the differences could be related to prior relationships with patients as some therapists were treated individually for a longer period in the recruitment phase of the treatment. Nevertheless, it seems to be important to have procedures ensuring that therapists communicate well together on own reactions, and that therapists' reactions are supervised by each other. That therapists have different countertransference reactions to the patient group is known in the clinical literature of ASPD. We recognized some of the counter transferences that were described by Yakeley and Meloy, like for instance fear of assault, helplessness and guilt, assumption of psychological complexity and fascination (Meloy & Yakeley, 2010). We worry that some of our positive findings on the alliance and cooperation with the patients are due to a countertransference of illusory treatment alliance. Furthermore, we suggest that our experiences of feeling cognitively tired and exhausted after group, our problems with remembering content from the group, and our experience of taking over the patients mentalizing momentarily during the group, are interesting supplements to what is already written about therapist experiences and countertransference with ASPD. We have no specific suggestion for a solution other than the importance of creating an open and transparent mentalizing environment for the therapists, and that supportive measures need to be taken. Perhaps we should also have a specific eye on the female therapists, as both of our female therapists in this project reported a various degree of discomfort with how patients could be personal and sort of mocking towards them in group or individual therapy. We follow the ASPD-MBT literature that suggests that in response to patients' teleological explanations of for instance relationships, therapist juxtaposition of own mental states is suggested (Bateman *et al*., 2013). In our findings juxtaposition of own mental state, that is to say to the patients how we feel in the moment contrasting their view, were experienced as important in order to deal with patients who talk about difficult subjects without boundaries. We feel it is important to underline that it is hard to work with these patients, and all therapists experienced changes in their private lives and own psychological functioning to various degrees. We support the notion of taking this aspect of working with ASPD very seriously and that organizations and therapists are strict on their need to uphold the framework of the treatment. We find the conclusions from a similar study as our own interesting, as their findings are much more negative, and therapists seem to be more loaded and strained in their MBT-ASPD work (Warner & Keenan, 2021). If the framework around the treatment delivery is not solid, there are potential consequences on the outcome of treatment as well, as we have seen in the studies from the Netherlands with young severe BPD inpatients. Their effect sizes on outcome in an inpatient facility delivering MBT were half after organizational turmoil, and there were no changes at the team or therapist level, which makes these findings even more interesting (Bales *et al*., 2017).

High-speed group culture

Fourth, it was intriguing to discover how full of life and tempo work with ASPD can be, and interesting that therapist struggle so much with the literal timing of when to get a word in. This type of group culture poses different challenges than other types of groups with PD patients. The tempo had both positive and negative aspects, and we think that a specific focus in how to deal with this particular challenge in MBT-ASPD would be interesting to further develop. We suspect that this high tempo of the group culture has in part to do with hierarchical interpersonal strategies of the patient group, and that taking the room with entertaining stories is one way of positioning yourself. Perhaps even a prosocial manner of positioning yourself since the stories are meant to be entertaining and often has aspects of trying to be supportive of each other. On the other hand, some of the patients are more direct and impulsive than others. Impulsivity is a core problem for patients with ASPD, but not for all patients with ASPD. Temperature and the level of entertainment in the group varies with the individual patients present. Is a high tempo and the party like quality of the dialogue an example of pseudomentalizing, the antisocial version? Pseudomentalizing has been described as potentially very destructive in group therapy (Esposito *et al*., 2021). Therapists often have problems with discovering when pseudomentalizing is present, they lack authority to steer the group away from pseudomentalizing and furthermore, we assume that a pseudomentalistic dialogue does not have the potential to produce change. Inderhaug & Karterud (2015) has written well about pseudomentalizing in groups, they suggested that therapist failed to manage authority and overplayed the not-knowing position as an explanation for chaotic group sessions. Esposito and colleagues (2021) have made an important contribution to the understanding of pseudomentalizing in groups with substance addicted patients, where they suggest that there are three types of pseudomentalizing where the intrusive type is perhaps what is most recognizable in our study. The intrusive pseudomentalizing appears certain about mental states and lacks any connection between thoughts and feelings (Esposito *et al*., 2021). Since pseudomentalizing does not appear in all group sessions, the therapeutic style (MBT-adherence) probably matters in generating a mentalizing dialogue (Esposito *et al*., 2021). The high tempo described from the therapists in this study suggests that they struggle with chaotic group sessions, and we suspect that pseudomentalizing is the dominant mental stance in the patients in these moments. We don't know if therapists have failed to implement authority or if the patient group is specifically impaired when it comes to normal societal communicational norms, like waiting for your turn, listen to the other, and stop and rewind. But in the ASPD manual the therapist position is suggested as that of authority in the sense the

