precious for the patients, and (3) four tentative strategies for pedagogical interventions in MBT.

3.3 | Hidden psychopedagogical agenda

The 33 transcribed sessions contain very few explicit examples of the teaching of psychological content or mechanisms (e.g., "Communication System 1"; A. Bateman et al., 2018). Hence, the first emergent theme was that MBT

TABLE 2 Average frequency of MBT interventions in 346 individual MBT sessions

	MBT adherence -Identified interventions per session (count) N_total = 346 Mean (SD)	MBT Quality N_total = 346 Mean (SD)	MBT quality scores 1-2 n = 67 (19%) Mean (SD)	MBT quality scores 3-5 n = 177 (51%) Mean (SD)	MBT quality scores 6-7 n = 102 (30%) Mean (SD)
Overall quality score	4.4 (1.7)	4.3 (1.6)	1.9 (0.3)	4.0 (0.6)	6.2 (0.4)
Specific MBT interventions					
Item 1: Engagement, interest, and warmth	N/A	4.2 (0.9)	N/A	N/A	N/A
Item 2: Exploration, curiosity, and a not-knowing stance	12.6 (5.6)	4.2 (1.1)	3.0 (1.5)	14.1 (2.9)	16.2 (3.6)
Item 3: Challenging unwarranted beliefs	1.6 (1.0)	3.7 (1.0)	2.0 (0.6)	1.0 (0.9)	2.5 (0.7)
Item 4: Adaptation to mentalizing capacity	N/A	4.3 (1.3)	N/A	N/A	N/A
Item 5: Regulation of arousal	N/A	4.4 (1.2)	N/A	N/A	N/A
Item 6: Stimulating mentalization through the process	N/A	4.3 (1.3)	N/A	N/A	N/A
Item 7: Acknowledging positive mentalizing	2.0 (2.1)	3.8 (1.1)	1.0 (0.6)	0.6 (0.8)	4.9 (1.3)
Item 8: Pretend mode		3.8 (1.4)			
Item 9: Psychic equivalence	0.5 (0.8)	3.6 (1.4)	0 (0)	0 (0.3)	1.5 (0.8)
Item 10: Affect focus	9.5 (3.1)	4.3 (1.3)	8 (2.8)	8.9 (2.5)	11.5 (3.3)
Item 11: Affect and interpersonal events	4.3 (2.5)	4.1 (1.1)	3 (1.3)	5.3 (2.5)	3.3 (2.1)
Item 12: Stop and rewind	0.4 (0.6)	3.7 (1.3)	1 (0.5)	0.1 (0.3)	0.5 (0.6)
Item 13: Validating feelings	4.3 (4.1)	3.8 (1.3)	1 (0.5)	2.6 (2.2)	9.3 (3.4)
Item 14: Relation to therapist	5.2 (5.0)	3.8 (1.3)	5 (1.7)	2 (1.6)	10.8 (5.2)
Item 15: Counter-transference	1.4 (1.7)	3.7 (1.3)	1 (0.9)	1.5 (1.6)	1.6 (2.3)
Item 16: Validating understanding	19.8 (6.6)	4.3 (1.3)	10 (3.7)	22.7 (5.2)	21.4 (3.6)
Item 17: Integrating group experiences	1.7 (2.3)	3.9 (1.3)	3 (1.5)	0.8 (1.7)	2.6 (2.9)
Total count: Identified MBT interventions per session	63 (19)		38 (4.8)	60 (8.0)	86 (9.8)

Karterud et al., according to the Adherence and Competence (quality) Scale for Individual MBT (MBT-I-ACS; Karterud et al., 2013). Standard deviations (SD) are given in the parenthesis.

therapists typically camouflaged their "pedagogical interventions" as Item 7 ("Acknowledging positive mentalizing"), 13 ("Validation of emotional reactions"), 15 ("Use of countertransference"), and 16 ("Monitoring understanding"). This is not surprising, as the therapists consented to research, and the manual does not advocate pedagogical interventions, metaphors, or interpretations. In terms of group therapy, the therapists followed the manuals and gave directive instruction to provide appropriate boundaries—for example, "It helps the group to know why someone is not participating today [is absent from the group]" or "It is important that you meet for therapy, even though I understand you have had mixed feelings about coming here."

This is another example of a therapist providing directive instructions to help set boundaries: Letting the children read the angry/hateful text messages that the parents sent to each other, was perhaps not ideal?:

Therapist: I was also thinking that it might be somewhat difficult for the children, maybe, to read the text messages from their mother. In a way so—involved in what happens between the two of you.

Patient: Eehhm

Therapist: I am also thinking that—it might be that it kind of gets—Anyway, I am thinking that the children are in a very difficult conflict of loyalty where they somehow must take sides with—with either you or their mother. So that is something that I am thinking about that must be hard. As a part of this picture.

