Therapists' Experiences with Mentalization-Based Treatment for Avoidant Personality Disorder

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Masteroppgave i sykepleievitenskap

7. juli 2020

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Navn:	**Dato:**
Mona Skjeklesæther Pettersen	7. juli 2020

Tittel og undertittel:

Artikkel: Terapeuters erfaringer med mentaliseringsbasert terapi ved unnvikende personlighetsforstyrrelse.

Refleksjonsoppgave: Mentaliseringsteoriens relevans i en sykepleiefaglig kontekst.

Sammendrag: Masteroppgaven består av to deler; en artikkel og en refleksjonsoppgave.

Formål: Studiens hensikt var å utforske terapeuters erfaring med en mentaliseringsbasert tilnærming til pasienter med unnvikende personlighetsforstyrrelse (UvPF). Hensikten med refleksjonsoppgaven var å utdype mentaliseringens relevans for terapeutisk, sykepleiefaglig arbeid.

Teoretisk forankring: Per nå finnes lite kunnskap om hva som er den virksomme behandlingen ved UvPF. Nyere forskning peker i retning av betydelige mentaliseringsvansker hos pasienter med denne lidelsen, og en mentaliseringsbasert tilnærming i behandling av UvPF er tatt i bruk noen steder.

Metode: Studien har et kvalitativt, deskriptivt design. Data ble innsamlet ved semi-strukturerte dybdeintervjuer med seks terapeuter og analysert ved tematisk analyse. I refleksjonsoppgaven utdypes begrepet mentalisering, og aspekter ved Hildegard Peplau sin teori trekkes inn for å belyse assosiasjoner mellom sykepleiefaglig arbeid og mentaliseringsteori.

Resultater: Analysen støttet to hovedtemaer, hvert med to undertemaer. Det første hovedtemaet, «knapphet på eksplisitte personlige narrativer», omfatter undertemaene «å engasjere den tilbaketrukne pasienten» og «å dra nytte av strukturen». Det andre hovedtemaet, «om å være terapeut», inneholder undertemaene «terapeuters emosjoner» og «å dra nytte av erfaring fra andre terapitilnærminger». I refleksjonsoppgaven diskuteres hvordan en mentaliserende holdning kan bidra til en pasientfokusert og undersøkende sykepleie. Videre omhandles betydningen av terapeuters evne til mentalisering og et utenfrablikk på egen atferd, samt forhold som kan påvirke dette.

Konklusjon: Informantene finner det terapeutiske arbeidet stimulerende og opplever at MBT treffer mye av kjernepatologien ved UvPF. Bruken av enkelte teknikker ser imidlertid ut til å kreve aktiv overveielse og det er muligvis behov for å tilpasse MBT i behandling av pasienter med denne lidelsen. Vår studie finner flere nyanser i terapeuters emosjonelle reaksjoner enn hva som tidligere er rapportert. Fremtidige studier bør undersøke effekten av MBT for pasienter med UvPF og se nærmere på hvilke behandlingsprosesser og intervensjoner som kan legge til rette for endring for pasienter med denne type personlighetspatologi.

Nøkkelord:
mentalisering, mentaliseringsbasert terapi, unnvikende personlighetsforstyrrelse, psykoterapi, kvalitativ metode

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Name:	**Date:**
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Title and subtitle:

Article: Therapists' Experiences with Mentalization-Based Treatment for Avoidant Personality Disorder.

Essay: The relevance of mentalization theory in a nursing context.

Abstract: Master's thesis consists of two parts; an article and an essay.

Purpose: The aim of the study was to inquire into therapists' experiences with a mentalization-based approach in the treatment of patients with avoidant personality disorder (AvPD). The purpose of the essay was to elaborate on the relevance of mentalization for therapeutic nursing practice.

Literature Review: To date, little knowledge exits of what is the most effective treatment for patients with AvPD. Recent research points to significant mentalizing difficulties in patients suffering from this disorder, and a mentalization-based approach in psychotherapy with avoidant patients is slowly emerging.

Method: The study deployed a qualitative, descriptive design. Data was gathered through semi-structured, in-depth interviews and analysed using thematic analysis. In the essay, the concept of mentalization is elaborated on and aspects of Hildegard Peplau's theory used to illustrate associations between nursing practice and mentalization theory.

Results: Our analysis supported two main themes. "Scarcity of explicit personal narratives" encompassed the subthemes "engaging the withdrawn patient" and "capitalizing on the structure". "On being a therapist" included the subthemes "therapists' emotions evoked" and "making use of experience from other therapeutic approaches". The essay discusses how a mentalizing stance may contribute to a patient-focused and investigative nursing practice. The importance of therapists' mentalizing ability and an outside perspective on own behavior, as well as factors potentially affecting this, is reflected upon.

Conclusion: The participants find the therapeutic work stimulating and mentalization-based therapy (MBT) to target much of the AvPD core pathology. The use of some techniques, however, warrants active consideration, and there may be a need to adjust MBT for use with avoidant patients. Our study reveals more nuances in therapists' emotional reactions than what has been reported earlier. Future studies should investigate the effect of MBT on AvPD patients and examine treatment processes and interventions that facilitate change in patients with this type of personality pathology.

Key words:
mentalization, mentalization-based therapy, avoidant personality disorder, psychotherapy, qualitative methods

INNHOLDSFORTEGNELSE

MASTEROPPGAVENS DEL 1: ARTIKKEL

Vedlegg

MASTEROPPGAVENS DEL 2: REFLEKSJONSOPPGAVE

MASTEROPPGAVENS DEL 1:

ARTIKKEL

Therapists' Experiences with Mentalization-Based Treatment for Avoidant Personality Disorder

TITLE PAGE

Title:

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Keywords:

Mentalization-Based Therapy, Avoidant Personality Disorder, Psychotherapy, Therapist Experience, Qualitative Methods

SUMMARY

Title: Therapists' Experiences with Mentalization-Based Therapy for Avoidant Personality Disorder

Recent research points to significant mentalizing difficulties in patients with avoidant personality disorder (AvPD), and a mentalization-based approach in psychotherapy with avoidant patients is slowly emerging. The aim of this study is to contribute to an understanding of the therapeutic issues such work might entail by exploring the experiences of therapists working in a mentalization-based treatment (MBT) program for patients with AvPD. The research questions are a) What are therapists' experiences of using MBT to treat patients who have been diagnosed with AvPD? and b) What do therapists perceive as therapeutic challenges when conducting mentalization based therapy with avoidant patients? In this qualitative study, semi-structured, in-depth interviews were conducted with six therapists. The data were analyzed using thematic analysis. Two main themes were supported. "Scarcity of explicit personal narratives" comprises findings related to gaining access to therapy material and engaging patients in therapy. "On being a therapist" encompasses emotional reactions of the participants and the use of experience from other therapeutic approaches. The participants find the therapeutic work stimulating, and their experience is that MBT targets much of the AvPD core pathology. The use of some techniques, however, warrants active consideration, and there may be a need to adjust MBT treatment for use with AvPD patients. Our study reveals more nuances in therapists' emotional reactions than has been reported earlier. Future studies should investigate the effect of MBT on patients with AvPD and examine treatment processes and interventions that may facilitate change in patients with this type of personality pathology.

Key words:

mentalization, MBT, avoidant personality disorder, psychotherapy, qualitative

INTRODUCTION

Avoidant personality disorder (AvPD) is characterized by feelings of inadequacy, hypersensitivity to negative evaluations, and fear of criticism and rejection, resulting in extensive avoidance of social interaction. The disorder is associated with considerable subjective suffering, impairment of work and social functioning, and high rates of co-occurring psychiatric disorders (American Psychiatric Association, 2013; Lampe & Malhi, 2018). Several studies have identified AvPD as being associated with a modest treatment outcome or an increased risk of relapse after treatment (Gude & Vaglum, 2001; Karterud et al., 2003; Kvarstein & Karterud, 2012; Seemüller et al., 2014; Vrabel et al., 2010). AvPD is among the most frequent personality disorders; the mean reported population prevalence in Western countries is 3.7% (range 1.2–9.3%) (Lampe & Malhi, 2018; Quirk et al., 2016; Winsper et al., 2020).

Despite the prevalence of AvPD and the considerable impact on those who are affected by it, research into treatment and efforts to develop specialized treatment programs have been scarce (Bo, Bateman, & Kongerslev, 2019; Simonsen et al., 2019; Sørensen, Wilberg, Berthelsen, & Råbu, 2019; Weinbrecht, Schulze, Boettcher, & Renneberg, 2016). According to Weinbrecht et al. (2016), cognitive behavioral therapy and schema therapy are the treatments for which the strongest empirical evidence exists. Other psychological treatments that have been reported to be helpful are psychodynamic psychotherapy, graded exposure, social skills training, supportive–expressive psychotherapy, and metacognitive interpersonal therapy (Alden, 1989; Barber, Morse, Krakauer, Chittams, & Crits-Christoph, 1997; Dimaggio et al., 2017; Kvarstein, Nordviste, Dragland, & Wilberg, 2017; Stravynski, Belisle, Marcouiller, Lavallée, & Eue, 1994). However, the number of studies is small, and large randomized controlled studies focusing on AvPD are rare (Lampe & Malhi, 2018). At this

point, it is unclear whether any kinds of psychotherapeutic treatment are more favorable than others (Simonsen et al., 2019). Moreover, AvPD is a heterogeneous condition with varying levels of severity. To be better able to tailor treatments to patients with AvPD, we need more knowledge of psychotherapeutic processes and the particular challenges or problems that therapists face when adapting or modifying different psychotherapies to this particular patient group.

In their review of research and insights in AvPD, Lampe and Malhi (2018) view research in the area of social cognition as especially promising. Social cognition concerns an individual's understanding of others' mental states. Mentalization is a broader construct that includes both the capacity to understand one's own and others' minds. It refers to the ability to implicitly and explicitly understand and interpret one's own and others' behavior as expressions of mental states, such as thoughts, feelings, fantasies, intentions, and wishes (Fonagy, Gergely, Jurist, & Target, 2002). Other related but only partly overlapping concepts are psychological mindedness and theory of mind. The capacity to mentalize is gradually developed from infancy through to attachment to a secure caregiver (Bateman & Fonagy, 2004). It is assumed that a good mentalizing ability is important for the development of a coherent self-image and relational functioning. Mentalization-based treatment (MBT) was originally developed to target mentalizing difficulties in patients with borderline personality disorder (BPD). However, insufficient or unstable mentalizing may play a role in many forms of mental disorders. MBT has captured broad interest, and therapies in which mentalizing is a central focus are currently being developed for other conditions as well (Bateman & Fonagy, 2013).

Recent research points to significant mentalizing difficulties in patients with AvPD. AvPD seems to be associated with a generally reduced awareness of and access to own mental states

(Dimaggio et al., 2017; Johansen, Normann-Eide, Normann-Eide, & Wilberg, 2013; Jordet & Ladegård, 2018). There are reports that individuals suffering from AvPD may have particular difficulties identifying, labeling, and expressing their inner experiences and feelings, as well as a limited understanding of what triggers affect and the compromised ability to identify and explain the reasons and motives underlying their own behavior (Moroni et al., 2016; Nicolò et al., 2011; Salvatore et al., 2016). They may also have difficulty taking other people's perspectives and reflect on the mental states and intentions of others as something independent of their own personal views and experiences. Self-focused and biased attention add to the problems with the realistic evaluations and interpretations of what goes on in others' minds. Individuals with AvPD are often driven by what is called maladaptive interpersonal schemes, which refer to rigid and poorly nuanced perceptions of oneself and others (Salvatore et al., 2016). It is assumed that such mentalizing difficulties are central to the interpersonal fear and avoidance that are typical of AvPD and may contribute to its maintenance.

Thus, a mentalization-based approach in psychotherapy with avoidant patients seems warranted and is slowly emerging. However, with the exception of a promising pilot study of eight adolescents attending an MBT group program for AvPD, the results of empirical studies have not been published (Bo et al., 2019; Simonsen et al., 2019). This is thus a minimally researched area. BPD and AvPD represent different clinical and therapeutic challenges, probably making adjustments necessary when working with AvPD patients (Jordet & Ladegård, 2018). In contrast to the typical mentalizing difficulties seen in patients with BPD, which seem mostly related to strong emotional activation in attachment situations, patients with AvPD appear to have more continuous mentalizing deficits based on generally poor access to mental states and low affect awareness (Johansen et al., 2018). However, we do not

know how therapists experience conducting mentalization-based therapy with patients who have these forms of mentalizing problems. To contribute to an understanding of what kind of therapeutic issues such work might entail, the present study explores the experiences of therapists working in an MBT program for patients with AvPD. The research questions were: a) How do therapists experience treating patients diagnosed with AvPD with MBT? and b) What do therapists perceive as therapeutic challenges in conducting mentalization-based treatment with avoidant patients?

METHOD

Design

The study employed a qualitative, descriptive design. Data were gathered through semi-structured, in-depth interviews and analyzed using thematic analysis (TA; Braun & Clarke, 2006).

Mentalization-based therapy (MBT)

MBT is a specialized psychodynamic therapy that is focused primarily enhancing and maintaining patients' ability to reflect on their own and others' thoughts, feelings, and intentions. Rather than being concerned with psychological insight, MBT is directed at the processes behind the insights and interpretations of one's own and others' behaviors. The main area of focus is the exploration of specific events—preferably current interpersonal episodes—in the patient's life. The therapist encourages the patient to actively mentalize such events and does so by clarifying and elaborating on the patient's affects, perceptions, and

behaviors. The therapist should hold an open, not-knowing stance and stimulate the patient's curiosity about his or her own internal world and the mental states of others. By maintaining an empathic, curious, and not-knowing attitude, the therapist gently challenges rigid attitudes, perceptions, and beliefs and invites the patient to explore alternative perspectives. Interpretations are used with caution and are presented as an alternative perspective as part of the exploration. Special attention is given to the patient's affects within interpersonal relationships, including that between the patient and the therapist. MBT is typically a team-based treatment program that consists of a combination of individual and group therapies, psychoeducative groups, and regular supervision.

Setting and treatment program

The therapists were recruited from an MBT treatment program offered at a psychiatric outpatient clinic. The treatment is based on the original MBT program for patients with BPD, with local adjustments and written outlines of the AvPD treatment program. The program consists of a combination of individual and group therapies. Initially, the patients take part in a weekly psychoeducational group for eight weeks; each group session lasts one and a half hours. The psychoeducational groups focus on topics that are relevant to AvPD, such as the concept and manifestations of personality disorder and specifically AvPD, attachment and the importance of attachment relationships, emotions and emotion regulation, mentalizing and a mentalizing stance, anxiety, depression and psychotherapeutic treatment. Individual therapy is offered in parallel with the psychoeducational groups, the main focus being to further thematize the topics taught, explore the patient's experiences of taking part in a group, and establishing an initial working alliance. During these eight weeks, both patients and therapists assess whether the group therapy format seems manageable and potentially beneficial for the patients. If so, the patients are usually put on a group therapy waiting list. Patients' own

motivations for therapy are emphasized, as many experience that people close to them have wishes and ideas on their behalf even though the patients do not feel ready.

The clinic offers regular MBT group therapy and expressive group therapy; the latter is also based on MBT principles. Patients participate in only one of them, and they are assessed on specific criteria regarding which type of group is more suitable. They are given information about both groups and invited to take part in the decision. Both the regular MBT groups and the expressive groups meet weekly for one and a half and two hours, respectively.

The regular MBT groups

The MBT groups are structured in line with guidelines for MBT group therapy for BPD (Bateman & Fonagy, 2004; Karterud, 2015). Each group session starts with the therapists giving a short summary of each patient's area of focus last time. This is followed by a "go-around," in which each patient is asked whether there is anything from the last time that he or she has been especially concerned about and what he or she wishes to work on today. Usually, three patients' current situations, events, or goals are chosen each time.

