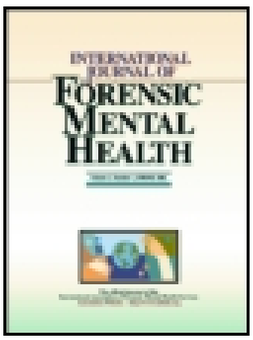

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Exploring Clinician Wellbeing within a Mentalization-Based Treatment Service for Adult Offending Males with Antisocial Personality Disorder in the Community

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ABSTRACT

Mentalization Based Treatment (MBT) is offered as a potential treatment for clients with Antisocial Personality Disorder (ASPD), however, research suggests that delivering MBT can often present challenges for clinicians. Furthermore, there is agreement that working with clients with ASPD can significantly impact upon staff wellbeing. This project highlights the challenges experienced by clinicians when delivering an MBT service with adult offending males with ASPD within the community. Interpretative Phenomenological Analysis was conducted following semi-structured interviews with six MBT clinicians. Findings highlight how the challenges of working with clients with ASPD presented a significant threat to clinicians' professional identity. These challenges were compounded by confusion surrounding the MBT model, lack of support from multidisciplinary staff and insufficient service infrastructure. MBT clinicians' attempts to overcome these barriers led to them striving and breaching time boundaries, leaving them at risk of burnout. These findings contribute to existing literature surrounding clients with ASPD and provide new insight into implementation barriers when delivering a community based MBT service with this client group.

KEYWORDS

Mentalization-based treatment; antisocial personality disorder; offending; clinician; wellbeing

Introduction

Psychological interventions for individuals with personality disorders have received significant attention within recent literature (Bateman et al., 2015). Personality disorders are usually characterized by persistent difficulties in social functioning, impulse control and affect regulation (American Psychiatric Association, 2013). Numerous personality disorders have been outlined in diagnostic manuals, although there is limited evidence surrounding effective treatments; particularly for antisocial personality disorder (ASPD) (Livesley, 2007). Individuals with ASPD are described as those engaging in repetitive, irresponsible, criminal and delinquent behaviors (American Psychiatric Association, 2013). Consequently, these individuals are regularly rejected from services or refuse treatment (Reid & Gacono, 2000). When engaging, poor attendance and persistent boundary violations leave staff feeling overwhelmed, often resulting in poor therapeutic outcomes (O'Brien et al., 2009).

ASPD affects approximately 2–5% of the adult population; however, the rate for males is 2–8 times that of females (Black, 2017). Furthermore, prison samples have found ASPD rates to be around 47% in male inmates and 21% in female inmates (Glenn et al., 2013). Whilst ASPD appears more common in males, females presenting similarly often receive a diagnosis of borderline personality disorder (Cale & Lilienfeld, 2002). Cale and Lilienfeld (2002) argue that cultural views surrounding gender maintain ASPD as a predominantly male issue. Despite these debates, there is agreement that individuals with ASPD traits place significant costs on the criminal justice system and health agencies (Gask et al., 2013).

Literature suggests that ASPD is one of the most challenging forms of psychopathology to effectively manage and treat (Freestone et al., 2015). The National Institute for Health and Care Excellence (NICE, 2013) recommend cognitive behavioral interventions that focus on reducing antisocial behavior and offending such as Cognitive Behavioral Therapy (CBT) and Dialectical

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Behavior Therapy (DBT) as effective interventions for clients with ASPD. However, Bernstein et al. (2019) suggest that adaptations to these treatments are necessary due to high rates of attrition and substance misuse problems. Ramsden (2018) states that high attrition and substance misuse difficulties represent how clients have learnt to protect themselves from rejection and trauma experienced throughout their lives.