In this case, the use of Item 15 ("I am thinking that it might be difficult...") was a way to challenge the patient's view but was also directly pedagogical, in presenting "common sense" regarding the child's struggle with being in a conflict of loyalty.

Another example of the use of Item 15 is found in this exchange in a group session:

Therapist: From time to time you have asked about routines. That you had a good and well-working time before the summer vacation, and then you describe around three months—that is, three months of acting-out, taking drugs, no structure. And then you get kind of surprised that you have a problem with drugs. Eh—that sounds a little strange. Because in my mind, that was kind of obvious. That you do have a problem with drugs. I was sitting here thinking.

Item 7 seemed like an important tool for MBT therapists to highlight new understanding (learning of mental content). In one group session, the following sequence occurred:

T: I am thinking that it is an important part of it. Because one thing is that you have not been getting high, and it is that which is giving you a very good ... feeling, that you feel proud. And also that you feel kind of more like a human being and that you recognize more of yourself in a way. What is it that—besides medication and—not illegal drugs—are there other things that make you feel good these days? And that you work well with your wife and that you don't ... attack her?

P_1: Yes, yes, I would think so. I do want to, I hope so, kind of. But I think that first and foremost it is because I am drug-free, and because my medication is so much reduced. (T2: Mhm.) So the chemistry inside my head is so changed. And I feel... Now when we have been out, I feel that when I normally would have exploded, or turned mad, or created a situation, I feel that I can think, No, just let it go, in a way. So I notice that I can reason, I notice that I manage to think before I talk.

T_2: You are mentalizing?

P_4: Yeah. (*Laughter in the group.*) That is exactly what I was thinking.

P_1 (*laughing*): Stop!

P_4: The therapy is working.

P_1: Yeah, yeah, yeah.

T_2: But that is wonderful, Kenneth! You managed to realize what the problem was, and then actually do something about it, without defending yourself from all of us and everyone else the way you normally do.

A typical example of Item 16 ("Monitoring understanding"), which could go on for quite long sequences, follows:

Therapist: In relation to other people. (P nods.) For maybe it has become a habit to fight and defend yourself and when you do that, you also feel attacked, or feel that you lose trust, turn so suspicious that you can almost not notice other perspectives or what they actually might have meant?

If the patient confirmed this, the therapists would typically continue presenting their knowledge as questions.

3.4 | Patients valued psychopedagogy

The patients were hungry for information about the therapy, and in the instances where the therapists conveyed psychological knowledge or the patient had learned concepts relevant for the treatment, they seemed enthusiastic. This sequence occurred after the patient had been in the psychoeducational group:

P: There I had a very nice time. (T nods.) Mhm.

T: Was there a difference between them?

(...)

P: It turned into—more like a general basic knowledge. And kind of something that... Those themes are not that obvious, and... those kinds of things. And then it is something that interests me, you know. Learning about having those kinds of aha-moments when I—

T: Mhm, yes. Did that happen yesterday? That you learned something?

P: Yes.

T: Yes. What kind of things?

P: What mentalization is, for one. That is a concept I haven't really understood.

T: Ok.

P: I thought it was something kind of spiritual... Superstition. I didn't really get what that concept was.

T: Ok. It's not that easy to understand. We have tried to talk about it in our initial meetings. What became clear for you yesterday?

P: I guess it was that it is kind of, in a way, it is... Mentalization is kind of how we think about ourselves and others. Eh, and that it is actually something—how everyone thinks, but there are different degrees of it.

T: Yes. How good to get that down in such a straightforward way, the way you put it.

P: Yes

T: Yes (*laughs*). It's not any more difficult than that, really.

P: No, it wasn't.

(*Both are laughing*.)

T: No. (*Laughing*.) And that is so ok, you know, to kind of get a grip of that concept. That that is what we are doing here. Yes. That that is what you will be studying, investigating, dwell on.

P: Mhm.

Further, in the few cases where therapists provided pedagogical interventions to some degree, the patients responded by thanking the therapists or displaying that they appreciated it in other ways (we interpreted this as a strengthening of the alliance):

T: Yes. Mhm. So, about defense. We have to—I take quite a few notes now, Michelle, because there are so many areas (P: Mhm.) that are important for us to look at and investigate. So, about defending oneself, it is important to defend oneself of course, but it sounds like you can do that a little—in a way, too much. (P: Yes.) Which can make things difficult for you.

P: Thank you for saying that, yes, that is very true.