The expressive MBT groups

The structure of these groups is mainly the same as for the regular MBT groups, except that patients are given a concrete assignment in each session, such as representing a given feeling or creating an expression for how they feel today. The patients share their work−for example, a painting or a drawing−and reflections with the other group members.

Individual therapy

Individual sessions take place once a week during the first year of treatment and last for approximately 45 minutes. In the second year of treatment, the frequency of individual sessions is gradually reduced from once every two weeks to once every three. Some patients choose to participate in only group therapy for the last six months of treatment.

The MBT groups are led by two therapists, and all patients have one of the group therapists as their individual one. The therapists working with the AvPD patients are all part of the same clinical team. Some therapists in the AvPD team are also part of the clinic's BPD team. The therapists on both teams receive two hours of video-based supervision per week. Supervision is divided between group and individual therapy. The maximum length of treatment is two years. Individual assessments of the length of treatment are made within the team. Some patients choose to end treatment early. The treatment is rarely prolonged beyond two years.

Participants

Of the six therapists recruited for the study, four were clinical psychologists who specialized in mental health and/or addiction. Two therapists were registered nurses who specialized in mental health and family therapy. Most of the therapists had additional competences from various courses and educations. At the time of the interviews, two were certified MBT therapists, three were in the process of finishing training courses in MBT (individual therapy format), and one therapist had not yet started any formal MBT training. Participants reported having between 10 and 25 years of clinical experience as therapists. All the participants reported having experience working therapeutically with patients with BPD and/or mixed personality disorders in addition to patients with AvPD

Researchers

The first author, MP, is a registered nurse (RN) with a special interest in mentalization and MBT. TW is a professor in psychiatry with several years of clinical and research experience with personality disorders, including AvPD, and a special interest in mentalization and MBT. AM is an RN and a professor in nursing. EB is an RN and a senior researcher. AM and EB bring experience in qualitative methods to this study.

Procedures

Recruitment

Therapists delivering mentalization-based treatment to patients with AvPD were purposively recruited. The first author contacted the Norwegian National Advisory Unit for Personality Psychiatry (NAPP), and NAPP contacted two Norwegian clinics offering MBT to patients with AvPD. The first author, having received contact information from NAPP, contacted one additional clinic within the Nordic countries. Information about the project and a request for participation were distributed to all three clinics. One hospital was interested, and the first author contacted the hospital and gave additional information about the study. All six therapists from the hospital's AvPD team were finally recruited.

Interviews

One-on-one semi-structured, in-depth interviews were the method of choice. The first author developed the interview guide, and the coauthors reviewed and added to it (the guide is available on request). The guide, which consisted of open-ended questions, assisted in structuring the interviews and addressed some predetermined themes while also giving the participants room to present and elaborate on their subjective experiences. We strived to avoid asking questions that would likely elicit responses that were founded in theoretical knowledge of what one should do, and instead asked questions that we perceived more likely to reflect

actual experiences. Some questions aimed to get the therapists focused and to let various situations and relations come to mind; they included “Please tell me about the last therapy session you had with a patient with AvPD” and “I would like you to think about two different individual therapies or two groups. Can you please tell me what comes to your mind when you think about this?” Other questions were more specific−for example, “What is it like to conduct MBT group therapy with patients with AvPD?”

To receive feedback on the interview guide, the first author conducted a pilot interview with an MBT therapist working at another clinic. The guide was then adjusted slightly. The pilot interview also gave some sense of how an interview situation might unfold, thus preparing for data collection. Data from the pilot interview were not used in the analysis.

The first author conducted all the interviews, each of which lasted between 50 and 60 minutes. The interviews took place over two days 14 days apart: three interviews on the first day and then three on the second. The interviews were conducted in the therapists’ respective offices in keeping with their wishes. They were audio recorded and transcribed verbatim for analysis.

Analysis

Thematic analysis (TA) (Braun & Clarke, 2006) was chosen to identify, analyze, and report patterns and themes within the data. TA is recognized as useful in psychotherapy process research and has been used in a number of important investigations in the counseling and psychotherapy field (Mörtl & Gelo, 2015; McLeod, 2011). The method’s freestanding from preexisting theoretical ground means that it is flexible and possible to use within different theoretical contexts and for different purposes (Clarke & Braun, 2018).

Underpinning this qualitative analysis is a hermeneutic philosophy, which is especially concerned with the interpretation of texts. The interpretation process involves a coming together of the worlds and understandings of the interpreter and the text, thus transforming the initial positions of both (McLeod, 2011). Hence, hermeneutic theory allows different understandings to be read from the text or the data set. For the first author, the analysis process of this study entailed being actively attentive to her own pre-understandings of the theme and of thoughts and reflections arising after the interviews and being aware that these pre-understandings might color her reading of the material. Effort was made to be open to the text and get a sense of its meaning partly by keeping in mind the hermeneutic principle that McLeod (2011, p.33) describes as the "use of empathy in respect of the author(s) of the text." In this case, this has meant reflecting on and trying to develop a sort of personal understanding of the therapists' world—for instance, their therapeutic responsibilities and rationales, the local cultural context in which they work, and organizational circumstances.

The analysis was conducted following the TA steps outlined by Braun and Clarke (2006). The transcription of the interviews was done by the first author and represented the initial step in getting familiarized with the data. Coding was done inclusively and in line with a bottom-up or data-driven approach. From the codes, tentative themes were developed. Finally, defining and naming themes was a back-and-forth process of moving between the entire data set, candidate themes, coded data extracts, and initial codes and reviewing the evidence for and consistency of the themes. Emergent patterns and themes were frequently discussed with coauthors TW and AM. TW read all the interviews, and AM read some of the interviews. Two main themes were finally defined and named, and each had two subthemes.

Compliance with ethical standards

All the participants gave their signed informed consent to participate. The project was approved by the Hospital Privacy Protection Officer and the Data Protection Services. As there are relatively few therapists delivering MBT to patients with AvPD, great care has been taken to ensure anonymity. Information about the participants' genders and ages have therefore been omitted. For the same reason, in the reporting of results and the use of citations, references to the participants' genders are random; for example, a male participant may be referred to as "she" and vice versa.

RESULTS

Our analysis supported two main themes. The first, "scarcity of explicit personal narratives", comprises findings related to the therapeutic work of gaining access to material and engaging patients in therapy, while the second theme, "on being a therapist", encompasses the emotional reactions of the participants and the use of experience from other therapeutic approaches.

Regarding the use of the frequency labels *all*, *most*, and *some participants* in the presentation of the findings, *all* refers to six participants—that is, the whole sample; *most* refers to four or five participants; and *some* refers to three participants. As the sample size of the study is small and the study focuses on a field that is little explored, it is considered expedient to also report findings that apply to only one or two participants. This is then referred to as *one* or *two participant(s)*.

Scarcity of explicit personal narratives

All the participants delineate therapy settings that are characterized by patients' avoidance and withdrawal. The patients are described as struggling both to talk about events and circumstances in their day-to-day lives and to express the emotional and cognitive content of their inner worlds. The participants find that the MBT approach makes sense by targeting the core problems of AvPD, but also that some interventions require care when used.

Engaging the withdrawn patient

All the participants convey a continuous effort in their therapeutic work to be about balancing the patients' needs for support and safety with challenging them, thereby making way for new experiences. Most describe trying to shift tolerably between validating the patient's experience and pain and being curious about how the patient came to certain conclusions about him/herself and the world. Some point to how patients may find this exploration annoying or perceive it as criticism and thus shame-inducing, especially within a group setting.

> The mere act of mentalizing…being curious—like "Are you sure? Are there any other ways to understand it?"—may trigger insecurity and a feeling of shame related to having misunderstood. Such misunderstandings…so often come with mentalizing deficits. […] They withdraw: "Right…just another failure. I didn't understand that either…you're questioning…" This curiosity we wish to be positive. Curiosity may also trigger insecurity.

Exploring and asking questions must therefore be done "gently," as two participants expressed. This involves being clear about their intentions both there and then and related to

exploration as a central aspect of therapy. All convey the value of being transparent in engaging patients. The transparency of one's own mind in the session is described to serve multiple functions: It has a reassuring effect; is a way of modeling and normalizing mentalizing activity; and is a way of demonstrating differences in perceptions, which can then be explored in a mentalizing fashion.

Some participants explain that they occasionally choose to share something from their personal lives with their patients, intending to normalize feelings and reduce shame, as well as to help the patients to dare to be open by demonstrating openness themselves. One example is to talk about a situation in which they experienced an emotion similar to what the patient is now trying to convey or manage. They emphasize the need to be aware when choosing this strategy and, for instance, not sharing anything that they themselves find difficult to manage. All the participants talk about what can be described as "creating material of what is absent." This pertains in part to what they refer to as nonevents—that is, events or situations that the patient was supposed to initiate or take part in but instead avoided. This concrete event of avoidance is then subject to exploration. One participant conveys how asking for events necessitates focusing both on the fact that there might have been an event that the patient avoids mentioning and on potentially exploring such nonevents.

> "No, nothing special happened"; that's what they often say. "Nothing's happened. Really? I would say I guess a lot has happened. What is it that you're searching for in your head when I ask if something's happened?" […] And then I need to help them to search. […] "So, why didn't anything happen? Were there any situations in which you refused something? Have you avoided taking part in things?" You have to help them

> to search, because their condition makes nothing seem important enough or big enough.

All convey the therapeutic strategy of explicitly thematizing the patients' lack of response or sharing, especially in group therapy. Some explain that they sometimes share their own thoughts about what the silence might be about in order to demonstrate mentalizing activity and that they are actively thinking about the patients' minds. Some underline the importance of challenging the patients to talk about what is happening within themselves as they sit there silently, helping them to direct their focus outward and connect to each other. As one participant explains, this is also to try to ensure that if a patient has shared something without getting any response from the others, he or she is not left fantasizing about the reasons for the lack of response but, rather, is given insight into what the others are thinking about, which might also offer validation and comfort.

All the participants also talk about engaging the patients by using the "here and now" and trying to notice when the patients display avoidance in the therapy room—for instance, by distancing themselves or changing subjects. After pointing this out, they invite the patient to explore what is going on. Some reflect on how it may be easy to fall into the trap of being too quick to interpret and suggest what is happening, the challenge thus being to remark on what they observe and to give the patients time to reflect and express their own understandings. One participant conveys the importance of awareness of how one responds to patients' silence:

> I myself need to be active in keeping my own mentalizing ability alive, for instance, when it becomes very silent or if I don't get any response. "Is it wise now to offer

> some suggestions, or should I wait and give you the chance to be aware and find out yourself?" I might be too quick sometimes, because the dynamics with some of the avoidant patients—not all of them, of course, but some of them are so quiet and withdrawn that it's hard sometimes to know if you've reached them.

Some describe assessing rather continuously how active versus how awaiting to be in therapy more generally. They emphasize that long silences and having a therapist who is "too laid-back" exacerbate anxiety and discomfort, while, at the same time, patients may need time to recognize how they feel or react. Two participants mention that it can be easy to misinterpret a lack of immediate response as a sign that the patient "did not get" what was asked and to therefore feel the need to elaborate further. In group therapy, all the participants describe being focused on actively inviting patients in, although they differ somewhat regarding how quick they are to do this.

Capitalizing on the structure

Most participants convey that they find support in the structure of the therapy program and/or groups when working to get to know the patients and gaining access to their minds and stories. Some explain that large proportions of the individual sessions are used to prepare and facilitate group therapy work, which is considered the primary part of the therapy program. Most mention that the fact that the patients they see individually are also part of their therapy groups provides opportunities to create therapy material and to help the patients to challenge their avoidant patterns.

> Many may need help to bring topics into the group, and sometimes, we use part of the individual sessions for this. "What are you going to talk about? You think that'll be

> too hard? OK. Then what would be a manageable place to start?" Negotiating and trying to give them some responsibility for this. And then they might show up for group having forgotten what we talked about, in which case I might say, "We talked about it…you and me. Remember? No? Is it all right if I mention it?"

Being present in the same group situations as the patient is delineated by some as facilitating the exploration of different perceptions of what happened, thus stimulating the patient's mentalizing activity. These patients, they describe, often vividly remember having said something stupid or having thought that others felt bored. They may profit from being reminded or made aware of the supportive feedback they got but have forgotten or it did not register. Two participants convey that seeing their patients both individually and in group therapy may facilitate alliance and attachment work. In individual sessions, they may ask for the patients' reactions to what the therapist said or did in the last group session, especially if the therapist had challenged or pushed the patients in any way. This checking out combined with the transparency of their own intentions creates opportunities to clear up misunderstandings and reduce relational insecurity.

Situations from the group or the patients' mere experiences of being in the group serve the function of events that can be mentalized about in individual therapy. According to some participants, this compensates to a certain degree for the patients' difficulties with introducing content from their own lives into therapy. The structure of the group sessions is referred to as helpful with regard to the patients' difficulties with sharing and their tendencies to withdraw. The therapists' summaries and questions at the beginnings of sessions are given as one example. The participants point to how sitting silently in a group for a long time increases both their anxiety and their thresholds for sharing. Patients may be aware of this but may be

unable to take the initiative themselves, thus needing therapeutic help with “breaking the sound barrier,” as expressed by one participant.

The participants also mention that they mostly work in a headline fashion in the groups, as being in focus for a longer period can be too demanding for avoidant patients. Additionally, this ensures that more patients will have time to work on their themes in the sessions. In the participants’ view, the period between each patient presenting some personal material should not be too long. One participant shares his reflections on how this structuring of the groups has both helpful and disadvantageous aspects:

> Sometimes I find the group structure somewhat limiting. […] I’ve heard that depth is achieved by working with something several times, and I do know that if, with this patient group, we had worked really in depth with some topic, the shame probably would’ve been much stronger—like “I’ve taken up all time and space.” So there’s something good in having to divide the time the way we do. [...]. But, occasionally, it feels a bit superficial. I can hear myself saying like, “All right…now we’ve talked about that. Is there anything here that you can take with you and continue to work on and maybe bring back to the group some other time? Is it OK if we change the subject now?”

Another participant also mentions how repetition makes for immersion and in-depth work. If a patient does not bring anything new to the group, the therapist might suggest working a bit more on previously talked-about topics, thus supporting the patient in not backing away from sharing. His experience is that a lack of new themes might also be a sign that the patient feels

the need to work more on a previous theme and that it can be useful to ask the patient about this.

On being a therapist

All therapists express being emotionally engaged with their patients and emotionally affected and challenged by therapeutic work. Related to diagnostic complexity and different therapeutic needs, some reflect on how they make use of former education and professional experience in therapy.

Therapists' emotions evoked

All the participants describe working with their patients as inspiring, meaningful, and interesting. Most mention their own urges and wishes to alleviate the patients' pain while simultaneously expressing a need to accept and tolerate the inner realities and emotions of their patients as something that cannot simply be changed and must be endured by both parties.

> It's challenging for me as a therapist to not try to remove the sense of guilt that many of them carry. I need to work on that; I talk about it in supervision; this, they are so quick to feel guilt, and it's just totally disproportionate to the situation, looking at it from the outside. But to tolerate this—like, "Right…this is what it feels like for you"—and not try to remove it. Because I'm not able to do that, though I want to, because witnessing it really hurts.

Challenging the patients' long held and familiar perceptions of themselves and of the world may be emotionally demanding for the participants, as well as for the patients. One of the

participants uses the words “brutal” and “mean” to describe how he sometimes feels when having to help patients to challenge themselves and realize how many of their problems are actually caused by their extensive avoidance. He relates this difficulty in part to his background as a trauma therapist, explaining that the trauma therapy tradition emphasizes support and emotional holding and containing to a larger degree than does MBT. Another participant expresses ambivalence related to the fact that already in the early phases of treatment and prior to achieving a solid treatment relationship, the MBT approach is concerned with making clear to the patient the need for him or her to change his or her negative notions and perceptions of him/herself. Observing how shame holds a central place in many of the patients’ identities, the therapist wonders whether a focus on removing this shame might weaken their sense of identity and thus inflict further pain. She conveys that she occasionally gets a sense of “hammering loose on what’s most vulnerable.”