Fonagy and Allison (2014) support this view, stating that clients with ASPD are sometimes deeply traumatized individuals who struggle to accept compassion and support, and refers to this experience as epistemic mistrust. However, although 'epistemic mistrust' serves to protect clients from further harm, it can result in poor engagement and frustration toward services that can leave clinicians feeling incompetent, inadequate and shameful as they struggle to effectively support them (Bateman & Fonagy, 2010). Challenges such as this can have a profound impact on professionals' wellbeing when working with client groups that may have experienced severe trauma, present with aggressive behavior and struggle to consistently engage in treatment such as those with ASPD (Montgomery et al., 2000; Penix et al., 2019). According to Montgomery et al. (2000) and Penix et al. (2019) the emotional demands experienced by clinicians when working with traumatized and aggressive clients can lead to issues such as vicarious traumatization, depersonalization and burnout. These challenges can ultimately result in feelings of disconnectedness from one's self, their profession, and the clients that they aim to support (Chang et al. (2018).

Evidently, working with clients with ASPD, can put clinicians at increased risk of diminished wellbeing and potentially helps to explain why few services currently offer support (Gibbon et al., 2010). Working with clients with ASPD within the community can be particularly challenging for clinicians, due to difficulties in engaging this client group consistently and high rates of attrition (Ramsden, 2018). Furthermore, because of the lack of experimental studies surrounding community-based treatments for clients with ASPD, little is understood about how community services can effectively enhance the support they offer and improve engagement and outcomes in this client group (Davidson et al. (2009).

However, a randomized controlled trial exploring the efficacy of CBT for clients with ASPD living within the community found that CBT did not improve outcomes when compared to treatment as usual for males with ASPD in the community (Davidson et al., 2009). Despite this, a more recent randomized controlled trial exploring Mentalization-Based Treatment (MBT) for individuals with ASPD has shown promising results for reducing anger, hostility, violence and offending within this client group (Fonagy et al., 2020).

MBT aims to enable clients to 'mentalize' more often, reducing the risk of chaotic social interactions and disruptive relationships which increase the risk of offending (McGauley et al., 2011). Mentalization is a broad concept referring to the ability to be attentive to the mental states of ourselves and others, both physically and psychologically (Bateman & Fonagy, 2016). Given that clients with ASPD are often unable or unwilling to perspective take or reflect on personal or other people's experiences, it is understandable that they often struggle to "mentalize", feel rejected and disrespected which can lead to antisocial behavior (Bateman & Fonagy, 2016). Consequently, enhancing people's ability to identify others' intentions and emotions can enhance social functioning and reduce antisocial behavior (Fonagy et al., 2020).

MBT is offered as both a group and individual intervention (Bateman & Fonagy, 2010). MBT group sessions are rooted in group analytic therapy and are designed to avoid the "chaotic and destructive processes" often experienced when working personality disordered clients (Karterud, 2018). Whilst some have found promising results for MBT with ASPD clients, others have suggested that MBT groups have been plagued by the chaotic group processes that MBT was initially designed to avoid (Inderhaug & Karterud, 2015). Inderhaug and Karterud (2015) also state that MBT therapists report struggling to establish themselves as group leaders as therapists sometimes misconstrue the 'not knowing', inquisitive and non-directive stance adopted by clinicians delivering MBT.

Yakeley and Williams (2014) suggest that the content within MBT for ASPD groups is often "highly disturbing" due to its focus on group members' chaotic and traumatic lifestyles. Consequently, the emotional and physical impact on clinicians attempting to deliver this service is potentially significant. For clinicians offering this service within the community, these difficulties may be compounded by issues such as high attrition rates and lack of support from services and other professionals.

Therefore, research exploring the challenges faced by clinicians when attempting to deliver an MBT service for adult offending males with ASPD in the community may encourage support for clinicians and help to enhance the effectiveness of MBT within this environment. Literature highlights that working with this client group can have a significant impact on clinician wellbeing and has also outlined challenges when delivering MBT. Therefore, this project aims to explore

how clinicians make sense of their experiences of delivering an MBT service for clients with ASPD in the community. Findings highlight the challenges faced by MBT clinicians and suggest areas of support that may prove beneficial.

Research question

How do clinicians make sense of the challenges they face when delivering an MBT service for adult offending males with ASPD in the community?