3.5 | Four tentative criteria for pedagogical interventions in MBT

By trying to inhabit the lived experience of being the therapist in MBT, we found what we perceived as a tendency to hesitate or stop themselves from performing clear and explicit pedagogical interventions, where it would be natural, and valuable for the patient. As adherence to the model is ideal, the mentalizing approach is overall careful in using pedagogical (interpretive) interventions, which can be viewed as an expression of a supportive superego in the therapist. However, in several of the instances where we did see the use of it, instead of witnessing what can be called a careful and sensitive two-ways search to stimulate mentalizing, we discovered what emerged as clumsy or stuttering monologues. The therapist

presenting "common knowledge" appeared doubtful by hesitating with the "forbidden pedagogical intervention." In several cases, it was possible to imagine the value of the intervention being better received, if presented from a more certain tone of voice. By doing so we identified four themes that seemed essential for pedagogical interventions in MBT. Let us first demonstrate our IPA by dissecting the following examples:

T2: I was just thinking that... the way to move forward, is maybe... you know (P3) you recognizing, and what it triggers in you (P3), and also I am thinking that... (to P1) that it might be something with you, (P1), that makes your reaction so strong, then I am thinking... that I might think that you perhaps have experienced people in your life who have in a way let you down in the same way, because you have experienced THEM as cowards, or...

P1: Mm

T2: or that they haven't dealt with it, or they haven't persevered, and then I think... you know, when... it... those extra strong reactions, they are often presented because of recognition with something.

P1: Mm

T2: I see that as valuable to talk about. That which for example triggers in you (to P1) when you get angry, or P5, or... others, what is it that... of own stuff, if you should use the expression "to take a close look in the mirror," right, like... what is it inside you, that makes you react with anger immediately?

This passage induced a "wobbly" feeling, and we interpreted it as a signal of self-doubt in the therapist—contrasting the positive self-doubt championed by Nissen-Lie et al. (2017). This sequence also differed notably from the surrounding parts of the transcripts, where the therapist seemed confident. The ingredients of such negative doubt could be enough to trigger epistemic freezing in the patient. Let us contrast this with the playful presentation of psychopedagogical in DBT. The following is a scene constructed from examples in the DBT manuals:

T: Yes, but you mentioned something about unfair. Which feeling do we get, it is a kind of...

P: It is a very bad feeling.

T: Yes, I don't doubt that. And I have experienced that feeling myself, that I feel unfairly treated. But we often call that feeling that often follows, or that triggers that feeling of feeling injustice about something. Do you remember us talking about that? You have it on the right side of your journal card (points), you have probably scored something on

P: Envy? (T: Yes, precisely) I scored five on that one

T: So for that reason you actually had five on envy (...) You feel an emotion, you say that you feel that it is unfair. I am being a little difficult because I am asking which feeling you think is underneath, and then we are, then we can agree that it might be envy. Which is a common human feeling, that all humans have, but that when one is afraid that, or feels that someone else... do you remember when we talked about this?

P: No.

One could ask: Which of the two sequences—apart from the content—feels most trustworthy, and why? It seems that advising against pedagogical interventions has some negative consequences for alliance and trust. In light of epistemic trust being fostered by the ability to trust (a) the content and (b) the source of the content (Wilson & Sperber, 2012), based on the extensive interpretation of the data we agreed on the following four crucial criteria for what pedagogical interventions should typically be performed to foster: (1) separate ability to think, and reason (independent reasoning); (2) adequate trust in the other as a source of (socially relevant) information (epistemic trust); (3) an ability to take different perspectives (mental flexibility); and (4) recognize other trustworthy sources for (social) knowledge (application of verified insights, knowledge or strategies)—a trust that this is not something resulting from the therapist's own projections, prejudices and/or preferences.

4 | DISCUSSION

The content, rather than the process in which it was acquired, has been proposed as central in the development of psychopathology (Kruglanski, 2013). It is further stated that "The epistemic process has implications for 'unfreezing' the maladaptive thought patterns and 'refreezing' in their stead alternative, more adaptive notions"

(Kruglanski, 2013, p. 6). The establishment of epistemic trust, cohesive group processes, and learning environments are crucial in the treatment of poorly functioning patients with a personality disorder. The present study addresses an aspect of psychotherapy that is as yet, poorly investigated. Although MBT acknowledges essential learning processes in therapy and applies psychoeducation in the introductory phase, there is little manual-based emphasis on using pedagogical interventions in the further therapy process with individual and group MBT (Karterud & Bateman, 2010).

The quantitative data generally signaled satisfactory treatment integrity including both adherence to MBT interventions and quality. Although the prevalence and quality of specific interventions varied, sessions with high global ratings tended to display a broad range of satisfactory interventions. We found that the most frequently used intervention was "Monitoring understanding" (Item 16; Karterud et al., 2013). The finding may be considered remarkable. The assumed hallmark of MBT: Item 2: "not-knowing stance" (A. Bateman & Fonagy, 2016; Karterud & Bateman, 2010) was also highly prevalent, but nonetheless surpassed by Item 16. It is noteworthy that the data suggested a significantly more active therapeutic stance in highly rated MBT, with a generally higher number of MBT interventions characteristic of sessions of better MBT quality. This was evident for both Items 2 and 16.