Other emotional reactions conveyed are frustration, irritation, and impatience. This seems especially related to the patients’ silence and withdrawal during the group therapy. Two participants talk about feelings of irritation and provocation in situations in which a patient has shared something difficult and then gets little or no response from his or her fellow group members. They admit to having moments of thinking of the patients as miserly and to failing to take responsibility and show concern for the others’ well-being. When sharing these examples of their emotional reactions, the participants simultaneously emphasize patients’ relational guardedness and lack of sharing as part of their reason for being in therapy in the first place.

> Sometimes, I get somewhat provoked or frustrated in a group. If someone holds back a lot or…Yes! That actually is one of the things I struggle with the most in groups…this

> scarcity of response and expressed support. […] When someone has shared something really difficult and…I do understand what happens in the other patients…that many are censoring themselves and feel like they have nothing of importance to say, but it feels like no one is offering anything. That might make me rather…impatient or provoked sometimes…like "Come on!"

Challenges related to the patients' rigid beliefs and resistance toward change are mentioned by one participant. She describes how it often appears that the patients have decided that certain things are unachievable for them or impossible to change despite their efforts. While acknowledging the patients' perceptions as understandable, she conveys how feelings of frustration might arise in her. Two participants talk about sometimes experiencing a sort of emotional contagion of the patients' anxiety, resulting in instances of performance anxiety in the therapy setting. Remembering being new to the team and leading a psychoeducational group, one participant describes how the patients' silence and lack of explicit participation in the group caused self-doubt and devaluation of his own work. He also tended to interpret the patients' passivity as a sign that they did not pay attention or did not understand what was taught. Another participant describes that she sometimes feels affected by the patients' shame. This may cause her to feel uncomfortable talking about the topic in question, even though it is actually the patient who feels shameful about the topic. One participant explicitly points to the need to be aware that countertransference reactions might arise when working with patients with AvPD, having observed that therapists are more inclined to be attentive to these types of reactions when working with patients with BPD or antisocial personality disorder.

The value of being part of a team and receiving mandatory and frequent supervision is conveyed by most participants. Some underline how when they are affected by their own

emotions or by the avoidant patients' seemingly mental standstill or stagnation, they might lose their own ability to mentalize sufficiently, thus needing forums to remind and train them to keep their own mentalizing activity going. One participant expresses that working together in teams and having adequate treatment resources are important, as the patients' conditions and range of difficulties might be difficult to fully discover and understand. Another participant points to the value of outside observations, as "one might get lost in relations."

Making use of experience with other therapeutic approaches

Some participants talk about how they make treatment adjustments based on former experience and competences from other therapeutic orientations. One of them conveys that she sometimes finds the MBT approach inadequate in meeting the patients' needs. She describes how patients with AvPD often present with comorbidity and a wide range of symptoms that might require a different treatment approach or a combination of treatment approaches. Having been trained in dialectical behavior therapy (DBT), she explains that she makes regular use of DBT skills in her current work with patients with AvPD, especially in the treatment of those with severe anxiety. This participant explains how, for instance, treating anxiety disorders may require the active use of exposure activities and techniques, which is not inherent in the MBT approach. She emphasizes the concepts of validation and radical acceptance, both of which are central to the DBT approach.

> Radical acceptance…that's really important to me. […] Like, everything happens for a reason, and when you don't understand everything… It's easy to start fighting ourselves when we don't understand ourselves. All we see is the tip of the iceberg, and to try to understand more of ourselves, it enables working together in better ways. These are the kinds of things I've brought from DBT, because it's an important part

> of… One might validate and understand oneself in light of one's story, or I might validate the other by the way I sit in the chair, changing position […] I could validate your strength by challenging you. Validation can be used in so many ways.

Two therapists with trauma treatment experience describe making active use of emotion regulation techniques in their current work, such as making the patients hold onto small massage balls and do breathing exercises or rearranging the room to create more physical space, thereby enabling the patients to avoid sitting face to face. This is especially during the first phases of treatment or if the patient dissociates or has a background that includes severe trauma. One of these participants explains how "the window of tolerance," a central concept in trauma therapy, is inherent in the navigation of his work, making him especially observant regarding whether a patient needs his help to regulate his or her emotions, for example, by changing the subject or using bodily techniques, such as breathing. He reflects on the degree to which this type of regulation work might be a temporary move away from the mentalizing project in a given session, pointing at the same time to the regulation of emotion being a clear constituent of a mentalizing approach. For the other participant with a trauma therapy background, this professional experience is conveyed as something that strengthens her ability to handle the patients' fear and emotional pain: "I don't get stressed by…I don't feel helpless when the other gets scared, because I feel like I have a lot of competence from working with trauma and anxiety and the like. So I don't get infected by that."

DISCUSSION

The aim of this study was to inquire into therapists' experiences with MBT for patients with AvPD. Overall, all the participants expressed finding the MBT approach useful in treating patients diagnosed with AvPD. Engaging the patients and gaining access to their personal narratives appears to be a central therapeutic undertaking. The participants describe how they apply certain strategies to bring forth therapeutic material, and they seem to find the treatment structure therapeutically helpful. The participants are emotionally affected in different ways in relation to the patients, something that they seem aware of and focused on handling. For some participants, their previous professional experience seemingly aids them in their work.

The scarcity of explicit personal narratives appeared to be a significant challenge for the therapists but was interpreted as part of the patients' core problems. Approaching the patients' limited access to their own mental states and general experiential avoidance may be challenging for both the therapists and the patients. To help the patients talk about themselves and to gain access to therapeutic material, the participants described using strategies consisting of basic mentalizing attitudes and MBT-related techniques. The use of some techniques seems, however, warrant active consideration. Central to the MBT approach is an explorative focus and a mentalizing stance of the therapist; there is "an attitude of openness, inquisitiveness, and curiosity about what's going on in others' minds and in your own," and such an attitude should be stimulated in the patient as well (Allen, Bateman, & Fonagy, 2008, p. 320) However, adopting a curious attitude may not come naturally to AvPD patients. Persons with avoidant attachment styles have been found to report less curiosity than do securely attached persons and have a more rigid cognitive style with a tendency to reject new information that may cause confusion and ambiguity (Mikulincer, 1997). Correspondingly, AvPD is associated with low affect consciousness regarding the affect interest/excitement

compared to BPD and lower self-report scores on the primary emotion seeking system (Johansen et al., 2013, Karterud et al., 2016). The basic MBT premise of an open-minded, curious, and inquisitive attitude on the therapist's part may thus be at odds with some basic tendencies in the patient. Based on our findings, this contrast may create the potential for the patients to misconstrue inquisitiveness as criticism. Instead of seeing the therapist's explorative questions as a way of engaging them both in a common effort to understand and clarify the patient's mental state, the patient may interpret the therapist's questions as signaling that the patient has misunderstood something or should have considered other options. Curiosity and inquisitiveness may thus add to the patient's negative self-image and shame, which is an effect that, if not dealt with, may cause further impairment of mentalization in this situation.

As MBT entails an explicit focus on affect and actively explores emotional states, one could ask whether more cognitively or behaviorally oriented treatments may be more tolerable and easier for AvPD patients to engage in, as they often have poor affect awareness and tend to overregulate emotions (DiMaggio et al., 2019; Johansen et al., 2013). However, at this point, for avoidant patients, there is no convincing evidence that cognitively oriented therapies are more helpful than psychodynamic or affectively oriented therapies (Emmelkamp et al., 2006; Schanche, Stiles, McCullough, Svartberg, & Nielsen, 2011; Svartberg, Stiles, & Seltzer, 2004). Nonetheless, the change processes and significance of an affect focus may be dissimilar in different therapies (Ulvenes et al., 2012). Interestingly, when the participants in the present study conveyed concerns about the patients' mental withdrawal and lack of sharing, they did not seem to differentiate between affective and cognitive content but referred to the patients' personal experiences more generally. A previous study found that there is a closer correlation between affect consciousness and mentalization capacity among patients with AvPD than among patients with BPD (Johansen et al., 2018). The affective and

cognitive components of inner mental states may be strongly interwoven and difficult to disentangle in patients with AvPD.

The group therapy component of an MBT program represents extra challenges for AvPD patients. From a typical AvPD perspective, groups imply several people potentially holding critical attitudes, which may increase patients' self-consciousness and trigger extensive anxiety, thereby further blurring the capacity to mentalize and making it even more difficult to share personal information (Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003). There has been discussion of whether some patients are too anxious to benefit from group therapy (DiMaggio et al., 2019; Scholing & Emmelkamp, 1993). However, groups may, if sufficiently regulated, offer an arena in which the individual has the possibilities to have new interpersonal experiences and to moderate his or her negative perceptions of him/herself and others (Boettcher, Weinbrecht, Heinrich, & Renneberg, 2019). Yet, the question of whether individual or group therapy generally has more benefit for AvPD patients remains unanswered. The participants in our study are aware of the need to regulate anxiety within the groups to create a sufficiently safe environment for the patients to participate in. They describe various strategies they use, such as working in the here and now, thematizing the patients' lack of responses, and challenging silence in an open and curious manner in order to support group members who have exposed themselves. They also make efforts to create therapeutic material of what is absent (i.e. nonevents), thus trying to limit the patient's withdrawal both individually and from the group.

Transparency is conveyed by the participants as a central therapeutic instrument. In the participants' view, transparency serves several functions by having a reassuring effect and thus reducing insecurity, as a way of modeling and normalizing mentalization activity and demonstrating differences in perceptions to be discussed in a mentalizing fashion. Being

transparent means modeling openness and making one's own mind available to others (Robinson, Skårderud, & Sommerfeldt, 2019), for example, by sharing one's own thoughts and reflections with the patient, and it pertains primarily to the "here and now" situation. MBT transparency is not to be confused with self-disclosure, which may be defined as "therapist statements that reveal something personal about the therapist" (Hill & Knox, 2001) and to which "outside of therapy" might be added (Hill & Knox, 2001; Hill, Knox, & Pinto-Coelho, 2018). We saw that some participants mentioned occasionally sharing something of this type of personal character with patients, intending to provide emotional support and model openness. The fact that they claimed to do this more toward AvPD patients than those with BPD indicates that the question of how personal one should be is present to a larger degree in therapy with AvPD patients. Reflecting on this, one might wonder whether it has something to do with therapists sensing a need to "convey themselves as subjects," as expressed by Sørensen, Wilberg, Berthelsen, and Råbu (2019, p. 10) in their article on the subjective experience of treatment by persons diagnosed with AvPD. An urge to be more personal could also be related to what therapists perceive as patients' lack of knowledge or confusion regarding normal emotional reactions due to the patients' limited social and relational experiences.

The therapists valued the combined group and individual therapy format, and parts of the individual sessions were used to stimulate the patients to expose themselves in the groups. MBT itself does not give any directions for combined (same therapist) versus conjoint (different therapists) therapy. A clear benefit of a combined format, as presented by the participants, is that the therapists' presence in both places contributes to the continuous pressure on the patients, thus limiting possibilities for avoidance and opportunities to explore different perspectives on what happens in the group. Considering the potential benefits of a conjoint format, it might be that having a separate individual therapist would offer AvPD

patients a sort of safe haven and a sense of being part of a relationship that is more "one's own." Additionally, a conjoint format represents more relationship experiences. However, working within a conjoint therapy format will likely necessitate close cooperation between therapists in order to counteract avoidant behavior. An empirical investigation of whether either format is more advantageous will be of clinical interest.

Emerging from our data are the participants' feelings in relation to their patients—what is also termed countertransference reactions. Research has shown that patients' level of personality organization and type of personality pathology may affect therapists' emotional responses to the patients in typical ways (Stefana et al., 2020). However, to date, research on countertransference reactions in the treatment of patients with AvPD is scarce, and most studies have been performed at cluster level—that is, on cluster C (dependent, obsessive–compulsive, and avoidant) patients. Such studies have found that patients with cluster C disorders tend to evoke more positive and less negative emotional reactions—such as parental and protective responses—in their therapists (Betan, Heim, Conklin, & Westen, 2005; Røssberg, Karterud, Pedersen, & Friis, 2008). Meehan, Levy, and Clarkin (2012) found that cluster C symptoms in patients with BPD were associated with low negative affect, but the therapists also reported that they were not thinking much about the patients between sessions and found the treatments less stimulating. The authors speculate if aggression is defensively denied, resulting in less enlivened therapy. Research focusing on specific personality disorders partly support the findings from cluster C studies by reporting associations between AvPD or avoidant traits and parental and protective responses, overinvolvement, and therapists' feelings of importance and helpfulness (Colli, Tanzilli, DiMaggio, & Lingiardi, 2014; Tanzilli, Colli, Del Corno, & Lingiardi, 2016; Thylstrup & Hesse, 2008). In a study by Genova and Gazillo (2018), anxious personality patterns were associated with both a parental and a disengaged response.

In our study, we find a range of emotional reactions experienced by the participants. Urges to alleviate the patients' painful emotions and suffering, as well as their emotional discomfort when making them aware of the need to change and challenge their thoughts and beliefs, are expressed. This may be understood as conveying some of the same aspects as the abovementioned findings regarding parental and protective responses. Among the more negative feelings experienced by our participants are frustration, irritation, impatience, and provocation. This seems partly related to patients' general withdrawal and reluctance to share, and, for some, to instances in which patients in group therapy collectively fail to respond to someone's sharing, sitting quietly and appearing to be inwardly focused instead. Such reactions are in line with the clinical considerations of Cummings, Hayes, Newman, and Beck (2011), who state that AvPD patients' tendency to withdraw from therapy may be frustrating for therapists who are eager to help their patients. They discuss how therapists who become frustrated and try to shake patients out of their avoidance over time may feel ineffective and disengaged as a result of the slow pace of therapy. In the present study, the additional experiences of being infected by patients' anxiety, thereby causing performance anxiety and the devaluation of their own work, are reported. Thus, our results suggest that patients with AvPD may trigger a broader spectrum of emotional reactions than previously reported (Breivik et al., 2020). Previous studies of countertransference reactions associated with AvPD or cluster C disorders have been based on therapists' self-report questionnaires. The use of a qualitative method with in-depth interviews in the current study seems beneficial for bringing forth a more nuanced picture of therapists' feelings toward their patients.

Different findings across studies may also depend on variations in therapist samples (e.g., different professional roles and years of experience), patient samples (e.g., comorbidity), and treatments. We can only speculate on the degree to which our findings are related to MBT or

any specific aspects of the MBT approach. Those of our findings that match others', such as the more protective reactions, may be interpreted as being primarily due to patient characteristics. However, Meehan et al. (2012) found that in the treatment of patients with BPD, therapists in transference-focused therapy reported experiencing more negative affect in the treatment compared to therapists in DBT and psychodynamically oriented supportive psychotherapy, thereby indicating that the type of therapy may affect the therapists' feelings. However, other research has found that therapists' emotional responses are not influenced by the therapists' orientation (Colli & Ferri, 2015).

Notably, in our study, no therapist reactions that resemble feelings of disengagement emerged. On the contrary, the participants report that working with the patients is stimulating. Among many possible explanations is the fact that the therapists were recruited from a specialized treatment program for patients with AvPD. They were also experienced and might have had a special interest in this type of personality pathology. Moreover, the treatment is team-based with close collaboration between therapists, including regular supervision. In the interviews, the participants demonstrate an awareness of the fact that they react emotionally to their patients. Some of them convey how supervision helps them to notice and manage these reactions. MBT supervision aims to support clinicians' mentalization capacities in relation to particular patients; that is, the focus is on mentalizing the relationship, which could counteract feelings of disengagement (Bateman & Fonagy, 2016). Supervision is generally recommended when working with patients with severe personality disorders, but for various reasons, this is a recommendation that may not be followed in ordinary clinical practice.