Methodology

Design

Due to the experiential research question selected for this project, qualitative methods are appropriate for examining participant experiences within the context being explored (Smith, 2004). Participant accounts were collected using semi-structured interviews before this data was analyzed using Interpretative Phenomenological Analysis (IPA) was selected.

Participants and recruitment strategy

In line with interpretative phenomenological orientation, a purposive sample of six clinicians who have delivered MBT with adult offending males with ASPD in the community was selected. A small sample size was recruited, as IPA is an idiographic approach concerned with understanding a particular phenomenon in a particular context (Smith, 2015). Smith et al. (2009) highlights that a sample size between four to seven is reasonable for an IPA study, as this allows for the development of meaningful insight into participants' experiences, but not so much that the researcher is overwhelmed.

To increase homogeneity within the sample, comprehensive inclusion and exclusion criteria were developed (Robinson, 2014). This ensures that a true picture of the phenomenon being explored was developed, thus increasing the study's credibility (Shenton, 2004). Inclusion criteria were clinicians who had delivered MBT with adult male offenders with ASPD in the community. Due to high prevalence of males with ASPD (Black et al., 2010), this study focused on clinician experiences of working with this population. Additionally, clinicians had to be employed by the NHS within England and work within community services with adult males with ASPD.

Exclusion criteria were MBT clinicians who work directly with the researcher, thus reducing researcher bias (Robinson, 2014). The researcher worked as an Assistant Clinical Psychologist within a community forensic service that offered MBT to individuals with ASPD, and therefore including clinicians from within the same service may have biased the topics covered during interviews, the responses provided by participants, and the interpretations of the data by the researcher. Clinicians with less than one year's experience delivering MBT with adult offending males with ASPD living within the community were also excluded as this would not provide enough time to fully understand the challenges of working with this client group within this context.

Participants included in the research were given the pseudonyms Sam, Lisa, Brian, Angela, Amy and Katie to protect their anonymity. All participants were employed within MBT services based within the community and their employment within these services ranged from 13 months to 3 years. All participants were employed by the NHS within the North West of England, with 5 participants employed as qualified Clinical Psychologists, whereas Angela was a group therapist.

Data collection

Semi-structured interviews were conducted with participants. Semi-structured interviews are identified as the most appropriate method of data collection when completing an IPA study (Shaw et al., 2014). Within this project, six semi-structured interviews were completed with MBT clinicians, with these interviews ranging from 45–75 minutes in duration. An iterative questioning style was used during interviews, allowing for a purposeful way of highlighting contradictions in participant accounts by using probes that allow the researcher to revisit information and disregard contradictions from the final analysis (Shenton, 2004).

Due to the exploratory nature of the research question and the richness of the data collected, the researcher decided that data saturation was reached after completing six interviews with participants.

Data analysis

IPA is an appropriate methodology for the current study, as it allows the researcher to explore in detail how participants make sense of their lived experiences and social worlds (Peat et al., 2019).

Existing literature does not identify a single method of interpreting data when completing IPA study's (Smith & Shinebourne, 2012). For the present study,

the researcher followed the analytical process outlined by Smith et al. (2009). This process began with the researcher reading each transcript several times. Line by line analysis allowed the researcher to make exploratory comments about how clinicians were making sense of their experiences of delivering MBT. During this phase, a reflective diary was updated to ensure that the researcher's preconceptions did not significantly influence the analytic process. Following this, emergent themes were identified based on the coding process. A structure was then developed to illustrate potential relationships between themes before superordinate themes were concluded.

During analysis, a curious stance, in which the researcher assumes a 'non-expert' position (Le Vasseur, 2003) was adopted, ensuring participants experiences were highlighted and not the researcher's predispositions. Following data analysis, findings were discussed with participants to gather their feedback on the analytical process and to confirm that the researcher effectively made meaning of their experiences of delivering MBT to clients with ASPD in the community. These reflections were also discussed during supervision with a qualified psychologist as recommended by Yardley (2000), thus increasing the project's confirmability.