Combining the quantitative group trends in the large sample with the qualitative in-depth study of single therapy sessions, therapists indirect pedagogical stance was observed for a range of intervention types, mainly scored under Item 16 ("Monitoring understanding"), but also to some extent Items 2 ("not-knowing stance"), 7 ("Acknowledging positive mentalizing"), 13 ("Validation of emotional reactions"), and 15 ("Use of countertransference").

Using IPA, the qualitative exploration indicated that therapists' pedagogical stance was present in the observed sessions, but often indirectly, coming across in a somewhat concealed or unclear manner. Typically, we observed long sequences where therapists introduced their own understanding/knowledge with an appended question mark. Hence, it appeared to us that MBT therapists lacked a repertoire or map for the pedagogical terrain. According to our observations, there were instances of "missed opportunities," as well as interventions with pedagogical content performed without clear or trustworthy precision. When we identified missed opportunities, what typically followed was a lengthy sequence where the therapist seemed to try to convey knowledge, but did not do so explicitly. There was a notable difference between sequences where the therapist facilitated the patient's arrival at own answers, (i.e., finding their answers from "inside-out"), and those characterized by long intervention sequences of Item 16. The main difference was related to a communicative process of clarity and facilitation of further understanding and reflection. An indirect pedagogical stance may be excellent for fostering mentalizing by developing Systems 2 and 3 but is not expected to nurture the patients' need for "food for thought" (i.e., System 1).

Despite MBT being operationalized as a "not-knowing" therapeutic approach, our observations indicate that pedagogical interventions—as in the other evidence-based treatments for BPD—nonetheless, pervade and color the actual therapies and interventions performed. We emphasize this observation as these sequences with such a camouflaged manner of interventions often seemed lengthy and unnecessarily unproductive. Pedagogical interventions have therapeutic potential, but their style of application needs to be carefully considered. By trying to inhabit the lived experience of the therapists and the patients, we reached a consensus of four principles we tentatively suggest a pedagogical stance in MBT could foster: (1) independent reasoning; (2) adequate epistemic trust; (3) ability to inhabit mental content in a flexible manner; and (4) application of verified insights and knowledge or strategies.

Exemplifying good mentalizing seems important in MBT. The conjoint aspect of group and individual therapy has been found favorable in treatment for people with personality disorders (Antonsen et al., 2017). Cohesiveness and trust between group members is an essential part of a process facilitating development (Alldredge et al., 2021) and better mentalizing—a relational environment encouraging new emotional and interpersonal learning. Groups are known to be better decision makers than (most) individuals (Keck et al., 2014), and a well-functioning group may also be better at mentalizing than most. Piper et al. (2007) reported that the higher the percentage of patients in a therapy group who had a history of relatively mature relationships, the better the outcome for all patients in the group, regardless of the form of therapy or the individual patient's quality of object relations score. In line with such an argument, Cologon et al. (2017) reported that therapists' reflective functioning (RF; operationalization of

mentalizing) predicted therapist effectiveness. Exemplifying good mentalizing may thus be an effective pedagogical stance in MBT—both in terms of being pedagogical, but also in terms of building alliance. The MBT-therapist can be seen as a teacher who teaches the patient how to learn (Fonagy et al., 2019). Pedagogical interventions may simultaneously foster group cohesion, clarify (e.g., map out) the terrain of therapy, and enable the patient to develop other learning relationships by providing micro-societies for social praxis.

Access to "the epistemic highway" (Campbell et al., 2021) would make the (MBT) therapist an effective teacher and requires that maladaptive knowledge or belief systems, typically culturally embedded, are addressed. This may seem challenging, as different "cultures may subscribe to divergent belief systems, and the potential heterogeneity in what different persons 'know for a fact' may be considerable" (Kruglanski, 2013, p. 11). Naturally, people display epistemic trust in different sources: "A cultist, for example, might believe that a statement is worth believing only if endorsed by the guru, and an experimental scientist might believe that hypothesis x is true only if an empirical outcome y was observed in a controlled experiment" (Kruglanski, 2013, p. 23).

As the use of metaphors and interpretations are often advised against in MBT (A. Bateman & Fonagy, 2016; A. W. Bateman & Fonagy, 2019), it makes sense, as we observed, that therapists seemed to seek other pedagogical strategies to provide mental building blocks (System 1). However, it is not to be underestimated that sharing general knowledge, using metaphors or teaching stories (e.g., tales), or ornamenting the dialogue with traces of transpersonal knowledge, can function as ostensive cues (Campbell et al., 2021). In the treatment of poorly functioning patients with BPD, "the epistemic process has implications for 'unfreezing' the maladaptive thought patterns and 'refreezing' in their stead alternative, more adaptive notions" (Kruglanski, 2013, p. 6).

In MBT, this may include presenting own knowledge in a mentalized manner, focusing more on a constructive rather than a transmissive learning process (D'Errico et al., 2012), the learning is understood as "an active construction of knowledge and competence, based on direct experience and inductive discovery of general laws" (p. 928). The mentalizing therapist should have a broad repertoire, but always with the intention of inspiring the patient to ask questions and investigate mental content.