In managing their emotional reactions to patients, some participants also convey that they profit from the experiences of other treatment approaches. We might infer that competences from other types of treatment may sometimes contribute to a professional confidence that

helps the therapists not to act on these reactions—for instance, by enabling them to withstand the urge to protect the patient and thus take part in his or her avoidance and instead dare to challenge the avoidance and tolerate the patient's anxiety as it unfolds. Related to their former professional experiences, some participants find it useful to employ strategies that are not specified within MBT. The degree to which one should adopt a more eclectic approach or shift between different therapeutic models when facing patients with a wide range of co-occurring psychiatric disorders is an important clinical question more generally. To date, there is little systematic research on this topic to guide clinicians who treat patients with personality disorders.

Our study has both strengths and limitations. All the participants in our sample have lengthy experience as therapists, are presently working with patients with both AvPD and BPD and have witnessed a broad spectrum of personality pathology. In the interviews, all the participants seemed positive; engaged; and willing to share, elaborate, and reflect on their own therapeutic practices and emotional experiences, thus contributing to the richness and nuance of the data. However, the participants were all recruited from a specialized outpatient clinic. Neither the therapists nor the patients are representative of the majority of therapists treating patients with AvPD with MBT or the patients suffering from AvPD in mentalization-oriented treatments. Additionally, all therapists were recruited from the same clinic, and the number of therapists was low. Including a larger number of therapists from different hospitals or teams might have brought more variance and supplementary perspectives into the gathered data.

CONCLUSIONS

The participants find working mentalization-based with patients with AvPD to be stimulating. In their experience, MBT targets much of the AvPD core pathology. However, the use of some techniques warrants active consideration, and there seems to be a need to adjust MBT for avoidant patients. This qualitative study revealed more nuances in therapists' countertransference reactions and more negative affect than has been reported previously. When adapting therapies to this patient group, such knowledge may be clinically useful. This includes the value of supervision. Although the participants in the present study are positive regarding the use of this approach, little is known about the effectiveness of MBT for patients who have been diagnosed with AvPD. Research investigating the effect of MBT in the treatment of avoidant patients, as well as studies exploring therapeutic processes and interventions that may facilitate change in patients with this type of personality pathology, is therefore needed.

ACKNOWLEDGEMENTS

We thank the participants who were willing to share their experiences.

DECLARATIONS

Funding

The researchers received no funding.

Conflicts of interest

The authors declare that they have no conflict of interest.

Availability of data and material

The interview guide is available on request. Datasets will not be made publicly available.

Code availability (software application or custom code)

Not applicable.

Authors' contributions

Not applicable.

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2) drafted the work or revised it critically for important intellectual content;

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* Based on/adapted from:

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ICMJE, Defining the Role of Authors and Contributors,

Transparency in authors' contributions and responsibilities to promote integrity in scientific publication, McNutt at all, PNAS February 27, 2018

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All authors are requested to include information regarding sources of funding, financial or non-financial interests, study-specific approval by the appropriate ethics committee for research involving humans and/or animals, informed consent if the research involved human participants, and a statement on welfare of animals if the research involved animals (as appropriate).

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Examples of such statement(s) are shown below:

• Free text:

All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by [full name], [full name] and [full name]. The first draft of the manuscript was written by [full name] and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Example: CRediT taxonomy:

• Conceptualization: [full name], …; Methodology: [full name], …; Formal analysis and investigation: [full name], …; Writing - original draft preparation: [full name, …]; Writing - review and editing: [full name], …; Funding acquisition: [full name], …; Resources: [full name], …; Supervision: [full name],….

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A Graduate Student's Guide to Determining Authorship Credit and Authorship Order, APA Science Student Council 2006

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Informed consent
Please note that standards could vary slightly per journal dependent on their peer review policies (i.e. single or double blind peer review) as well as per journal subject discipline. Before submitting your article check the instructions following this section carefully.

The corresponding author should be prepared to collect documentation of compliance with ethical standards and send if requested during peer review or after publication.

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The corresponding author will include a summary statement on the title page that is separate from their manuscript, that reflects what is recorded in the potential conflict of interest disclosure form(s).

See below examples of disclosures:

Funding: This study was funded by X (grant number X).

Conflict of Interest: Author A has received research grants from Company A. Author B has received a speaker honorarium from Company X and owns stock in Company Y. Author C is a member of committee Z.

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When reporting a study that involved human participants, their data or biological material, authors should include a statement that confirms that the study was approved (or granted exemption) by the appropriate institutional and/or national research ethics committee (including the name of the ethics committee) and certify that the study was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the reasons for their approach, and demonstrate that an independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study. If a study was granted exemption from requiring ethics approval, this should also be detailed in the manuscript (including the reasons for the exemption).

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If human cells are used, authors must declare in the manuscript: what cell lines were used by describing the source of the cell line, including when and from where it was obtained, whether the cell line has recently been authenticated and by what method. If cells were bought from a life science company the following need to be given in the manuscript: name of company (that provided the cells), cell type, number of cell line, and batch of cells.

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Antibody: Luciferase antibody DSHB Cat# LUC-3, RRID:AB_2722109

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Summary of requirements
The above should be summarized in a statement and placed in a "Declarations" section before the reference list under a heading of 'Ethics approval'.

Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

Examples of statements to be used when ethics approval has been obtained:

• All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the Bioethics Committee of the Medical University of A (No. ...).

• This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of University B (Date.../No. ...).

• Approval was obtained from the ethics committee of University C. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

• The questionnaire and methodology for this study was approved by the Human Research Ethics committee of the University of D (Ethics approval number: ...).

Examples of statements to be used for a retrospective study:

• Ethical approval was waived by the local Ethics Committee of University A in view of the retrospective nature of the study and all the procedures being performed were part of the routine care.

• This research study was conducted retrospectively from data obtained for clinical purposes. We consulted extensively with the IRB of XYZ who determined that our study did not need ethical approval. An IRB official waiver of ethical approval was granted from the IRB of XYZ.

• This retrospective chart review study involving human participants was in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The Human Investigation Committee (IRB) of University B approved this study.

Examples of statements to be used when no ethical approval is required/exemption granted:

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When biological material is donated for or data is generated as part of a research project authors should ensure, as part of the informed consent procedure, that the participants are made what kind of (personal) data will be processed, how it will be used and for what purpose. In case of data acquired via a biobank/biorepository, it is possible they apply a broad consent which allows research participants to consent to a broad range of uses of their data and samples which is regarded by research ethics committees as specific enough to be considered “informed”. However, authors should always check the specific biobank/biorepository policies or any other type of data provider policies (in case of non-bio research) to be sure that this is the case.

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here. (Download docx, 36 kB)

Summary of requirements
The above should be summarized in a statement and placed in a "Declarations" section before the reference list under a heading of 'Consent to participate' and/or 'Consent to publish'.

Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

Provide "Consent to participate" as a heading

Sample statements for consent to participate:

Informed consent was obtained from all individual participants included in the study.

Informed consent was obtained from legal guardians.

Written informed consent was obtained from the parents.

Verbal informed consent was obtained prior tothe interview.

Sample statements for "Consent to publish":

The authors affirm that human research participants provided informed consent for publication of the images in Figure(s) 1a, 1b and 1c.

The participant has consented to the submission of the case report to the journal.

Patients signed informed consent regarding publishing their data and photographs.

Sample statements if identifying information about participants is available in the article:

Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.

Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.

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Vedlegg 2 – Skriftlig informert samtykke

UiO : Det medisinske fakultet
Universitetet i Oslo

Vil du delta i forskningsprosjektet
Mentaliseringsbasert terapi ved unnvikende personlighetsforstyrrelse"?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å bidra til økt kunnskap om terapeuters erfaring med en mentaliseringsbasert tilnærming til pasienter med unnvikende personlighetsforstyrrelse (UvPF). I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål
Så langt er en mentaliseringsbasert tilnærming i behandlingen av pasienter med UvPF lite utprøvd, og det er behov for kunnskap om hvordan en slik tilnærming kan modifiseres for å bli effektiv for disse pasientene. Utforskning av terapeuterfaringer kan gi grunnlag for hypoteser og peke ut retninger for videre studier. Formålet med dette mastergradsprosjektet er derfor å bidra til økt kunnskap om terapeuters erfaring med mentaliseringsbasert terapi (MBT) til pasienter med unnvikende personlighetsforstyrrelse.

Intervjuene vil utforske i hvilken grad terapeutene opplever at en mentaliseringsbasert tilnærming er hensiktsmessig for denne pasientgruppen; hvilke eventuelle utfordringer terapeutene opplever i arbeidet, terapeutenes refleksjoner omkring eget arbeid og deres oppfatninger av hva pasienter med unnvikende personlighetsforstyrrelse generelt har behov for i terapi.

Innhentede opplysninger vil bli brukt i artikkelen som skrives som del av masteroppgaven, samt i eventuell senere undervisning om temaet og ved formidling av funn i aktuelle fora, som eksempelvis til ansatte i Nasjonal kompetansetjeneste for personlighetspsykiatri.

Hvem er ansvarlig for forskningsprosjektet?
Universitetet i Oslo (UiO) er ansvarlig for prosjektet.

Hvorfor får du spørsmål om å delta?T
Vi søker å rekruttere terapeuter som arbeider mentaliseringsbasert og i team med pasienter med unnvikende personlighetsforstyrrelse, og derfor blir du spurt om å delta. Det tas sikte på å inkludere 5-7 terapeuter.
Leder(e) ved aktuelle avdelinger kontaktes og forespør sine terapeuter om å delta. Nasjonal kompetansetjeneste for personlighetspsykiatri har bidratt med informasjon om aktuelle behandlingsmiljøer, samt med kontaktopplysninger.

Hva innebærer det for deg å delta?
Dersom du velger å delta i prosjektet, innebærer det at du lar deg intervjue, samt svarer på et kort spørreskjema med bakgrunnsopplysninger. Intervjuet vil vare i mellom 45 og 60 minutter. Intervjuet blir tatt opp på lydbånd og senere transkribert.

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Telefaks: 22 85 05 70
postmottak@medisin.uio.no
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Vedlegg 2 – Skriftlig informert samtykke

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Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykke tilbake uten å oppgi noen grunn. Alle opplysninger om deg vil da bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg. Informasjonen du gir i intervjuene vil ikke få konsekvenser for dine nåværende eller fremtidige arbeidsforhold.

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Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

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Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?
Prosjektet skal etter planen avsluttes innen 31.12.2020. Datamaterialet blir da anonymisert og slettet etter 5 år pga. artikkel-publiseringen.

Hvor kan jeg finne ut mer om studien?
Hvis du har spørsmål til studien ta kontakt med:

- Masterstudent Mona Skjeklesæther Pettersen, tlf. 995 12 790 eller epost: m.i.s.pettersen@studmed.uio.no
- prosjektansvarlig ved Universitetet i Oslo, professor Anne Moen, epost: anne.moen@medisin.uio.no, medveileder Elin Børøsund (epost: elin.borosund@rr-research.no) eller medveileder Theresa Wilberg (epost: UXTHWI@ous-hf.no).

Dine rettigheter
Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke.

Vedlegg 2 – Skriftlig informert samtykke

På oppdrag fra Universitetet i Oslo har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket. Hvis du ønsker å benytte deg av dine rettigheter, ta kontakt med:

- Masterstudent Mona Skjeklesæther Pettersen, tlf. 995 12 790, epost: m.i.s.pettersen@studmed.uio.no
- prosjektansvarlig ved Universitetet i Oslo, professor Anne Moen, epost: anne.moen@medisin.uio.no
- Vårt personvernombud: personvernombud@uio.no.
- NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller telefon: 55 58 21 17.

Med vennlig hilsen

Anne Moen

Prosjektansvarlig

Mona Skjeklesæther Pettersen

Masterstudent

Intervjuguide

Terapeuters erfaring med mentaliseringsbasert terapi til pasienter med unnvikende personlighetsforstyrrelse.

Spørsmål (og underpunkter til bruk ved behov)

1) Kan du fortelle litt fra den siste terapitimen du hadde?

- Tenkte du noe på forhånd; tenkte du noe etterpå, om hva du gjorde; om hva du ev. ideelt sett burde ha gjort annerledes.
- Husker du noen vurderinger du gjorde underveis, eksempelvis om hva du skulle følge opp, fokusere på?

2) Et fokus for terapien er å øke pasientens mentaliseringsevne. Kan du si noe om hvordan du vanligvis gjør det?

- Eventuelle utfordringer knyttet til dette.

3) Opplever du at en mentaliseringsbasert tilnærming har noe for seg for pasienter med unnvikende personlighetsforstyrrelse?
- Utdype: Hvorfor/hvorfor ikke? Dersom ja; hva ved denne tenkningen har noe for seg? Hva ved MBT-teorien oppleves som nyttig? (Følge det som kommer opp.)

4) Er det spesielle utfordringer du opplever ved å jobbe mentaliseringsbasert med denne pasientgruppen?

Vedlegg 3 – Intervjuguide med skjema for bakgrunnsinformasjon

- Tenk gjerne på en konkret terapi/terapitime; hvilke utfordringer opplevde du, og hvordan løste du det?

5) Jeg vil gjerne at du tenker på to forskjellige individualterapier eller to forskjellige grupper. Kan du fortelle litt om det som dukker opp hos deg når du tenker på det?

- Kan være temaer pasientene er opptatt av; hva du som terapeut gjør eller er opptatt av, hva ved MBT-tenkningen er det du bruker?

6) Pasienter med unnvikende PF er ofte utrygge, også i timene, og mange distanserer seg. Hva er din erfaring med dette?

- Hvordan forsøker du å håndtere det? Har du et eksempel?

7) Gruppeterapi: Hvordan er det å drive mentaliseringsbasert gruppeterapi med disse pasientene?

- Hvordan anvender du/dere MBT-tenkningen i gruppeterapi? Hva er eksempelvis erfaringen med å dele historier/bringe inn hendelser?
- Hvilken nytte/funksjon har gruppeterapien for disse pasientene, tenker du?
- Eventuelle utfordringer? Forskjell på utfordringer i individual- vs. gruppeterapi?

8) Hva er ditt inntrykk av hva pasientene setter pris på at du gjør; hva de responderer på?

- Er det noe du gjør overfor disse pasientene som du vanligvis ikke gjør?

9) Dersom du legger MBT-tenkningen til side: Hva tenker du er viktig i terapi med disse pasientene?

10) Jeg er nysgjerrig på hvordan du opplever å jobbe med denne pasientgruppen, kan du si litt om det?

Vedlegg 3 – Intervjuguide med skjema for bakgrunnsinformasjon

11) Er det ellers noe du ønsker å si noe om om, noe du brenner inne med eller tenker det er viktig at jeg får vite som du ikke har spurt om?

Spørsmål til terapeuter - bakgrunnsinformasjon

Masteroppgave: Mentaliseringsbasert terapi ved unnvikende personlighetsforstyrrelse

Hensikten med disse spørsmålene er å få noe informasjon om din utdannelsesbakgrunn og din erfaring som terapeut.

1) Din grunnutdannelse:

2) Eventuell videreutdanning:

3) Har du gjennomført/er du i gang med utdannelse/kurs innen mentaliseringsbasert terapi? Beskriv:

4) Hvor lenge har du arbeidet som terapeut totalt?

5) Antall års arbeidserfaring med pasienter med unnvikende personlighetsforstyrrelse:

6)
   a. Hvor mange pasienter med unnvikende personlighetsforstyrrelse har du hatt?

   b. Hvor mange pasienter med unnvikende personlighetsforstyrrelse har du i dag?