therapist keeps patients on the 'task', but at the same time take the position as the group's servant, that steers only to get patient back on track and intervenes with the purpose of increasing mentalizing in the patients (Bateman *et al*., 2019). Utilizing the case formulation in group therapy could be a useful therapeutic intervention to deal with the deterioration and chaos which can appear with severe personality disorder (Karterud, 2018).

Are we on the way of gaining pro-sociality and mentalizing?

We do not investigate effect of treatment or patients experience in this study. We look forward to investigating these questions scientifically in publications down the road. Nevertheless, we ask the question if ASPD-MBT has something to offer, from the therapist perspective. The quick answer is that we do not know. Treatment optimism has been surrounding the team since launching the pilot. In fact, we are so optimistic that we wanted to investigate our experiences scientifically as we did in this study. However, deep diving into our experiences demonstrated for us that some of our experiences are negative, and that negative implications on therapist well-being is one possible outcome of working as an MBT-ASPD therapist. Another aspect of this work that worries us is the concept of illusory treatment alliance (Meloy & Yakeley, 2010). There has been a collective sense of good and fruitful collaboration with the patients in group, at the same time we suspect that pseudomentalizing is dominating the group culture and this would imply that little change will happen with patients' level of mentalizing. Could it be that we are blind to a potential lacking effect of the treatment? However, the positive processes of getting to know the patients better, being surprised by patients' level of motivation and tolerance for differing perspectives and gaining more competence as clear and concise therapists leads us to carefully conclude, that even though there is uncertainty, there is also hope. We look forward to the first results from the RCT in London (Fonagy *et al*., 2020), and the RCT on adolescents with conduct disorder in Germany (Taubner *et al*., 2021). Hopefully, treatment pessimism on ASPD will look different during the coming decade.

Conclusions

This focus group study investigated therapist experiences with MBT-ASPD. We found four major themes on therapist experiences. Through getting to know the patients better, and how they related to their peers in group therapy, therapist experienced fewer negative preconceptions and more confidence in their role as a clear and concise therapist. Second, therapists experienced that upholding boundaries and clear expectations to patients together with a non-judgmental stance, was essential as overarching strategies in MBT ASPD. Third, countertransference and changes in therapist psychological functioning needs to be monitored and supportive measures must be taken to manage therapist countertransference. Lastly, there is a specific characteristic of MBT-ASPD groups that involves high tempo and a mocking humorous interaction, this group culture both excited and exhausted the therapist.

Limitations and future directions

This is a small qualitative study performed by five colleagues within an autoethnographical framework performing a focus group. There are many potential pitfalls with this methodology like bias, preconceptions, blindness to findings, and producing conclusions that were already made prior to the study. We have tried to be transparent about the analytical process and reflexive on these potential pitfalls as is recommended in qualitative methodology (Malterud, 2001). Critical voices on collaborative reflexivity and studies on own practice is that the process of compromising and negotiations between researchers could potentially reduce the complexity of the insights compared to single researcher studies (Finlay, 2003; Halkier, 2010). There could be some elements of truth to this critique, although we would also like to stress that as this could be the case for some of our findings, other parts of our findings became richer and more complex because of the negotiations between us. We could also investigate the potential conflicts and potential disagreements between us, which has enrichened the analyses of the data.

There is very little research on therapist experience with ASPD, the studies we found point to very differently emotionally laden experiences. The importance of organizational structures should be investigated further so that we can scientifically establish contextual mechanisms important in this line of work. Furthermore, we know little of the mechanisms of change with ASPD. Suggestions on the importance of group therapy has been made both in the clinical literature and in national guidelines (NICE, 2009). There is a need for process studies and qualitative investigations on how patients experience mechanisms of change in MBT groups, and process studies that investigate mechanism of change through other analytical methods.

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