Reflexivity

The researcher was employed as an assistant psychologist within a community based MBT service and therefore, had prior experience of observing and delivering MBT with offending males with ASPD. Consequently, the researcher may have had experiences and beliefs surrounding MBT and clients with ASPD that influenced the design and analysis of the project. The researcher had worked within this service for around twelve months when completing the project and had also had discussions with MBT for ASPD clinicians that may have influenced their belief about what findings may have been beneficial in order to support clients with ASPD and MBT clinicians. Furthermore, participants were aware of the aims of the project and this could have potentially influenced the accounts they provided and the topics they chose to discuss. Consequently, the researcher's position may have influenced the accounts provided by participants and their interpretation, although several steps were taken to reduce biases, ensure rigor and improve project transferability.

The researcher also took a number of steps to ensure that researcher bias was reduced and the project was rigorous at all stages, thus increasing the likelihood that findings are dependable and transferable to other services. The methods used to ensure rigor in this project are discussed in more detail below.

Ethical considerations

This project was approved by Manchester Metropolitan University research ethics committee (Ref: 5558) and NHS Research & Development Department before commencing. Furthermore, the researcher adhered to British Psychological Society Code of Ethics and Conduct to ensure risk of harm was minimized and the therapeutic approach was not undermined (BPS, 2018).

Analysis and discussion

Following the completion of interviews, all six interview transcripts were analyzed to make sense of participants' experiences of the challenges faced when delivering an MBT service with clients with ASPD in the community. Common themes within the dataset were identified by synthesizing common patterns that emerged. Two superordinate themes were identified: (1) 'Threats to Clinician Identity'. (2) 'Implementation Barriers of MBT Approach'. Superordinate theme one included three subordinate themes, whereas superordinate theme two included two subordinate themes. These are discussed individually.

Threats to clinician identity

Throughout the analytic process, participants highlighted how the MBT service presented threats to their professional identity. Clinicians strived to support the client group but were left disillusioned by client disengagement, confusion surrounding MBT, and challenges from fellow professionals. Participants reported feeling isolated, vulnerable and inadequate, leaving them questioning their ability as clinicians. Three subordinate themes emerged to create this superordinate theme: (1) Client Vulnerability Leads to Clinician Self-Sacrifice. (2) Confusion Surrounding MBT Concept. (3) Stigmatized Clients, Isolated Clinicians.

Client vulnerability leads to clinician self-sacrifice

All six clinicians perceived the client group as powerless and stigmatized, stating that they felt it was their responsibility to provide a supportive service. Although clients with ASPD are notoriously difficult

to engage, participants often became concerned that poor engagement was due to their lack of proficiency in delivering MBT. Clinicians attempted to overcome these concerns by going "above and beyond" for clients.

> The ethos within the team is that the client group are already powerless and don't get access to very much, so MBT is one of the few therapies available to them. We believed that we should be offering as much as possible, and it undoubtedly led to us pushing ourselves more than we probably should have. (Katie, lines 131–134)

Katie's transcript highlights that clinicians felt responsible for clients, resulting in clinicians striving to deliver an effective service. However, participants also suggested that the drive to support clients was influenced by a desire to maintain their identity as a supportive and competent clinician. It appeared that maintaining this aspect of identity took precedent over managing time boundaries and maintaining wellbeing.

> I think our drive to deliver a suitable service was emotionally driven by feelings of inadequacy and failure when attendance was poor each week. We definitely breached our own time boundaries when doing this. (Lisa, lines 114–116)

The emphasis on maintaining one's professional identity may explain why many professionals working with this client with ASPD experience issues such as burnout. The client group's behavior is characterized by mistrust and disengagement, meaning they are a difficult group to support (Black, 2017). However, these challenges appeared to trigger feelings of incompetence and shame in participants and consequently presented a direct threat to their professional identity, which is often influenced by their ability and desire to help others (Gibbon et al., 2010).