It may be argued that pedagogical interventions can stimulate the capacity to mentalize at different levels. Level 1: The therapist expects that the patient has access to mentalizing capacity and nudges mildly, inviting the patient to further reflection over a situation. Even if the patient failed to mentalize the episode, such an intervention would be in line with the literature on pedagogy, stemming back to Socrates—we learn better when we discover that we do not know. Level 2: The therapist expects that the patient has the moderate capacity to mentalize (there and then), and the dialogue between the therapist and patient becomes more exchange of mentalizing perspectives. The pedagogical stance of the therapist would be that of presenting what the collective opinion normally would hold. Level 3: The therapist presents a more general mentalizing perspective on the patient's situation, in the form of common knowledge, scientific information, or culture.

For further illustration, let us revisit the patient who allowed her child to read the hateful text messages she received from the other parent: Given that the patient had a good capacity for mentalizing, the therapist may for instance ask what they might think the child experiences when reading the text messages. This would be Level 1, inviting the patient to discover why this is perhaps not the best idea. Level 2 would be taking a more active role in the argument (mentalizing process), as illustrated in the example above when the therapist presents an alternative perspective by saying: "Anyway, I am thinking that the children are in a very difficult conflict of loyalty where they somehow must take sides with—with either you or their mother." At Level 3 the therapist could share what science says regarding emotional stress for development of children's brains under such conditions and their attachment style.

In DBT, the transmission of knowledge/wisdom includes narratives from Zen Buddhism to teach skills and concepts, such as mindfulness, and Wise Mind (Linehan, 2014). Interestingly, the Berlin wisdom model considers knowledge as the core of wisdom (Kunzmann & Baltes, 2003). In this view, there are three main factors that contribute to the development of wisdom: (1) general personal attributes, such as intelligence and personality; (2) expertise-specific factors, such as experience with life problems, availability of mentors, and motivation; and (3) facilitative experiential contexts, such as age, parenthood, or work contexts (Baltes & Staudinger, 2000).

However, sharing knowledge with patients with a distorted epistemic trust seems an art. Traditionally, the teacher creates a pedagogical stance where the student/pupil develops their own reflective skills, not blind trust (D'Errico et al., 2012, p. 929). Applied to therapy, patient(s) must not become manipulated, or overidentified with the therapist's own presumptions. It is said that too much trust in the (wrong) teacher is a way to describe what may to some extent cause BPD (Campbell et al., 2021). On the other hand, too little trust in the teacher/parent/therapist (epistemic vigilance) is often a challenge for therapists (Campbell et al., 2021). Thus, the overriding aim of pedagogical interventions, is that patients recognize their own experiences in a collective library of shared human experience, that patients may start to disentangle the puzzle of their personal terrain by witnessing the territory from the perspective of the common view.

A "pedagogical stance" is recently proposed as an intervention in MBT (Karterud et al., 2020) and seems supported in the present study, former studies focusing on the alliance, epistemic trust, and psychoeducation in MBT (Ditlefsen et al., 2020; Folmo et al., 2020; Sharp et al., 2020). As the MBT manual now promotes such interventions, new empirical studies can be performed.

4.1 | Strengths and limitations

A strength of the present study is the large sample of rated MBT sessions ($N = 346$) and IPA performed on a large number of MBT sessions ($N = 33$). The focus is original and there are generally few studies investigating therapy dialogues and therapist interventions in MBT. Treatment integrity was based on evaluated fidelity instruments (Folmo et al., 2017; Karterud et al., 2013). The mixed-methods approach is another strength, as it supports the findings from two different angles, the "objective findings" of patterns amongst the rated MBT Items, and the subjective experiential view from the "lived experience" of the individual case. The high fidelity ratings for the 33 MBT sessions included in the IPA signal high-quality MBT, but may also imply that these therapists are aware of being observed, and abnormally adherent to the model. This may have influenced our interpretation of the inflexibility indicated by the transcripts concerning pedagogical stance. Further, results may be limited by possible researcher bias as several authors engage in MBT research and clinical work (Falkenström et al., 2013). On the other hand, understanding of the approach is required for the assessment of treatment integrity and may also improve the more profound qualitative analyses. We have provided a detailed description of the authors' reflexivity bias in the methods section. The author group includes traditions outside the field of MBT. Moreover, the investigation expands former MBT manuals which have not directly emphasized a pedagogical stance (A. Bateman & Fonagy, 2016; Karterud & Bateman, 2010). Qualitative analyses were performed on transcripts of sessions already included in other research projects. Therapist performance in a research setting, requiring videotaped material may be restricted due to fear of being evaluated, or unnatural perfectionism. It thus, cannot be ruled out, that our observations of therapists seeming unfree, bound or limiting their interventions, could partly be explained by such circumstances. The frequent use of "Monitoring understanding" (Item 16) in the 33 sessions in the IPA lends support to the suggestion that the frequent use of Item 16 in the 346 quantitative part of this study was also "camouflaged" pedagogics, but this is only an assumption.