7) Har du erfaring med å jobbe med pasienter med andre typer personlighetsforstyrrelser? Utdyp gjerne.

MASTEROPPGAVENS DEL 2:
REFLEKSJONSOPPGAVE

Mentaliseringsteoriens relevans i en sykepleiefaglig kontekst

INNHOLDSFORTEGNELSE

1.0 INNLEDNING

Fokus for masterstudien har vært terapeuters erfaringer med mentaliseringsbasert terapi (MBT) til pasienter med unnvikende personlighetsforstyrrelse (UvPF) (Pettersen, Moen, Børøsund og Wilberg, 2020). Seks MBT-terapeuter – to spesialsykepleiere og fire psykologer – ble intervjuet om sine erfaringer med en mentaliseringsbasert tilnærming til denne pasientgruppen.

Studien har altså et hovedsakelig psykoterapeutisk fokus, som likevel er sykepleiefaglig relevant: Spesialsykepleiere arbeider som psykoterapeuter innen psykisk helsevern og rusomsorg. De har behandleransvar og deltar i utvikling av behandlingsprogram. Spesialsykepleiere kan videre utdanne seg til MBT-terapeuter, i Norge blant annet ved Institutt for mentalisering (Institutt for mentalisering, 2020). Studiens problemstilling og funn har med andre ord klar relevans for kunnskapsutvikling i sykepleie.

I det følgende skal det først dreie seg om mentalisering mer generelt. Mentaliseringsteori omhandler fenomener som angår oss alle. Oppgaven vil utdype studiens problemstilling og søke å reflektere over hvordan sykepleiere i terapeutiske settinger kan dra nytte av mentalisering og aspekter ved MBT. Det tas ikke sikte på noen uttømmende fremstilling av hva mentaliseringstenkningen kan bidra med; heller er det refleksjon rundt hvordan å ha oppmerksomhet rettet mot eget og andres sinn kan være til hjelp i et sykepleiefaglig og spesielt terapeutisk arbeid. Sykepleiere arbeider kontinuerlig i relasjon og står ofte i krevende mellommenneskelige interaksjoner. Aspekter ved Hildegard Peplau (1952, 1997) sin teori om mellommenneskelige relasjoner i sykepleie trekkes inn i refleksjonen for å belyse assosiasjoner mellom sykepleiepraksis og mentaliseringsteori.

2.0 MENTALISERING

"Mentalizing well helps all human activities." (Robinson, Skårderud og Sommerfeldt 2019, s.194).

2.1 Om mentaliseringsbegrepet

Mentalisering viser til *å oppfatte egen og andres atferd som uttrykk for mentale tilstander* - tanker, følelser, fantasier, forestillinger - og kan defineres som «the capacity to make sense of self and of others in terms of subjective states and mental processes» (Fonagy og Bateman, 2007, s. 83). Å mentalisere handler om å ha fokus på mentale tilstander hos seg og andre. Innen psykisk helsevern og rusomsorg vil dette ofte dreie seg særlig om å kunne reflektere aktivt omkring tanker og følelser. Å mentalisere godt kan beskrives som å føle klarere (Skårderud, 2016). Mentalisering er omtalt som selve grunnlaget for å kunne skape og opprettholde meningsfulle mellommenneskelige relasjoner, siden mentalisering muliggjør å innta andres perspektiv samtidig med at vi er bevisst egne tanker, følelser og behov (Fonagy, Gergely, Jurist og Target, 2002).

Mentalisering og mentaliseringskapasitet kan sies å ha og foregå langs fire ulike dimensjoner (Bateman og Fonagy, 2016). Den mest fundamentale omhandler *automatisk/implisitt versus kontrollert/eksplisitt* mentalisering. Automatisk mentalisering er ubevisst og rask prosessering av egne og andres mentale tilstander; kontrollert mentalisering handler om bevisst å reflektere over hva som skjer. Videre handler dimensjonene om mentaliseringskapasitet knyttet til *selv eller til andre* og om et fokus på *interne eller eksterne forhold*. Eksempelvis kan pasienten kun basert på terapeutens ansiktsuttrykk gjøre seg bastante antakelser om terapeutens tanker om henne. Hun legger overdreven vekt på eksterne faktorer og ser bort fra alt som kan foregå

«på innsiden av» terapeuten. Den siste dimensjonen dreier seg om *kognitiv versus affektiv prosessering.* Man kan gjenkjenne og resonnere omkring en bestemt mental tilstand, og man kan ha evnen til å forstå hvordan en bestemt mental tilstand *føles* (Bateman og Fonagy, 2016). Når man mentaliserer, altså er i en mentaliserende tilstand og ikke opplever mentaliseringssvikt (jfr. 2.3), er disse fire dimensjonene i en balanse som gjør oss i stand til å være oppmerksomme på og rommende for det som skjer i oss selv, samtidig med at vi kan «tune inn» på andre menneskers mentale opplevelser og være emosjonelt tilgjengelige for dem (Bateman og Fonagy, 2016; Luxmoore og McEvoy, 2017).

Mentalisering overlapper delvis med flere andre begreper, som refleksivitet, selvrefleksjon, observerende ego, oppmerksomt nærvær, empati, emosjonell intelligens og metakognisjon (Allen, 2003; DiMaggio og Lysaker, 2015; Skårderud og Sommerfeldt, 2013). Mentalisering favner imidlertid bredere, og integrerer elementer fra evolusjonsteori, tilknytningsteori, utviklingspsykologi, psykoanalyse og nevrovitenskap (Fonagy et al., 2002; Skårderud og Sommerfeldt, 2013). Mentaliseringsbegrepet kan hjelpe oss med å være presise på hva vi snakker om. «One good reason is grammatical: We need a verb. We need a way to refer to a mental activity. [...] Alternatives like “psychological mindednessing” […] or “observing egoing” simply will not do» (Allen, 2003, s.96). Et alternativ kunne være å snakke om fortolkning, *interpretation;* «a competence that allows primates to make sense spontaneously and effectively of each other in terms of behavioral dispositions and psychological attributes, such as character traits, emotions, feelings, and attitudes» (Bogdan, 1997, s.1). Imidlertid kan mye i verden tolkes og fortolkes, mens mentalisering handler om et begrenset område som fortolkes: oss selv og andre mennesker, og gir oss dermed et eget begrep til bruk i denne sammenhengen (Allen, 2003). Vi vil i det videre også se at mentalisering og mentaliseringsbegrepet bidrar med forståelse og språk for hva som kan skje med oss når vi

står i stressende og emosjonelt krevende situasjoner, som sykepleiere opplever mange av, og som vil påvirke og muligvis svekke vår evne til å *forholde oss på meningsfullt vis til den andre* (Peplau, 1997, jfr. 3.1).

2.2 Mentalisering og tilknytning

Mentaliseringsteori har røtter i John Bowlby sin tilknytningsteori (Skårderud og Sommerfeldt, 2013). Begrepet tilknytning viser til utviklingen av det sterke følelsesmessige båndet mellom barn og omsorgspersonen i barnets første leveår. Utvikling av mentaliseringsevne ses som avhengig av kvaliteten på det sosiale miljøet barn vokser opp og lærer i, på relasjonene i familien, og ikke minst av kvaliteten nettopp på barnets tidligere tilknytninger, fordi disse reflekterer i hvilken grad barnets subjektive opplevelser ble tilstrekkelig speilet av en omsorgsperson (Bateman og Fonagy, 2016).

Et eksempel på speiling er at dersom barnet gråter, så viser omsorgspersonen med ansiktsuttrykk og lyder at vedkommende skjønner at barnet har det dårlig. Den voksne *speiler* barnets ubehag. Barnet «finner igjen seg selv» i omsorgspersonens oppmerksomhet, som Skårderud og Sommerfeldt (2013, s.76) uttrykker det. Samtidig tar omsorgspersonen ansvar og viser barnet at følelsen er håndterbar, gjennom å trøste ved smil og pludring og ved å lindre ubehaget barnet har. Den voksne formidler slik både en forståelse av barnets indre tilstand *og* at situasjonen er til å håndtere og ordne opp i.

Barn lærer altså å mentalisere ved å bli mentalisert; at en annen holder deres sinn i sitt eget (Allen, Fonagy og Bateman, 2008). Trygg tilknytning fremmes om man som barn opplever å bli sett av omsorgspersonen, og tilknytningen fremmer igjen evnen til mentalisering, «en åpen

nysgjerrighet overfor andres mentale tilstander og hvordan vi kan erfare virkeligheten på forskjellig vis» (Skårderud og Sommerfeldt, 2008, s.1067).

Utrygg tilknytning, derimot, kan følge av eksempelvis psykiske traumer i barndom og svekker eller hemmer de mentaliserende evnene (Skårderud og Sommerfeldt, 2008). Man antar at vansker med affektregulering, oppmerksomhet og selvkontroll som stammer fra en eller annen form for dysfunksjonelle tilknytningsrelasjoner, utvikles som følge av sviktende tilegning av robuste mentaliseringsevner (Bateman og Fonagy, 2016).

> From this perspective, mental disorders in general can be seen as arising when the mind misinterprets its own experience of itself and of others, to the extent that a mental picture of others is inferred from one's experience of oneself (Bateman og Fonagy, 2016, s.6).

Hvor godt vi mennesker evner å forstå oss selv og andre som voksne, handler derfor mye om i hvilken grad våre mentale tilstander fanges opp og forstås av oppmerksomme, omsorgsfulle og ikke-truende voksenpersoner når vi er barn (Bateman og Fonagy, 2016).

2.3 Mentaliseringssvikt

Ved noen lidelser, spesielt personlighetsforstyrrelser, spiller evne til mentalisering en sentral rolle. Mentaliseringsbasert terapi (MBT) ble opprinnelig utviklet for å behandle pasienter med emosjonelt ustabil personlighetsforstyrrelse (Bateman og Fonagy, 2004, 2006) på bakgrunn av en forståelse av at svikt i nettopp mentaliseringsevnen er «den patogene kjernen» (Karterud, 2012, s.26) hos pasienter med denne lidelsen. Premisset for MBT er at en bedret mentaliseringsevne vil gi pasientene økt evne til følelsesregulering (Skårderud, 2016). MBT søker å bidra til økt opplevelse av selvsammenheng og identitet og å styrke evne til relasjonell

fungering, som igjen vil dempe symptomer, eksempelvis utagering i ulike former (Karterud, 2012). Dette impliserer at mentalisering generelt er en ferdighet som, i varierende grad, kan arbeides med og utvikles (Allen et al., 2008).

Alle mennesker vil oppleve at mentaliseringskapasiteten varierer med ulike kontekster og relasjoner. Kapasiteten er ikke konstant og vil raskt reduseres når vi kjenner oss truet, usikre eller emosjonelt overveldet. «Mentaliseringsevnene er sterkt avhengige av følelsesmessige og relasjonelle sammenhenger. I affekt vil også de som vanligvis mentaliserer godt, få svakere evne til å forstå den andre. Sinne, frykt og angst gjør oss mentalt blindere» (Skårderud og Sommerfeldt, 2008, s.1068).

Mentaliseringssvikt innebærer altså et midlertidig eller mer omfattende fall i evnen til å kunne tenke og reflektere rundt egne og andres mentale tilstander (Karterud, 2013). Man kan snakke om en «re-emergence of nonmentalizing modes» (Bateman og Fonagy, 2016 s.16).
Slike ikke-mentaliserende modi og måter å tenke på har paralleller til hvordan små barn tenker og oppfører seg før de har utviklet mentaliseringskapasitet. Man kan dermed også kalle det for pre-mentaliserende modi. Disse måtene å oppleve seg selv og omverdenen på har en tendens til å dukke opp når man mister mentaliseringsevnen (Bateman og Fonagy, 2016).

Det er beskrevet tre grunnformer for *ikke-mentalisering*. *Psykisk ekvivalens* innebærer at man setter likhetstegn mellom mentale tilstander og virkeligheten. «Det er en umiddelbarhet mellom mental og fysisk erfaring, en slags kortslutning, som undergraver tvil og usikkerhet» (Skårderud og Sommerfeldt, 2013, s.94). Man lukker seg for andre måter å oppfatte seg selv eller andre på. En annen form for ikke-mentalisering er *forestillingsmodus*, hvor mentale tilstander på et vis er frakoblet virkeligheten (Allen et al., 2008). Man kan hypermentalisere eller pseudomentalisere, altså si mye om mentale tilstander, men med lite egentlig mening

eller tilknytning til virkeligheten. «Språket går på tomgang, og det kan være uklart hva samtalen egentlig handler om» (Skårderud og Sommerfeldt, 2013, s.19). Eksempelvis kan vi bekymre oss svært for noe uten å få tak i hva vi egentlig tenker og føler.

Teleologisk modus, den tredje formen for mentaliseringssvikt, viser til at mentale tilstander gjenkjennes og er til å tro på kun dersom utfallene av dem faktisk kan observeres. Uttrykk for affekt fra en annen person er til å tro på kun dersom uttrykket inneholder fysisk kontakt som et kyss eller berøring. «Jeg tror det ikke før jeg ser det» (Skårderud, Sommerfeldt og Fonagy, 2012, s.26).

Mentalisering er en grunnleggende menneskelig og sosial kapasitet, og vi holder på med det hele tiden – godt eller mindre godt.

2.4 Mentalisering og self-awareness

Vi ser likheter mellom mentalisering og det mer sykepleiefaglig benyttede *self-awareness,* eller selvbevissthet.[1] Det er skrevet mye om betydningen av self-awareness innen sykepleiefeltet (Rasheed, Younas og Sundus, 2018). Self-awareness kan defineres som «a multidimensional, introspective process used to become aware of, scrutinize, and understand one's thoughts, feelings, convictions, and values on an ongoing basis, with the use of this understanding to consciously and authentically guide behavior» (Eckroth-Bucher, 2010, s.304). Self-awareness handler om sykepleierens evne til å forstå sin indre verden, hvordan denne påvirkes av interaksjoner med pasienter, og hva dette igjen gjør med sykepleierens holdning og handling i møte med pasientene (Satran et al., 2020).

[1] Fordi det norske «selvbevissthet» i dagligtalen ofte brukes om en persons oppfatning av egen verdi og egenart og knyttes til identitet (Svendsen, 2020) og slik gjenspeiler noe litt annet enn self-awareness slik dette brukes i den aktuelle sammenheng, benyttes her det engelske begrepet.

Både mentalisering og self-awareness innebærer å utforske og være bevisst egne indre tilstander. En sentral ulikhet er imidlertid at mentalisering, i motsetning til self-awareness, retter seg eksplisitt mot *den andre* og den andre sine mentale tilstander. Dette tydeliggjøres i de enklere beskrivelsene av mentalisering: «A shorthand idea for mentalizing is keeping mind in mind» (Allen et al. 2008, s.312), ens eget eller andre sitt sinn; og «Seeing yourself from the outside and others from the inside» (Allen et al. 2008, s.3). Man er *mindful,* bevisst, på hva andre tenker og føler, i tillegg til å være bevisst egne tanker og følelser. Self-awareness dreier seg om *mentalisering av selv*, mens mentalisering også har et iboende fokus på mentalisering av andre (Allen et al., 2008). Dermed handler mentalisering også eksplisitt om empati, kort definert som et ønske om å identifisere en annen persons tanker og følelser, for så å respondere på dette med en passende emosjon (Baron-Cohen, 2003). I en sykepleiekontekst kan vi beskrive empati som evnen man har til å forstå og møte pasientens emosjonelle og fysiske behov (Satran et al., 2020). Empati kan altså sies å "go beyond" mentalisering, siden empati krever en emosjonell respons (Allen et al., 2008), en form for handling, i motsetning til «kun» en mental forestilling om den andre sitt sinn. Mentaliseringens tydelige andre-fokus betyr imidlertid ikke at self-awareness kun handler om selvet; å være self-aware gir nettopp muligheten til å fokusere på og tilpasse seg den andre, for øvrig et fokus vi finner igjen hos Hildegard Peplau (1952).