Branscombe et al. (1999) alludes to the concept of social identity threat and its consequences. Commonly, those who experience a threat to their social identity experience disruptions in their psychological wellbeing (Steele et al., 2002). To overcome this, they can strike back either physically or symbolically to recover this aspect of themselves and their wellbeing (Stets & Burke, 2000). For MBT clinicians, client disengagement and their unwillingness to accept support appeared to present a significant threat to the way they perceived themselves as clinicians. It appears that the clinicians' method of 'striking back' was to attempt to 'rescue' clients by striving and breaching time boundaries as they fought to retain this aspect of their professional identity. However, to achieve this, clinicians often neglected self-care strategies that maintain their wellbeing.

Confusion surrounding MBT concept

The second subordinate theme highlights participants' contrasting experiences of delivering MBT. For Brian, Lisa, Amy and Katie, delivering MBT to this client group left them feeling confused about what the task of MBT is, resulting in concerns that their confusion may have been transferred to group members.

> The concepts of mentalization are challenging and difficult to grasp. It leaves you feeling fairly stranded, and sometimes you feel as though you don't know what you are doing. If you feel like that then your clients feel like that and that doesn't create a great space. (Brian, lines 195–198)

Whilst the majority of participants held this view, Angela and Sam reported feeling liberated by the 'not knowing' stance and the unstructured aspect of MBT. Despite experiencing similar feelings of confusion initially, Angela and Sam stated that learning to tolerate their own anxiety, embracing MBT's 'not knowing' stance and remaining curious offered them therapeutic freedom that other models do not allow. Sam and Angela also reported that adopting this curious approach allowed them to learn from this client group and improve their understanding of clients' mind states.

> The most important thing has been learning to tolerate my anxiety and maintain my own mentalizing and curiosity. Always be curious, that's what I've found most helpful. I'm constantly surprised by clients' mind states and that's helpful as it stops us from jumping to conclusions around what's going on for them. (Angela, lines 204–207)

Angela's transcript highlights divergence within the data. It appears that clinicians who place emphasis on maintaining their identity as an 'expert' struggle to tolerate the uncertainty that delivering MBT offers. Furthermore, clinicians were concerned that their confusion and anxiety would be detrimental to group members. Murphy and McVey (2010) support their view, suggesting that group members need clear guidance from therapists to benefit. However, Lonargáin et al. (2017) found that within MBT groups, participants found their relationship with facilitators most important to their engagement and clinical outcomes. Ramsden (2018) agrees, stating that establishing a positive therapeutic relationship with individuals with ASPD has the potential to alleviate distress and mitigate symptoms.

Consequently, this potentially offers insight into why clinicians who embraced the not knowing, non-expert stance felt liberated by the MBT model. This approach facilitated valuable insight into the mind states of MBT group members, potentially allowing for greater opportunities to develop the therapeutic alliance. This appeared to reduce the threat to clinicians' professional identity by increasing their confidence that they were delivering a useful service for clients, whereas clinicians who struggled to tolerate this threat were left feeling vulnerable and inadequate.

Stigmatized clients, isolated clinicians

As part of the community MBT service, MBT clinicians regularly work with other professionals such offender managers within probation services. Clinicians alluded to the importance of these relationships but suggested that developing and maintaining positive relationships was challenging. Participants felt that other professionals struggled to manage their difficult feelings toward clients and wanted MBT clinicians involved in the study to cross boundaries and 'rescue' them from clients with ASPD. However, if they were unable to do this, relationships with professionals sometimes broke down.

> Probation officers often have intolerable feelings surrounding this client group, which means they often want us to rescue them. When you are unable to do that, they feel that you have let them down and can become angry toward us. We become the object of their difficult feelings. (Sam, lines 170–173)

The clinicians also suggested that that the way professionals perceived client behavior presented challenges. Participants formulated this client group as vulnerable and remained empathic by acknowledging how their traumatic experiences influence their challenging behavior. However, participants reported that other professions commonly focus on their diagnosis of ASPD; a label which carries significant stigma. Consequently, understanding ASPD through a medical model can result in professionals becoming dismissive and punitive toward clients as they struggle to comprehend their behavior (Glenn et al., 2013). These contrasting outlooks left clinicians feeling isolated. 3 participants reported feeling unable to share certain information regarding clients as they feared it may be misinterpreted and used to punish clients with ASPD. Brian discusses how he breached his own time boundaries to protect clients from this experience.