5 | CONCLUSION

The current study showed that MBT therapies are pervaded by an indirect form of pedagogical intervention, typically manifesting as the frequent use of interventions validating the coherence of therapists' and patients' perceptions (i.e., Item 16; Karterud et al., 2013). More research on pedagogical interventions is needed, and this study signals that this field deserves more attention. Meanwhile, MBT therapists may wish to learn such content-based interventions and may draw inspiration from other fields such as from the more skills-based treatments, DBT or ST.

5.1 | Clinical relevance

Pedagogical stance is a newly proposed intervention in MBT. The current study signaled that pedagogical interventions strengthened the alliance and epistemic trust in MBT. We propose to teach the patients how to think, not what to think, how to understand emotions, not what to feel, and how to approach a situation, not how to live. Pedagogical interventions should foster (1) independent reasoning; (2) epistemic trust—a trust in interpersonal knowledge (e.g., common sense, science, wisdom shared across times and cultures); (3) mental flexibility, and (4) application of culturally verified insights and knowledge or strategies. The advent of pedagogical interventions may make MBT easier to learn, perform and operationalize, as it would come to include targeting the learning of content in a direct, rather than an indirect manner.

DATA AVAILABILITY STATEMENT
Data set for the quantitative analysis (fidelity ratings for 346 individual MBT sessions) available upon request.

ORCID
Espen J. Folmo 🆔 https://orcid.org/0000-0001-8271-3271

PEER REVIEW
The peer review history for this article is available at https://publons.com/publon/10.1002/jclp.23335

REFERENCES

Alldredge, C. T., Burlingame, G. M., Yang, C., & Rosendahl, J. (2021). Alliance in group therapy: A meta-analysis. *Group Dynamics: Theory, Research, and Practice*, *25*(1), 13–28.

Antonsen, B. T., Kvarstein, E. H., Urnes, Ø., Hummelen, B., Karterud, S., & Wilberg, T. (2017). Favourable outcome of long-term combined psychotherapy for patients with borderline personality disorder: Six-year follow-up of a randomized study. *Psychotherapy Research*, *27*(1), 51–63.

Baltes, P. B., & Staudinger, U. M. (2000). Wisdom. A metaheuristic (pragmatic) to orchestrate mind and virtue toward excellence. *American Psychologist*, *55*(1), 122–136. https://doi.org/10.1037//0003-066x.55.1.122

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

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

Bateman, A. W., & Fonagy, P. (2019). *Handbook of mentalizing in mental health practice*. American Psychiatric Pub.

Beck, A. T., Davis, D. D., & Freeman, A. (2015). *Cognitive therapy of personality disorders*. Guilford Publications.

Beck, E., Bo, S., Jørgensen, M. S., Gondan, M., Poulsen, S., Storebø, O. J., Fjellerad Andersen, C., Folmo, E., Sharp, C., & Pedersen, J. (2020). Mentalization-based treatment in groups for adolescents with borderline personality disorder: A randomized controlled trial. *Journal of Child Psychology and Psychiatry*, *61*(5), 594–604.

Bion, W. R. (1994). *Learning from experience*. Jason Aronson.

Bo, S., Sharp, C., Fonagy, P., & Kongerslev, M. (2017). Hypermentalizing, attachment, and epistemic trust in adolescent BPD: Clinical illustrations. *Personality Disorders*, *8*(2), 172–182. https://doi.org/10.1037/per0000161

Campbell, C., Tanzer, M., Saunders, R., Booker, T., Allison, E., Li, E., O'Dowda, C., Luyten, P., & Fonagy, P. (2021). Development and validation of a self-report measure of epistemic trust. *PLOS One*, *16*(4), e0250264. https://doi.org/10.1371/journal.pone.0250264

Cologon, J., Schweitzer, R. D., King, R., & Nolte, T. (2017). Therapist reflective functioning, therapist attachment style and therapist effectiveness. *Administration and Policy in Mental Health*, *44*(5), 614–625. https://doi.org/10.1007/s10488-017-0790-5

D'Errico, F., Leone, G., & Poggi, I. (2012). P*edagogical stance, the teacher's position and its social signals*. 2012 International Conference on Privacy, Security, Risk and Trust and 2012 International Confernece on Social Computing, Amsterdam, Netherlands.

Ditlefsen, I. T., Nissen-Lie, H., Andenæs, A., Normann-Eide, E., Johansen, M. S., & Kvarstein, E. H. (2020). "Yes, there is actually hope!"–A qualitative investigation of how patients experience mentalization-based psychoeducation tailored for borderline personality disorder. *Journal of Psychotherapy Integration*, 31, 257–276. https://doi.org/10.1037/int0000243

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage Handbook of Qualitative Research in Psychology* (pp. 179–194). Sage.