3.0 HILDEGARD PEPLAU: SYKEPLEIER-PASIENT-RELASJONEN

Å mentalisere kan altså beskrives som å se seg selv utenfra og andre innenfra (Skårderud, 2016). En slik formulering av hva mentalisering dreier seg om, fanges opp i arbeidene til den psykiatriske sykepleieren og teoretikeren Hildegard Peplau. Peplau har spesielt fokusert på og

bidratt til å utvikle teoretiske perspektiver om den mellommenneskelige relasjonen i sykepleie.

3.1 Sykepleiens hensikt

Særlig relevant for sykepleieres rolle er det i følge Peplau (1989) at man, noe avhengig av kontekst, har mer tid å tilbringe med pasienten enn hva legen har, og at man observerer pasienten i en rekke ulike situasjoner. Dette gir unike muligheter til å bli kjent med pasienten og med pasientens opplevelse av sin situasjon, og legger en føring på sykepleiere om å «relate meaningfully to the reaction of the patient to his or her illness» (Peplau, 1989, s. 43). Sykepleiere skal ikke passivt være oppmerksomme på og registrere pasientens reaksjoner, man skal gå aktivt inn og hjelpe pasienten med å bli bevisst på og forstå egne reaksjoner. I tillegg skal man gi helseinformasjon og slik styrke pasientens evne til å håndtere situasjonen. Å hjelpe pasienten med å anerkjenne og forstå egne reaksjoner her og nå vil kunne bidra til at pasienten opplever økt selvforståelse som hun eller han kan dra nytte av på lengre sikt (Peplau, 1997).

3.2 Karakteristika ved sykepleierens arbeid

På bakgrunn av den over beskrevne hensikt, må sykepleierens bidrag til pasient-sykepleier-relasjonen inneholde noen spesifikke egenskaper (Peplau, 1989). Et første kjennetegn på profesjonell sykepleie er at fokuset er på pasienten, som innebærer at sykepleieren må sette til side personlige og sosiale behov og fokusere på «[to] aid the patient in exploring his or her concerns and observations» (Peplau, 1989, s.45). Peplau (1989) beskriver at hun, når hun underviser i psykiatrisk sykepleie, opplever at sykepleiere har store vansker med å legge vekk «personal nurse concerns» (s.45) og i stedet fokusere på det pasienten erfarer og opplever. Om sykepleieren blir for personlig i kontakten, kan pasienter tenke at de blir bedømt på

sosialt grunnlag, slik som ellers i livet i når målet er å bygge sosiale relasjoner, og oppleve at de må være «gode nok» som en part i relasjonen. Denne type oppfatninger hos pasienter kan motvirkes ved at sykepleiere unnlater å dele med pasienten egne vansker, forventinger og bekymringer (Peplau, 1989).

En andre egenskap handler om at sykepleiere skal benytte det Peplau (1989) kaller *participant observation* heller enn å benytte *spectator observation.* Heller enn å stå som tilskuer og observere kun pasienten, er sykepleieren deltaker i sin egen observasjon; hun observerer også seg selv på en ærlig og granskende måte - hun er *self-aware* (jfr. 2.4) - med mål om en atferd som tjener pasienten.

> "Participant observation requires the nurse to notice not only the behavior of the patient but her own as well. An interaction is an ongoing drama; the nurse enters the patient's room and says something, the patient responds to the nurse, the nurse then reacts to the patient, and so on. […] For example, the patient may evoke in the nurse the feeling of anger or disgust, a response the nurse must then manage in one way or another." (Peplau, 1989, s.46).

En sykepleier med stort behov for å bli likt eller anerkjent, eksempelvis, kan havne i et atferdsmønster overfor pasienten som tilfredsstiller dette personlige behovet. En konsekvens kan være at sykepleieren ikke fanger opp viktige problemstillinger og behov hos pasienten (Peplau, 1992).

En tredje egenskap knyttet til sykepleie er i følge Peplau (1989) at sykepleien primært er undersøkende. Man må signalisere tydelig til pasienten at man har tid, eksempelvis ved å sette

seg ned og si at man har tid. Å undersøke handler videre om å stille spørsmål, om aktivt å følge opp det pasienten kommer med av utsagn og kommentarer, og om å lytte når pasienten forteller; spesielt etter «the naunces of hidden meaning» (Peplau, 1989, s.48).

> "There is often too hasty an effort on the part of the nurses to make pronouncements, to reach conclusions, to give advice and close off situations rather than to find out, to seek to know, to leave situations open to further discussions not yet neatly pinned down, even with relevant or good answers. (Peplau, 1989, s.47).

I sykepleiens undersøkende natur kan vi se paralleller til det som i kapittel to ble referert til som eksplisitt mentalisering, som altså innebærer aktiv utforskning av ulike perspektiver og tolkninger. I det videre trekkes tråder mellom å inneha en mentaliserende holdning (Bateman og Fonagy, 2016) i møte med pasienter og det å få til en undersøkende og pasientrettet sykepleie (Peplau, 1989), spesielt i terapeutisk sammenheng. Peplau er opptatt av sykepleieres evne til å vurdere og tilpasse egen atferd til pasientens behov. Mentaliseringsteorien gir språk for noe av det som skjer når vi opplever vansker med nettopp dette. På bakgrunn av funnene i studien til Pettersen et al. (2020) trekkes det frem spesielt én faktor som innvirker på evnen til self-awareness og mentalisering - *emosjonell påvirkning* i relasjoner.

4.0 EN MENTALISERENDE HOLDNING OG IKKEVITENHET

I artikkelen til Pettersen et al. (2020) fremkommer at et sentralt fokus for terapeutene er å *frembringe* terapeutisk material; dette kommer ikke av seg selv. Terapeutene må være «på» for å få pasienten til å dele av egne historier og hendelser fra hverdagen, og beskriver hvordan de arbeider for å engasjere pasienten i en utforskende dialog. Når man som sykepleier skal hjelpe pasienter med å bli bevisst på og forstå sine egne reaksjoner (Peplau, 1989), er det nyttig å merke seg terapeutenes eksempler fra klinikken (Pettersen et al., 2020), som viser at man ikke kan for gitt uten videre å få tilgang til pasienters opplevelser og reaksjoner. De synliggjør også at pasienters taushet ikke nødvendigvis er synonymt med at de ikke har noe å dele eller ikke egentlig ønsker å dele. På denne bakgrunnen kan man anta at sykepleiere kan dra nytte av en mentaliserende holdning – *a mentalizing stance* – i pasientmøter. En mentaliserende holdning handler om å ha en undersøkende, empatisk, åpensinnet og ikke-vitende tilnærming til egne og andres mentale tilstander (jfr. 2.1) og om en evne til å se og vurdere flere perspektiver (Bateman og Fonagy, 2016). Det handler om å være eksplisitt nysgjerrig på egne og andres oppfatninger av virkeligheten. Man stiller spørsmål som undersøker pasientens oppfatninger og forståelse av situasjonen (Bateman og Fonagy, 2016). Slik kan vi hjelpe til med å klargjøre for pasienten hva som skjer i vedkommende og vi gir oss selv økt mulighet til å forstå hva pasientens behov i situasjonen er, slik Peplau (1997) vektlegger. Informantene i studien til Pettersen et al. (2020) beskriver at de vier mye oppmerksomhet til pasienten og relasjonen «her og nå». Terapeutene er oppmerksomme på endringer i pasientens atferd, som når pasienten brått blir stille eller flytter blikket. De påpeker observasjonen for pasienten og inviterer pasienten til å kjenne etter og si noe om hva som skjer. Et slikt her og nå-fokus behøver ikke å være begrenset til terapeutisk arbeid; derimot kan det sies å være et aspekt ved sykepleiefaglig arbeid generelt og en del av å hjelpe

pasienter med å «articulate and know more about their reactions to their illness» (Peplau, 1997, s.164).

Den ikke-vitende komponenten i en mentaliserende holdning er sentral og handler om anerkjennelse av at pasientens mentale tilstander er ugjennomsiktige (Allen et al., 2008). Det dreier seg *ikke* om at man ikke har kunnskap; det man i utgangspunktet er ikke-vitende om, er pasientens mentale tilstander (Bateman og Fonagy, 2016). En ikke-vitende holdning står i kontrast til ubegrunnede antakelser og raske konklusjoner om andres tanker og følelser. Man er bevisst på at man ikke vet og fremviser aktiv vilje til å forstå mer og til å ta pasientens perspektiv. I terapi bidrar fokuset på ikkevitenhet til at terapeuten opprettholder nysgjerrighet rundt pasientens mentale tilstander. Deler av årsaken er at man i en mentaliseringsbasert terapi ønsker at nysgjerrighet med tiden skal smitte, altså pasienten skal bli mer nysgjerrig på egne mentale tilstander. Skårderud og Sommerfeldt (2013) kaller det *nysgjerrighet by proxy,* altså *ved en annen*. Informantene til Pettersen et al. (2020) snakker nettopp om at de formidler nysgjerrighet rundt hvor pasientens forestillinger om seg selv kommer fra, for slik å stimulere pasientens nysgjerrighet på seg selv, i tillegg til å demonstrere at pasientens oppfatninger er nettopp oppfatninger og ikke er faktisk bilde av virkeligheten – det finnes alternativer.

I mange sykepleiesettinger vil sykepleierens nysgjerrighet på pasientens opplevelser kanskje primært ha en her og nå-funksjon, som beskrevet over, og vi kan tenke at det i tillegg til å bidra til utforskning er viktig i en innledende fase for å bli kjent og bygge relasjon, og dermed for det videre forløp. «[It] is during this time period, in the orientation phase, that the nurse's behavior signals a pattern of receptivity and interest in the patient's concerns or fails in this regard." (Peplau, 1997, s.164).

Samtidig som at en mentaliserende holdning kan underbygge engasjement og utforskning, kan det også, slik Pettersen et al. (2020) fant, være utfordringer knyttet til aktiv utforskning av pasientens opplevelser. Dette gjelder eksempelvis i møte med pasienter med mer omfattende mentaliseringssvikt relatert til redusert bevissthet omkring affekt og mentale tilstander generelt, som ved unnvikende personlighetsforstyrrelse. Sterke emosjoner kan true mentalisering hos ethvert menneske, og dersom man ikke vet hva man føler, kan spørsmål om hva man føler, oppleves frustrerende (Skårderud og Sommerfeldt, 2013). Funn i studien til Pettersen et al. (2020) indikerer at å bli møtt med en nysgjerrig og undrende holdning kan oppleves vanskelig for mennesker som selv kjenner lite på nysgjerrighet og som er spesielt sårbare for andres vurdering. En av informantene fremholder hvordan det å sette spørsmålstegn ved en opplevelse eller forestilling kan oppfattes som kritikk og medføre skam hos pasienten; altså misforstås terapeutens hensikt. I tråd med det Peplau (1989, 1997) skriver om *participant observation* og sykepleierens tilpasning av egen atferd til pasientens behov, beskriver flere av informantene (Pettersen et al., 2020) hvordan transparens – å modellere åpenhet og gjøre eget sinn tilgjengelig for andre (Robinson, Skårderud og Sommerfeldt, 2019) - har flere funksjoner i terapien; blant annet nettopp trygging og tydelighet. Når terapeuten vet at pasienten er var for å oppleve seg kritisert og underlegen og at utforskning kan bidra til slik opplevelse, forklarer terapeuten hensikten med å sette spørsmålstegn ved pasientens opplevelser. Terapeuten er transparent og forklarer hvorfor han eller hun gjør som hun gjør; at hensikten ikke er å formidle til pasienten at vedkommende tar feil, men å stimulere pasientens mentalisering og bidra til nyansering og alternative perspektiver (Pettersen et al., 2020).

Funn fra studien til Pettersen et al. (2020) peker videre på at det å få til ikkevitenhet i praksis – slik at det merkes for pasienten at man er genuint interessert i vedkommendes perspektiv og erfaringer - fordrer terapeutens evne til ro, tålmodighet og til å utholde stillhet. En av

informantene beskriver hvordan manglende respons fra pasienten gjør at hun får behov for å spørre eller forklare mer fordi hun er usikker på om hun har «fått napp». En annen terapeut snakker om at det kan være fort gjort for ham å gå inn og tolke og forklare eksempelvis pasientens atferd før pasienten har fått tid nok til å kjenne etter. Begge formidler at hensikten er å være hjelpsom, men at dette ofte ikke er terapeutisk hensiktsmessig, også fordi pasienten selv skal opparbeide mentaliseringsevnen og dermed må få tenke seg om (Pettersen at al., 2020). Peplau (1989) (jfr. 3.2) peker på at sykepleiere kan være for opptatt av å komme frem til konklusjoner og av å gi råd, heller enn av å søke å forstå mer. Et undersøkende fokus innebærer derimot å balansere uttalt interesse og aktiv tilstedeværelse med en evne til å lene seg tilbake og avvente, slik at man unngår å bli for styrende og videre faktisk får mulighet til innblikk i pasientens perspektiv.

Andre funn i studien (Pettersen et al., 2020) peker på hvordan det med pasienter som er preget av skam, selvkritikk og en form for feilslått beskyttende unnvikelse kan være ekstra viktig både å bruke tid og å demonstrere åpenhet for å lytte og forstå, fordi pasientene er så lite vant med og engstelige for å komme frem med sitt eget. Informanter i studien beskriver at det å dele noe personlig fra eget liv - altså bruk av selvavsløring (Hill and Knox, 2001; Hill, Knox and Pinto-Coelho, 2018) - kan hjelpe tilbakeholdne pasienter med selv å våge å åpne opp om tanker og følelser, men at det er nødvendig å være bevisst på hva man deler og unngå det som oppleves vanskelig å håndtere. At terapeuten deler noe personlig har altså til hensikt å hjelpe pasienten med å dele noe personlig, og det er således snakk om noe kvalitativt annet enn den delingen Peplau (1989; 1992) advarer mot, der fokuset ikke er på pasienten og der sykepleierens deling av noe personlig er motivert av hennes egne behov.

Unnvikende personlighetsforstyrrelse er blitt linket til høy grad av introversjon (Meyers,

2002; Rettew, 2000). Introverte personer foretrekker generelt å analysere og vurdere informasjon og å reflektere før de responderer, og kan ha vansker med å dele ufullstendige ideer (Colley, 2018; Wisser and Massey, 2019). De henter frem informasjon fra langtidsminnet i større grad enn ekstroverte personer, konstruerer mer komplekse assosiasjoner og behøver mer tid (Condon and Ruth-Sahd, 2013). Pasienter med unnvikende personlighetsforstyrrelse og personer med en mer introvert personlighet kan altså ha en måte å prosessere informasjon og stimuli på som gir behov for tid. Terapeutene (Pettersen et al., 2020) reflekterer rundt årsaker til vanskene pasienter med UvPF har med å være åpne om seg selv og å engasjere seg. At terapeutene ikke kommer spesifikt inn på temperament og personlighetsstil kan ha mange forklaringer; ikke minst at fokuset i studien lå på terapeutiske tilnærminger og utfordringer. Det er uansett verdt å tenke på om kunnskap om kognitiv stil og måter å prosessere informasjon på kan være nyttig for sykepleiere med tanke på å opprettholde tålmodighet og interesse. Klinisk erfaring tilsier at det å ha økt kunnskap om et fenomen, eksempelvis om hva som gjør noen pasienter mer tilbakeholdne med å dele, kan gjøre at man tåler mer eller bedre evner å møte det som skjer på konstruktivt vis. Dette synliggjøres også i studien til Pettersen et al., (2020). En informant forklarer hvordan han må hjelpe pasientene med å komme frem med hendelser. Når pasienten sier at ingenting er skjedd, kan ikke terapeuten si «neivel, da så» og la temaet ligge; han må utforske. Tilsynelatende opplever ikke terapeuten at pasienten «ikke vil» dele; han forklarer derimot tausheten på bakgrunn av egen fagkunnskap om at pasientenes problematikk medfører forestillinger om at ingenting er viktig nok eller verdt å dele – og kommer dem i møte med det utgangspunktet.