> I was often worried that they may take information you have passed on out of context. Often you would have words representing your view that weren't authentic, so I felt I had to go to the team meetings when I didn't really have the time or resources. It felt draining. (Brian, lines 208–211)

This excerpt highlights how professionals' frustration toward clients presented significant challenges for participants. Clinicians' efforts to cultivate multidisciplinary working often resulted in increased workload, as they were forced into managing the organizational anxiety surrounding clients. It is possible that other professionals may have internalized clients' lack of engagement and difficult behavior as a personal challenge from clients, potentially triggering feelings of incompetence and shame.

The profound affective impact this experience has on workers can result in practices unconsciously managing this organizational anxiety at the expense of clients by blaming them as an organizationally sanctioned response (Obholzer & Roberts, 2003). Consequently, services often mirror the traumatic and dismissive attachment experiences of clients by becoming increasingly punitive and rejecting, thus activating clients' dysfunctional attachment systems, leaving them feeling shameful, rejected and increasing antisocial behavior (Bateman et al., 2016).

For the clinicians, attempting to support this client group within a 'non-mentalizing' system led to them feeling isolated. Often clinicians perceived inability to 'rescue' professionals from intolerable feelings resulted in them becoming the source of professionals' anger. For clinicians, who often define themselves in terms of positive personal characteristics, it is not uncommon to perceive themselves as being 'dragged down' by negative systems and groups, thus increasing distance between themselves and the groups of systems within which they work (Branscombe et al., 1999). This distance between participants and other professionals led to participants feeling helpless, further establishing the threat to their identity as a clinician.

Theme conclusion

This superordinate theme highlights how challenges presented by clients with ASPD in the community, the concept of MBT and difficulties in delivering MBT effectively and differing views to other professionals left MBT clinicians feeling isolated and inadequate. Clinicians desire to support clients with ASPD, whilst also facing challenges from other staff members who at times held punitive views toward this client group, represented a significant threat to participants' professional identity, in which their ability to help clients is important. Clinicians believed that the only way to effectively support clients with

ASPD and maintain this aspect of their professional identity was to go 'above and beyond'. However, this required breaching time boundaries and neglecting their own wellbeing as clinicians, which often led to clinicians feeling burnt out and overwhelmed by the challenges they faced. Consequently, this superordinate theme responds to the research question by highlighting how delivering the MBT service to this client group presented numerous challenges which significantly impacted upon participant's identity and wellbeing.

Implementation barriers of MBT approach

The second superordinate theme highlights how delivering an MBT service for clients with ASPD in the community presented significant implementation barriers. Participants outlined a number of issues that limited their ability to deliver an effective service. Identified barriers were grouped to develop two subordinate themes: (1) Limited Opportunities to Develop MBT Skills. (2) Insufficient Service Infrastructure.

Limited opportunities to develop MBT skills

All participants highlighted their frustration at feeling unable to develop their MBT proficiency. Participants reported feeling confused about the MBT concept and expressed feeling stuck, as poor client engagement and retention left them with insufficient opportunities to put MBT skills into practice and make sense of the approach.

> It's hard, because you're stuck feeling a bit confused about what MBT actually is but then you don't get the opportunity to practice because there are often no group members to develop your MBT skills with. (Lisa, lines 64–66)

Clinicians also reported that even when people did attend, the 'rolling group' structure adopted within MBT presented further challenges, as having different group members attending each week left them unsure of how to approach sessions. New group members required a session outlining the concept of MBT, however, for existing members this meant they were often faced with repetitive content. Participants believed this had a disruptive impact on the group.