Ellison, W. D. (2020). Psychotherapy for borderline personality disorder: Does the type of treatment make a difference? *Current Treatment Options in Psychiatry*, 7(3), 416–428.

Fairbairn, W. R. D. (1954). *An Object-Relations Theory of the Personality*. Basic Books.

Falkenström, F., Markowitz, J. C., Jonker, H., Philips, B., & Holmqvist, R. (2013). Can psychotherapists function as their own controls? Meta-analysis of the "crossed therapist" design in comparative psychotherapy trials. *The Journal of Clinical Psychiatry*, 74(5), 482–491. https://doi.org/10.4088/JCP.12r07848

Finlay, L., & Gough, B. (2008). *Reflexivity: A practical guide for researchers in health and social sciences*. John Wiley & Sons.

Folmo, E. J., Karterud, S. W., Bremer, K., Walther, K. L., Kvarstein, E. H., & Pedersen, G. A. F. (2017). The design of the MBT-G adherence and quality scale. *Scandinavian Journal of Psychology*, 58(4), 341–349. https://doi.org/10.1111/sjop.12375

Folmo, E. J., Karterud, S. W., Kongerslev, M. T., Kvarstein, E. H., & Stanicke, E. (2019). Battles of the comfort zone: Modelling therapeutic strategy, alliance, and epistemic trust-a qualitative study of mentalization-based therapy for borderline personality disorder. *Journal of Contemporary Psychotherapy*, 49(3), 141–151. https://doi.org/10.1007/s10879-018-09414-3

Folmo, E. J., Stanicke, E., Johansen, M. S., Pedersen, G., & Kvarstein, E. H. (2020). Development of therapeutic alliance in mentalization-based treatment-goals, bonds, and tasks in a specialized treatment for borderline personality disorder. *Psychotherapy Research*, 1(5), 604–618. https://doi.org/10.1080/10503307.2020.1831097

Fonagy, P. (2002). *Affect regulation, mentalization, and the development of the self* (p. 2002). Other Press.

Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of Personality Disorders*, 29(5), 575–609. https://doi.org/10.1521/pedi.2015.29.5.575

Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2019). Mentalizing, epistemic trust and the phenomenology of psychotherapy. *Psychopathology*, 52(2), 94–103. https://doi.org/10.1159/000501526

Garred, S., & Gough, E. M. (2021). *Den terapeutiske relasjonen i DBT og MBT* [Unpublished master's thesis, University of Oslo]. https://www.duo.uio.no/bitstream/handle/10852/87426/1/Hovedoppgave_Den-terapeutiske-relasjonen-i-DBT-og-MBT_Elina_Susanne.pdf

Guntrip, H. (1973). *Psychoanalytic theory, therapy, and the self: A guide to the human personality in Freud, Erikson, Klein, Sullivan, Fairbairn, Hartmann, Jacobson, and Winnicott*. Basic Books.

Hedges, L. E. (1983). *Listening perspectives in psychotherapy*. Jason Aronson.

Imsen, G. (2011). *Hva er pedagogikk*. Universitetsforlaget.

Karterud, S. (2011). *Manual for mentaliseringsbasert psykoedukativ gruppeterapi (MBT-I)*. Gyldendal akademisk.

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

Karterud, S. (2015). *Mentalization-Based Group Therapy (MBT-G): A theoretical, clinical, and research manual*. OUP.

Karterud, S., & Bateman, A. (2010). *Manual for mentaliseringsbasert terapi (MBT) og MBT vurderingsskala. Versjon individualterapi*. Gyldendal Akademisk.

Karterud, S., Folmo, E., & Kongerslev, M. (2020). *Mentaliseringsbasert terapi MBT*. Gyldendal Akademisk.

Karterud, S., Pedersen, G., Engen, M., Johansen, M. S., Johansson, P. N., Schluter, C., Urnes, O., Wilberg, T., & Bateman, A. W. (2013). The MBT Adherence and Competence Scale (MBT-ACS): Development, structure and reliability. *Psychotherapy Research: Journal of the Society for Psychotherapy Research*, 23(6), 705–717. https://doi.org/10.1080/10503307.2012.708795

Keck, S., Diecidue, E., & Budescu, D. V. (2014). Group decisions under ambiguity: Convergence to neutrality. *Journal of Economic Behavior & Organization*, 103, 60–71. https://doi.org/10.1016/j.jebo.2014.03.026

Kernberg, O. F., & Caligor, E. (1996). A psychoanalytic theory of personality disorders. In M. F. Lenzenweger & J. F. Clarkin (Eds.), *Major theories of Personality Disorder* (pp. 106–140). Guilford Press.