I terapi med pasienter med personlighetsforstyrrelser, og spesielt innenfor eksempelvis en mentaliseringsbasert tilnærming hvor man vektlegger psykoedukasjon (Skårderud og

Sommerfeldt, 2013), kan det være nyttig å tematisere kognitive aspekter med pasientene. Tatt i betraktning deres forventinger om kritikk og avvisning virker det rimelig å anta at pasientene kan kjenne seg utilstrekkelige og også skamfulle dersom de ikke klarer å respondere i tråd med en slags innbilt norm eller det de tenker at terapeuten forventer. Å få bekreftelse på at terapeutene forstår årsakene til at det tar tid å klare å delta, kan bidra til å redusere pasientenes angst og selvfordømmelse og videre gjøre det lettere for dem å mentalisere og engasjere seg.

5.0 TERAPEUTENS EGEN MENTALISERING

Man vil ikke klare å møte pasienten med en undersøkende og nysgjerrig holdning uten selv å være i en mentaliserende modus. Mentalisering innebærer en bevissthet både om seg selv og andre. Det er således et viktig poeng at dersom man selv har havnet i en ikke-mentaliserende modus, vil man ikke være i stand til å møte pasienten på mentaliserende vis. Mentaliseringssvikt kan smitte. «In short, mentalizing begets mentalizing and, conversely, non-mentalizing begets non-mentalizing." (Allen et al., 2008, s. 105).

En av informantene (Pettersen et al., 2020) forklarer at pasienter med unnvikende personlighetsforstyrrelse ofte er preget av den formen for mentaliseringssvikt som kalles psykisk ekvivalens. Tanker og følelser blir *for virkelig*; «too real to a point where it is extremely difficult for the individual to entertain possible alternative perspectives. [...] There is a suspension of doubt, and the individual increasingly believes that their own perspective is the only possible» (Bateman og Fonagy, 2016, s.16). Informanten beskriver at det i møte med psykisk ekvivalens kan være fort gjort for terapeuter å hoppe på «dårlige prosesser», som å bli sittende og diskutere med pasienten. Hensikten er god; det kan være å overbevise pasienten om at vedkommende tar feil i sine negative antakelser om hva «alle» tenker om ham eller henne. Imidlertid er pasienten ikke mottakelig for dette i en slik mental tilstand. Det

terapeuten derimot kan gjøre, er å synliggjøre eget sinn, altså å være transparent; å dele med pasienten noen egne tanker om pasienten. Man sier dermed ikke «du tar feil», men heller «jeg har en annen oppfatning», og tydeliggjør slik at det finnes ulike måter å oppfatte noe eller noen på. En av informantene (Pettersen et al., 2020) beskriver en mentaliserende intervensjon:

> [Noen er] skråsikre på at de vet hva andre tenker om dem. De er skråsikre på at de vet hva jeg tenker om dem. Så det er ganske vanlig at jeg utfordrer dem på det. «Kan det være at de andre i gruppa eller på jobb eller i familien din tenker noe annet enn det du tror? Hva kunne det være?». Og for mange er det helt umulig å komme med noe annet, de er så skråsikre, de er så fastlåst «så negativt tenker alle» […] og da kan jeg si «Jeg sitter her og jeg er folk og jeg tenker ikke sånn om deg» og så kan jeg si hva jeg tenker og spørre «Hvordan er det å høre?»

Terapeuten kan derimot sies ikke å være i en mentaliserende modus dersom han eller hun blir sittende og diskutere med pasienten i stedet for å «løfte blikket» og reflektere rundt hva pasienten egentlig er i behov av at terapeuten sier eller gjør i den situasjonen.
Heller enn å diskutere hva som er galt eller riktig, altså innhold, er fokuset i MBT på prosessen bak innholdet, slik informantene beskriver at de er opptatt av. Når man som sykepleier har havnet i en slik ekvivalenstenkning, vil man kunne begynne å anta hva pasienten trenger i stedet for å spørre eller å anta at man vet hva som gjorde at pasienten «var så avvisende» i morges. Sykepleierens fokus rettes vekk fra pasienten (Peplau, 1989) og sykepleierens perspektiv blir «det eneste» og stenger slik for en nysgjerrig og åpensinnet leting eller andre forståelser.

Sykepleiere blir emosjonelt påvirket i samhandling med pasienter, slik Peplau (1989) illustrerer når hun skriver om sykepleier-pasient-interaksjonen som et pågående drama (jfr. 3.2). Dette er nok en grunn til at sykepleiere bør ha aktiv oppmerksomhet og refleksjon omkring pasientrelasjoner og egen atferd – møter med andre mennesker gjør noe med oss, også når vi har på uniformen eller har ID-kortet dinglende i bukselommen.

> The nursing field is characterized by emotionally charged situations, as nurses constantly encounter human suffering, pain and helplessness, unpleasant sights and smells, and conflicts with peers, patients, and families. It is at such times that nurses must count on their mentalization capabilities, in order to preserve their own wellbeing while continuing to provide optimal medical care. However, it is exactly at such times that their mentalization process may collapse, as they encounter external situations that touch on their own personal inner worlds and unprocessed emotional experiences. (Satran et al., 2020, sidetall ukjent).

I artikkelen til Pettersen et al. (2020) omhandler et av hovedfunnene terapeutenes emosjonelle reaksjoner i relasjon til pasientene. Terapeutene gav uttrykk for utålmodighet, frustrasjon og prestasjonsangst i møte med pasientenes taushet og tilbaketrekning. Noen satte ord på at det kunne kjennes «slemt» eller som å «hamre løs» å utfordre pasientenes selvoppfatninger eller å jobbe aktivt for å få pasientene til å utfordre seg, som kan vitne om et ønske hos terapeuten om å beskytte og gi omsorg.

Generelt virket terapeutene i vår studie bevisst på at de blir emosjonelt påvirket av pasientene og også på at følelsen terapeuten har, kan virke inn på hva han eller hun gjør eller ikke gjør der og da i terapisituasjonen eller i terapiforløpet. Eksempelvis forteller en av terapeutene

(Pettersen et al., 2020) at han opplever det vanskelig å unngå å gå inn og støtte og forstå «for mye». Dette er stadig tema i veiledning for at han skal klare å utfordre og pushe pasienten nok til å bidra til endring. To terapeuter forteller at de har gruet seg for å holde psykopedagogiske grupper, fordi de tolket pasientenes stillhet i gruppen som at det de hadde å komme med var av dårlig kvalitet eller uengasjerende. Hun forteller at terapeutene gikk flere runder for å sortere og påminne seg selv om at pasientenes taushet sannsynligvis primært bunner i deres problematikk og ikke i selve undervisningsopplegget.

Sykepleiere vil komme til å oppleve at mentaliseringsevnen svikter. Vi kan snakke om en Catch-22 (Allen et al., 2008, s.316): «Mentalizing is most difficult when you most need to do it». Heldigvis er det mulig å mentalisere og å lære av det også i etterkant og slik gjøre etterpåklokskapen om til et framsyn (Allen et al., 2008). Når situasjonen har roet seg er det lettere å tenke klart. Å bevisst å jobbe for å gjenvinne og å «benytte seg av» en mentaliserende holdning rundt en situasjon i etterkant kan gi flere handlingsalternativer videre. Flere informanter i studien til Pettersen et al. (2020) beskriver hvordan de aktivt jobber med å opprettholde egen mentalisering i møte med pasientenes «mentale stillstand». En viktig faktor for å få det til, forteller de, er obligatorisk og jevnlig veiledning i team. Veiledningen virker å ha en bevisstgjørende funksjon ved at fokuset på og kunnskapen om mentalisering og mentaliseringssvikt holdes oppe og styrker terapeutenes mulighet til å identifisere når de selv er i ferd med å tape mentaliseringsevne eller å være forberedt på «smittesituasjoner», som når det oppstår taushet i en gruppesetting (Pettersen et al., 2020).

Peplau (1989) gir et eksempel fra klinikken og skriver at liknende situasjoner kan oppstå en rekke steder i helsevesenet. Sykepleieren spør en pasient om hvor lenge det er siden mannen hennes tok henne med på hjemmebesøk, hvorpå pasienten svarer at hun ikke er nødt til å

fortelle sykepleieren om slike ting, og at flere slike spørsmål vil gjøre at hun går sin vei. Sykepleieren responderer med å si at pasienten ikke er nødt til å svare, og lar seg dermed, i følge Peplau, «skremme vekk». Hun gir seg, fordi fokuset hennes er at hun må få pasienten til å bli, uavhengig av om det har terapeutisk verdi. Det som egentlig er av betydning her, skriver Peplau, er at pasienten har en rekke slike tilsynelatende ufarlige, intimiderende strategier som gjør at hun unngår utforskning av hvordan situasjonen hennes faktisk er og kommer da heller ikke ut av det, noe sykepleieren gjennom å trekke seg, bidrar til. Peplau skriver videre at pasienten i de neste samtalene med sykepleieren kjente seg stadig mer ukomfortabel og må ha plukket opp at sykepleieren var sårbar og til liten hjelp. Når sykepleieren en stund senere ikke vek unna og i stedet var tydelig på at hun trengte informasjon for å kunne hjelpe, responderte pasienten ved å svare å spørsmålet og begynte også å ta tak i egne vansker.

Eksempelet gir assosiasjoner til det terapeutene i studien sier om å balansere støtte og validering på den ene siden med utforskning og utfordring på den andre siden. Validering beskrives av en av informantene (Pettersen et al., 2020) som nødvendig beroligelse og en følelse av å være forstått, men ikke i seg selv tilstrekkelig for endring; pasientene må også utfordres. «Uhemmet validering», som hun kaller det, fører til at man bekrefter deres oppfatning av seg selv. ««Ja, det er noe galt med deg. Du må gå her i fem år du. Stakkar deg. Dette klarer ikke du alene.» Det er mer skadelig.»

En annen informant (Pettersen et al., 2020) påpeker hvordan å støtte oppunder eksempelvis en pasients unnvikende atferd kan være kontraproduktivt, og at det kan være vanskelig likevel å la være å gjøre det:

> Jeg kan kjenne at det er lett- Eller at den jeg snakker med har et behov for at jeg skal skjønne og støtte opp under behovet for å trekke seg eller for å si nei og sette grenser, «ikke press meg, når jeg har det så fælt så må det jo være bra for meg å ikke presse meg». Og så tenker jeg at jobben er å hjelpe dem med å se hvor store problemer de får for at de gjør det så mye. Og det føles av og til brutalt, slemt. At du skal få dem til å utfordre seg og gjøre ting som skaper så mye ubehag. Og stå i det mens vi jobber videre i terapien da. Det er liksom ikke noen sånn quick fix på det.

Peplau (1989) skriver om sykepleieren som etter hvert gav pasienten den motstanden vedkommende trengte og slik bidro til å bryte et mønster som var til skade for pasienten, mens terapeuten over setter ord på paradokset pasienten trenger hjelp til å se. Å unnlate å utfordre og i stedet innrette seg i pasientens atferdsmønster og forsøk på beskyttelse, vil i verste fall bidra til å opprettholde pasientens lidelse og sykdom (Peplau, 1989).

Både pasienten i eksempelet (Peplau, 1989) og pasientene terapeuten refererer til, uttrykker på ulike vis ønske om å bli latt i fred, slippe å måtte gjøre noe som kjennes ubehagelig. Vi kan se for oss at pasienten i eksempelet har en mer avvisende fremtoning, mens pasientene med UvPF som terapeuten tenker på, i større grad uttrykker engstelse og utrygghet, som videre kan være en mulig forklaring på ulike følelser hos hjelpere; å bli skremt, å kjenne på at det man gjør er slemt eller brutalt. Å agere på disse følelsene - å slutte å spørre eller slutte å utfordre - vil være å se vekk fra pasientens behov og i stedet – kanskje utilsiktet – sette egne behov først.

Man kan også se for seg andre forklaringer på unnlatende atferd fra hjelperes side. Sykepleieren i eksempelet (Peplau, 1989) kan ha tenkt at pasientens utgang ville være et

nederlag for henne som sykepleier og vært motivert av dette når hun trakk seg. Det kan også være at hun ikke evnet å se pasientens helhetssituasjon eller samtalen deres «utenfra» i stor nok grad til å identifisere pasientens gjentakende mønster som bidro nettopp til å holde pasienten fast i en uønsket situasjon og som tvert imot trengte å bli utfordret.

Vi vet ikke, men vi kan tenke at sykepleieren (Peplau, 1989) på et tidspunkt mellom samtalene og med mer avstand til følelser som ble vekket i situasjonen, har mentalisert rundt pasientrelasjonen, rundt pasientens og egen atferd i situasjonen og hva som har gjort at hun trakk seg eller hva som gjør at pasienten ikke åpner seg. Kanskje har hun diskutert med en kollega og fått flere blikk på situasjonen og evnet å se pasientens egentlige behov i et større perspektiv og så justert egen atferd i møte med pasienten slik at pasientens egentlige behov, som pasienten selv kanskje ikke er klar over eller ennå ikke har våget å vedkjenne, blir styrende. Dette er nettopp blant det den obligatoriske veiledningen i MBT-tilnærmingen skal bidra til, og som illustreres i dette utsagnet fra en informant (Pettersen et al., 2020): «Og så dette med veiledning; jeg synes det er helt supert ved å være med i et MBT-team. Står man fast så er man ikke alene. Man kan gå seg vill i relasjoner.»

6.0 KONKLUSJON

Oppgavens hensikt har vært å reflektere rundt mentaliseringsteoriens nytte i et sykepleiefaglig, terapeutisk arbeid. Hildegard Peplau understreker et sentralt, tilsynelatende selvsagt og likevel komplisert premiss for sykepleieres arbeid: At fokuset skal være på pasienten. Å inneha en mentaliserende holdning – en åpen, undersøkende, empatisk og ikke-vitende tilnærming - kan være til hjelp i arbeidet med å få innblikk i pasientens reaksjoner og med å rette seg inn mot pasientens behov. Å møte pasienten på slike vis fordrer imidlertid at sykepleieren selv er i en mentaliserende modus. Vi er alle sårbare for mentaliseringssvikt, spesielt i emosjonelt krevende situasjoner - situasjoner sykepleiere opplever mange av.

Sykepleiere blir emosjonelt påvirket av sine pasienter, og denne påvirkningen er gjensidig i relasjonen; som et drama som utspiller seg. Mentaliseringsteorien kan bidra med språk og forståelse for hva som skjer når vi blir fanget i pasientens sort-hvit-tenkning eller unnvikelsesmønster eller når vi agerer primært på våre egne følelser. Hos Peplau understrekes at sykepleiere må ha et granskende blikk på egen praksis og unngå å utagere overfor pasienten, altså å la egne følelser og behov komme i veien for å hjelpe. Som vi har sett, kan slike utenfrablikk være krevende å få til. Informantene i studien til Pettersen et al., som alle er erfarne terapeuter, gir uttrykk for nødvendigheten av veiledning og teamarbeid. Peplau påpeker at det ofte er sykepleiere som tilbringer mest tid med pasienten. Det kan således være verdt å vurdere behovet for økt fokus på mentalisering, mentaliseringssvikt, emosjonell påvirkning i relasjoner og ikke minst systematisk veiledning innen sykepleiefaget, spesielt innen psykiatri og rusomsorg, samt i andre kontekster hvor man arbeider med pasienter med omfattende behov og stort lidelsestrykk.