> Connecting sessions would be difficult. The amount of times you have to revisit the concepts of MBT is challenging. It disrupts the group and just as you start getting somewhere with clients, it feels like you have to go back to square one. (Brian, lines 292–294)

For MBT group members, the rolling group potentially left them experiencing heightened anxiety as they were required to consistently develop new relationships, something that presents significant challenges for individuals who often perceive unfamiliar people as threatening. Furthermore, their ability to develop meaningful relationships with facilitators was disrupted. For some clients, it appears that this was too overwhelming, resulting in reduced motivation and disengagement. Self-determination Theory (SDT) (Deci & Ryan, 1985) suggests that intrinsic motivation is more likely to flourish in environments characterized by relatedness and a sense of security (Ryan & Deci, 2000). The rolling group appeared to disrupt this process, leaving clients unable to develop secure attachments with facilitators and fellow group members. Instead, this lack of consistency and relatedness mirrors their distant and chaotic attachment experiences (Luntz & Widom, 1994) leaving them feeling disconnected and disillusioned with the MBT service, often resulting in disengagement.

For participants, client disengagement left them questioning their competence. However, a source of comfort appeared to be the external supervision they received. Participants described this as valuable for increasing their understanding of MBT and reducing anxiety. However, participants reported that supervision felt too infrequent, meaning the team's main source of support was peer supervision.

> Those regional and national supervision elements were really useful to share practice experience, think about difficulties, and to express feelings within a safe space. However, whilst this was helpful, it was pretty infrequent. Our main source of support was peer support, which was helpful but insufficient. (Amy, lines 324–327)

Whilst peer supervision was helpful, all participants reported similar concerns surrounding the MBT service, meaning this supervision alone failed to offer sufficient containment to reduce participants' anxiety. Consequently, participants were left with insufficient support and opportunities to improve their MBT proficiency. The lack of available support thwarted participants' need for competence and increased feelings of inadequacy. According to SDT, the need for competence is a basic need that is essential for optimal functioning and personal wellbeing (Ryan, 2009). Furthermore, social contexts that engender conflicts between basic needs can result in individuals feeling alienated, lacking intrinsic motivation and suffering diminished wellbeing (Deci & Ryan, 2008). This experience is reported by Katie below:

> When I am not proficient at something it doesn't sit very well with me … I started to feel dismissive

> toward the service and a little bit demotivated. (Katie, lines 205–206)

It appears that structural limitations within the MBT service led to both clients and clinicians becoming alienated. Clinicians' need for relatedness and competence were thwarted, which affected engagement and intrinsic motivation. For participants, their views of the MBT service became increasingly negative, as insufficient opportunities for skills development prolonged feelings of incompetence, potentially impacting upon their self-efficacy and wellbeing.

Insufficient service infrastructure

Participants were employed by the MBT service for one to two days per week. However, clinicians believed that this timeframe was insufficient to create a service that meets the needs of the client group. Participants felt that due to the severe trauma and chaotic lifestyles of clients, their schedule was insufficient to allow them to develop a robust psychological understanding of their presenting behaviors and consideration of how to support them.

> Sometimes, it feels as though it is just about getting assessments done and getting someone into the group. These men have been exposed to severe trauma and horrible attachment experiences, there wasn't enough time to develop a robust psychological formulation that we can use to understand and help them. (Angela, lines 275–278)

It appeared that participants felt restricted by what they perceived as insufficient infrastructure surrounding the group. Katie suggested that service developers "did not give enough consideration to the magnitude of what you were asking the men to do". Lisa spoke about "how this was potentially the first time the men had engaged in a therapeutic intervention, and the labor intensiveness of supporting their engagement was overlooked and underestimated by the service". Clinician accounts highlight the belief that the client group is again misunderstood and isolated. Clinicians desire to support clients however, led to some singlehandedly "filling the gaps" within the service.