Kruglanski, A. W. (2013). *Lay epistemics and human knowledge: Cognitive and motivational bases*. Springer Science & Business Media.

Kunzmann, U., & Baltes, P. B. (2003). *Beyond the traditional scope of intelligence: Wisdom in action*. American Psychological Association.

Kvarstein, E. H., Pedersen, G., Folmo, E., Urnes, O., Johansen, M. S., Hummelen, B., Wilberg, T., & Karterud, S. (2019). Mentalization-based treatment or psychodynamic treatment programmes for patients with borderline personality disorder—the impact of clinical severity. *Psychology and Psychotherapy*, *92*(1), 91–111. https://doi.org/10.1111/papt.12179

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

Leichsenring, F., Leibing, E., Kruse, J., New, A. S., & Leweke, F. (2011). Borderline personality disorder. *Lancet*, *377*(9759), 74–84. https://doi.org/10.1016/S0140-6736(10)61422-5

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.

Linehan, M. (2014). *DBT? Skills training manual*. Guilford Publications.

Luyten, P., Campbell, C., & Fonagy, P. (2020). Borderline personality disorder, complex trauma, and problems with self and identity: A social-communicative approach. *Journal of Personality*, *88*(1), 88–105. https://doi.org/10.1111/jopy.12483

Moller, C., Karlgren, L., Sandell, A., Falkenstrom, F., & Philips, B. (2017). Mentalization-based therapy adherence and competence stimulates in-session mentalization in psychotherapy for borderline personality disorder with co-morbid substance dependence. *Psychotherapy Research: Journal of the Society for Psychotherapy Research*, *27*(6), 749–765. https://doi.org/10.1080/10503307.2016.1158433

Morken, K. T. E., Binder, P.-E., Arefjord, N. M., & Karterud, S. W. (2019). Mentalization-based treatment from the patients' perspective–what ingredients do they emphasize? *Frontiers in Psychology*, *10*, 1327. https://doi.org/10.3389/fpsyg.2019.01327

Muran, J. C., & Digiuseppe, R. A. (1990). Towards a cognitive formulation of metaphor use in psychotherapy. *Clinical Psychology Review*, *10*(1), 69–85. https://doi.org/10.1016/0272-7358(90)90107-L

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

Ostlie, K., Stanicke, E., & Haavind, H. (2018). A listening perspective in psychotherapy with suicidal patients: Establishing convergence in therapists and patients private theories on suicidality and cure. *Psychotherapy Research: Journal of the Society for Psychotherapy Research*, *28*(1), 150–163. https://doi.org/10.1080/10503307.2016.1174347

Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., Weideman, R., & Rosie, J. S. (2007). Group composition and group therapy for complicated grief. *Journal of Consulting and Clinical Psychology*, *75*(1), 116–125. https://doi.org/10.1037/0022-006X.75.1.116

Polanyi, M. (1966). *The tacit dimension*. Routledge & Kegan Paul.

Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructionism. In N. Denzin & Y. Lincoln (Eds.), *The Landscape of Qualitative Research: Theories and Issues* (2nd ed., pp. 189–214). Sage.

Schwartz, D. (2011). An Aristotelian view of knowledge for knowledge management, In D. Te'eni, & D. Schwartz (Eds.), *Encyclopedia of Knowledge Management* (2nd ed., pp. 39–48). IGI Global.

Sharp, C., Shohet, C., Givon, D., Penner, F., Marais, L., & Fonagy, P. (2020). Learning to mentalize: A mediational approach for caregivers and therapists. *Clinical Psychology-Science and Practice*, *27*(3), e12334. https://doi.org/10.1111/cpsp.12334

Smith, J. E., Flower, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research*. Sage.

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

Spinhoven, P., Giesen-Bloo, J., van Dyck, R., Kooiman, K., & Arntz, A. (2007). The therapeutic alliance in schema-focused therapy and transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, *75*(1), 104–115. https://doi.org/10.1037/0022-006X.75.1.104

Stänicke, E., & Killingmo, B. (2013). Object trust: A specific kind of analytic change. *Psychoanalytic Psychology*, *30*(3), 423–437. https://doi.org/10.1037/a0032036

Walker, S. (2018). *Interpretive phenomenological analysis: identifying the "relational" in systemic inquiry*. SAGE Publications Ltd. https://doi.org/10.4135/9781526440709

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.

Wilson, D., & Sperber, D. (2012). *Meaning and relevance*. Cambridge University Press.

Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach*. Professional Resource Press/Professional Resource Exchange.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2006). *Schema therapy: A practitioner's guide*. Guilford Press.

Zanarini, M. C., Conkey, L. C., Temes, C. M., & Fitzmaurice, G. M. (2018). Randomized controlled trial of web-based psychoeducation for women with borderline personality disorder. *Journal of Clinical Psychiatry*, *79*(3), 16m11153. https://doi.org/10.4088/JCP.16m11153