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Vedlegg – Godkjenninger

NSD NORSK SENTER FOR FORSKNINGSDATA

Meldeskjema 272798

Sist oppdatert

17.07.2019

Hvilke personopplysninger skal du behandle?

- Navn (også ved signatur/samtykke)
- Lydopptak av personer

Type opplysninger

Skal du behandle særlige kategorier personopplysninger eller personopplysninger om straffedommer eller lovovertredelser?

Nei

Prosjektinformasjon

Prosjekttittel

En mentaliseringsbasert tilnærming til pasienter unnvikende personlighetsforstyrrelse.

Begrunn behovet for å behandle personopplysningene

Lydopptak vil være øke kvalitet i innsamlet empirisk materiale som er gjenstand analysene

Ekstern finansiering

- Andre

Annen finansieringskilde

masterstudent

Type prosjekt

Studentprosjekt, masterstudium

Kontaktinformasjon, student

Vedlegg – Godkjenninger

Mona Skjeklesæther Pettersen, m.i.s.pettersen@studmed.uio.no, tlf: 99512790

Behandlingsansvar

Behandlingsansvarlig institusjon

Universitetet i Oslo / Det medisinske fakultet / Institutt for helse og samfunn

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

Anne Moen, anne.moen@medisin.uio.no, tlf: 22850540

Skal behandlingsansvaret deles med andre institusjoner (felles behandlingsansvarlige)?

Nei

Vedlegg – Godkjenninger

Utvalg 1

Beskriv utvalget

terapeuter

Rekruttering eller trekking av utvalget

førstekontakt via 3. person

Alder

22 - 70

Inngår det voksne (18 år +) i utvalget som ikke kan samtykke selv?

Nei

Personopplysninger for utvalg 1

- Navn (også ved signatur/samtykke)
- Lydopptak av personer

Hvordan samler du inn data fra utvalg 1?

Personlig intervju

Grunnlag for å behandle alminnelige kategorier av personopplysninger

Samtykke (art. 6 nr. 1 bokstav a)

Informasjon for utvalg 1

Informerer du utvalget om behandlingen av opplysningene?

Ja

Hvordan?

Skriftlig informasjon (papir eller elektronisk)

Tredjepersoner

Skal du behandle personopplysninger om tredjepersoner?

Nei

Vedlegg – Godkjenninger

Dokumentasjon

Hvordan dokumenteres samtykkene?

- Manuelt (papir)

Hvordan kan samtykket trekkes tilbake?

Ved kontakt med en av følgende:
· Masterstudent Mona Skjeklesæther Pettersen, tlf. 995 12 790, epost: m.i.s.pettersen@studmed.uio.no
· prosjektansvarlig ved Universitetet i Oslo, professor Anne Moen, epost: anne.moen@medisin.uio.no
· Vårt personvernombud: personvernombud@uio.no.
· NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller telefon: 55 58 21 17.

Hvordan kan de registrerte få innsyn, rettet eller slettet opplysninger om seg selv?

Ved kontakt med en av følgende:
· Masterstudent Mona Skjeklesæther Pettersen, tlf. 995 12 790, epost: m.i.s.pettersen@studmed.uio.no
· prosjektansvarlig ved Universitetet i Oslo, professor Anne Moen, epost: anne.moen@medisin.uio.no
· Vårt personvernombud: personvernombud@uio.no.
· NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller telefon: 55 58 21 17.

Totalt antall registrerte i prosjektet

1-99

Tillatelser

Skal du innhente følgende godkjenninger eller tillatelser for prosjektet?

Behandling

Hvor behandles opplysningene?

- Maskinvare tilhørende behandlingsansvarlig institusjon

Hvem behandler/har tilgang til opplysningene?

- Prosjektansvarlig
- Student (studentprosjekt)

Vedlegg – Godkjenninger

Tilgjengeliggjøres opplysningene utenfor EU/EØS til en tredjestat eller internasjonal organisasjon?

Nei

Sikkerhet

Oppbevares personopplysningene atskilt fra øvrige data (kodenøkkel)?

Ja

Hvilke tekniske og fysiske tiltak sikrer personopplysningene?

- Opplysningene anonymiseres
- Opplysningen krypteres under lagring
- Flerfaktorautentisering
- Andre sikkerhetstiltak

Hvilke

Lydfilene lagres i TSD; UiO

Varighet

Prosjektperiode

17.06.2019 - 31.12.2020

Skal data med personopplysninger oppbevares utover prosjektperioden?

Nei, data vil bli oppbevart uten personopplysninger (anonymisering)

Hvilke anonymiseringstiltak vil bli foretatt?

- Personidentifiserbare opplysninger fjernes, omskrives eller grovkategoriseres
- Lyd- eller bildeopptak slettes

Vil de registrerte kunne identifiseres (direkte eller indirekte) i oppgave/avhandling/øvrige publikasjoner fra prosjektet?

Nei

Tilleggsopplysninger

Vedlegg – Godkjenninger

Vedlegg – Godkjenninger

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD sin vurdering

Prosjekttittel

En mentaliseringsbasert tilnærming til pasienter unnvikende personlighetsforstyrrelse.

Referansenummer

272798

Registrert

17.07.2019 av Anne Moen - anne.moen@medisin.uio.no

Behandlingsansvarlig institusjon

Universitetet i Oslo / Det medisinske fakultet / Institutt for helse og samfunn

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

Anne Moen, anne.moen@medisin.uio.no, tlf: 22850540

Type prosjekt

Studentprosjekt, masterstudium

Kontaktinformasjon, student

Mona Skjeklesæther Pettersen, m.i.s.pettersen@studmed.uio.no, tlf: 99512790

Prosjektperiode

17.06.2019 - 31.12.2020

Status

24.07.2019 - Vurdert

Vurdering (1)

24.07.2019 - Vurdert

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet med vedlegg 24.07.19. Behandlingen kan starte.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være

Vedlegg – Godkjenninger

nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde:

https://nsd.no/personvernombud/meld_prosjekt/meld_endringer.html

Du må vente på svar fra NSD før endringen gjennomføres.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle alminnelige kategorier av personopplysninger frem til 31.12.2020.

HELSEPERSONELL SIN TAUSHETSPLIKT
Helsepersonell har taushetsplikt. Det er derfor viktig at intervjuene gjennomføres slik at det ikke samles inn opplysninger som kan identifisere enkeltpasienter eller avsløre taushetsbelagt informasjon. Vi anbefaler at dere er spesielt oppmerksom på at ikke bare navn, men også identifiserende bakgrunnsopplysninger må utelates, som for eksempel alder, kjønn, sted, diagnoser og eventuelle spesielle hendelser. Vi forutsetter også at dere er forsiktig ved å bruke eksempler under intervjuene.

Forsker og informant har et felles ansvar for det ikke kommer frem taushetsbelagte opplysninger under intervjuet. Det kan derfor være hensiktsmessig om forskeren avklarer dette med informanten i forkant av intervjuet.

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse som kan dokumenteres, og som den registrerte kan trekke tilbake. Lovlig grunnlag for behandlingen vil dermed være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a.

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

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

DE REGISTRERTES RETTIGHETER
Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20).
NSD vurderer at informasjonen om behandlingen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.
Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

Vedlegg – Godkjenninger

FØLG DIN INSTITUSJONS RETNINGSLINJER
NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).
Dersom du benytter en databehandler i prosjektet må behandlingen oppfylle kravene til bruk av databehandler, jf. art 28 og 29.

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

OPPFØLGING AV PROSJEKTET
NSD vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til med prosjektet!
Tlf. Personverntjenester: 55 58 21 17 (tast 1)

Vedlegg – Godkjenninger

Sykehuset i Vestfold

HELSE SØR-ØST

INTERNT NOTAT

Til: Klinikksjef Inger Meland Buene		**Kopi til:**	Seksjonsleder Henning Jordet Fagsjef KPR Fagdirektør
Fra: Personvernombudet		**Ref.:**	**Sak 19/08755** Studentprosjekt - Mastergrad – Spørreundersøkelse – Mona S Pettersen, UiO
Dato: 19.09.2019			

PERSONVERNOMBUDETS TILRÅDING

Innsamling og behandling av personopplysninger for prosjektet
«Terapeuters erfaring med en mentaliseringsbasert tilnærming til pasienter med unnvikende personlighetsforstyrrelse.»

Prosjektplan (utdrag)
«Unnvikende personlighetsforstyrrelse (UvPF) har vært gitt lite oppmerksomhet, både på forskningsfeltet og i behandlingsapparatet. Studier viser imidlertid at denne psykiske lidelsen er forbundet med stor grad av subjektiv lidelse og funksjonssvikt og den har høy prevalens, spesielt i kliniske settinger.

Mentalisering antas å være sentralt for å kunne forstå underliggende psykopatologi ved personlighetsforstyrrelser. Mentalisering handler om å ha fokus på mentale tilstander hos en selv og hos andre, slik som eksempelvis å tenke rundt det en føler. Å mentalisere kan også beskrives som å se seg selv utenfra og andre innenfra og som to hold mind in mind. Ved personlighetsforstyrrelser sees svikt i evnen til å mentalisere. Mentaliseringssvikt er kjennetegnet ved «et fall i evnen til å tenke nyansert og refleksivt om egen og andres mentale tilstander».

På bakgrunn av teorien om at mentaliseringssvikt er sentral del av patologien også hos pasienter med UvPF, prøver man nå ut mentaliseringsbasert terapi (MBT) i tilpasset form overfor disse pasientene. MBT er en behandlingstilnærming opprinnelig utviklet for å behandle pasienter med emosjonelt ustabil personlighetsforstyrrelse (EUPF). Fordi pasienter med henholdsvis en EUPF og en UvPF er ulike hva gjelder psykopatologi og mentaliseringssvikt, er tilpasninger fra manualen i tilnærmingen til pasienter med UvPF nødvendig.

Denne masterstudien ønsker å utforske terapeuters erfaringer med bruk av en slik tilpasset mentaliseringsbasert tilnærming til pasienter med UvPF.»

Mottatte dokumenter – grunnlag for tilrådingen
- Prosjektbeskrivelse Vår, 2019 – Masteroppgave – Universitetet i Oslo (UiO)
- Intervjuguide
- Kopi av informasjonsskriv/samtykkeskjema
- Meldeskjema til NSD 17.07.2019 (ref. 272798)
- NSDs vurdering 24.07.2019 (ref. 272798)
- Godkjenning fra ledelsen i Klinikk psykisk helse og rus. 13.09.2019

Vedlegg – Godkjenninger

Sykehuset i Vestfold

HELSE SØR-ØST

Behandling av person-/helseopplysninger i forbindelse med mastergrad – behandlingsgrunnlag
Personvernombudet i Sykehuset i Vestfold (SiV) har mottatt melding om behandling av alminnelig kategori personopplysninger fra mastergradsstudent ved VID vitenskapelige høgskole.

Lokalt personvernombud skal på vegne av dataansvarlig vurdere prosjektet ut fra personvernkonsekvenser og om kravene til informasjonssikkerhet og internkontroll ivaretas. Dette følger av personvernforordningen art. 39 nr. 1 a) - c).

Det er et absolutt krav at det foreligger adgang til behandling av personopplysninger (behandlingsgrunnlag jf. personvernforordningen art. 6 og 9 og nasjonale lovbestemmelser).

Sykehuset i Vestfold har mottatt NSD sin vurdering av prosjektet. NSD er personvernrådgiver for UiO. Det legges til grunn at prosjektet har nødvendige godkjenninger i UiO.

Personvernombudet i Sykehuset i Vestfold slutter seg til NSDs vurderinger og konkluderer slik:

- Det anses å foreligge et lovlig behandlingsgrunnlag; det skal gjøres en samtykkebasert behandling av alminnelige kategorier personopplysninger i tråd med personvernforordningen art. 4 nr. 11 og art. 7. Behandlingsgrunnlaget er ut fra det personvernforordningen art. 6 nr. 1 bokstav a). Prinsippene for behandling av personopplysninger anses ivaretatt jf. personvernforordningen art 5.1 a - e
- Informasjonen som deltakerne mottar ifm spørreundersøkelsen oppfyller personvernforordningens krav til form og innhold jf. art. 12 nr.1 og art. 13.
- Spesielt om konfidensialitet:
  Helsepersonell har taushetsplikt. Det er derfor viktig at intervjuene gjennomføres slik at det ikke samles inn opplysninger som kan identifisere enkeltpasienter eller avsløre taushetsbelagt informasjon. Det er anbefalt å ha spesielt oppmerksomhet på at ikke bare navn, men også identifiserende bakgrunnsopplysninger må utelates, som for eksempel alder, kjønn, sted, diagnoser og eventuelle spesielle hendelser. Det forutsettes også at forsiktighet ved bruk av eksempler under intervjuene. Forsker og informant har et felles ansvar for det ikke kommer frem taushetsbelagte opplysninger under intervjuet. Det kan derfor være hensiktsmessig om forskeren avklarer dette med informanten i forkant av intervjuet.
- Innhenting, lagring og sletting av personopplysninger:
  Studenten har utarbeidet et kort spørreskjema og en intervjuguide med 11 spørsmål. Leder(e) i aktuelle avdelinger i SiV kontaktes og bistår i rekruttering av informanter. Informantene svarer på spørreskjemaet og intervjues i 45 - 60 minutter. Studenten skal gjøre bruk av lydopptakutstyr i forbindelse med intervjuene. Lydopptakene transkriberes i etterkant. Navn og kontaktopplysninger erstattes med en kode som lagres på egen navneliste adskilt fra øvrige data. Lydfiler og bakgrunnsopplysninger skal lagres i Tjenester for sensitive data (TDS) i UiO.

  Prosjektet skal etter planen avsluttes innen 2020. Lydfilene slettes 5 år etter avslutning (pga artikkelpublisering). Alle opplysninger vil bli anonymisert i masteroppgaven; det vil ikke være mulig å knytte informantens identitet til datamaterialet.

  Ut fra dette anses det at krav til sikkerhet art. 32 (lovlighet, rettferdighet og åpenhet, formålsbegrensning, dataminimering, riktighet, integritet og konfidensialitet samt lagringsbegrensning.)

Personvernombudet i SiV sin tilråding
Personvernombudet **tilrår** at personopplysninger utleveres til/brukes i forbindelse med mastergradsprosjektet under disse forutsetningene:

1. Databehandlingsansvarlig: Universitetet i Oslo (UiO)

Vedlegg – Godkjenninger

Sykehuset i Vestfold

HELSE SØR-ØST

Forskningsansvarlig: UiO
Prosjektansvarlig: Professor Anne Moen, UiO
Mastergradsstudent: Mona S Petterersen, UiO
Prosjektperiode: 17.06.2019 – 31.12.2020

2. Behandling av personopplysninger i prosjektet skjer i samsvar med og innenfor det formål som er oppgitt i prosjektbeskrivelsen, meldingen til NSD og øvrige dokumenter i saken. Dersom formålet eller databehandlingen endres må personvernombudet i Sykehuset i Vestfold informeres om dette.

3. Når resultatene fra studien blir publisert skal alle data være anonymisert og det vil ikke være mulig å gjenkjenne enkeltpersoner.

4. Mastergradsstudentene sender sluttmelding til personvernombud@siv.no ved prosjektets slutt.

Klinikkledelsen i klinikk psykisk helse og rusbehandling har godkjent gjennomføringen av spørreundersøkelsen. Fagdirektør er orientert om studentprosjektet.

Personvernombudet er ansvarlig kontaktperson i SiV.

Prosjektet er registrert i oversikten over tilrådinger og uttalelser til forskning og kvalitetsprosjekter som Personvernombudet fører for sykehuset. Oversikten er offentlig tilgjengelig.

Ida Mollerud
Personvernombud
Sykehuset i Vestfold HF

e-post: personvernombud@siv.no