> I have to put the brakes on myself sometimes because I try to fill the gap that the service should fill for an individual… but I'd rather that than someone have nothing at all. (Brian, lines 335–337)

Brian's transcript illuminates how participants felt responsible for the client group due to the lack of support available to them. Despite clinicians striving to offer support, they were thwarted by the MBT services infrastructure which failed to account for the client group's trauma and attachment styles, thus leaving them unable to practice as they desired. Clinicians were left restricted by time constraints, insufficient support and limited resources, as the client group's vulnerabilities were underestimated at a service level. Consequently, despite the clinicians' best efforts, their ability to deliver an effective service appeared to be significantly affected.

Ramsden (2018) paper supports participants' view, stating that until services appreciate the client groups' challenges and support clinicians, outcomes for clients with ASPD will remain inconsistent. Furthermore, Normalization Process Theory (NPT) (Murray et al., 2010) offers additional support, highlighting that services should address how staff will be affected by the intervention, consider their main concerns, foreseeable future concerns and whether the intervention will fit these concerns to become an effective service. Clinician accounts suggest that there are numerous implementation issues that must be addressed for the MBT service to become effective for this client group. Whilst recent trial data suggests that MBT may be an effective intervention for clients with ASPD in the community, the long-term efficacy of interventions depends on the applicability to the "real world" (May et al., 2009), something that at present, appears to be questionable in community based MBT services.

Theme conclusion

This superordinate theme highlights the systemic challenges faced when implementing an MBT service for offending males with ASPD in the community. Often, insufficient service infrastructure left participants feeling restricted and unsupported due to limited supervision and opportunities for skills development. Clinicians highlighted how a lack of appreciation of the client groups' vulnerability at a service level impacted upon clients' ability to engage. Consequently, clinicians felt that they had to work in conditions that thwarted their basic needs for relatedness and competence, impacting upon their intrinsic motivation and personal wellbeing as they attempting to "fill the gaps" within the service infrastructure.

General conclusion

Findings highlight the challenges experienced by clinicians when attempting to deliver an MBT service for adult offending males with ASPD in the community. Participants reported feeling responsible for clients and wanted to deliver an effective service, however, difficulties in interpreting the MBT model and insufficient support from other professionals left them

feeling isolated and questioning their competency. These challenges presented a significant threat to participants' identity, which they attempted to overcome by striving and breaching their own time boundaries. However, insufficient service infrastructure meant that these efforts were often thwarted. Consequently, participants suggested that until the client group's difficulties are understood and appreciated at a service level, MBT outcomes will remain inconsistent.

Strengths and limitations

This project aimed to explore the impact of delivering an MBT service for adult offending males with ASPD in the community, which is currently an under researched area. Findings can be used to identify potential areas of support required to clinicians when delivering this service and improve our understanding of the challenges faced when working with clients with community-based clients with ASPD. However, findings are based upon the idiosyncratic experiences of a small sample of MBT clinicians recruited from community services within the North West of England and are potentially difficult to generalize to other MBT services throughout the country that may experience different systemic and social challenges (Shinebourne, 2011).

Key implications and directions for future research

The project highlights significant challenges faced by clinicians when delivering an MBT service for adult offending males with ASPD in the community. Areas for improvement in service infrastructure and methods to improve clinician support are highlighted. These findings potentially help to address the risk of MBT clinician burnout and improve MBT outcomes for clients with ASPD.

Future research should build upon these findings and quantitively measure changes in clinician well-being when more frequent supervision and increased support are available. Furthermore, research should qualitatively explore clinicians' perceptions of services which adopt rolling groups versus fixed groups, and MBT services that involve the same therapist in all components versus those that use several therapists. The impact that these changes have on clinicians should be measured quantitively to compare the impact of these approaches.

These changes will allow future research to understand the impact of delivering MBT with ASPD clients across a range of services, such as inpatient and prison services, who may have considerably different experiences to participants included within this study. It is possible that clinicians from within different services may require different support to community based MBT clinicians and may also have contrasting views about the practicality and effectiveness of delivering MBT to clients with ASPD in services with different team relations and service infrastructure. Research such as this may potentially increase the transferability of findings and improving the efficacy of MBT for clients with ASPD in future.

Conflict of interest

The authors have no conflicts of interest to report.

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