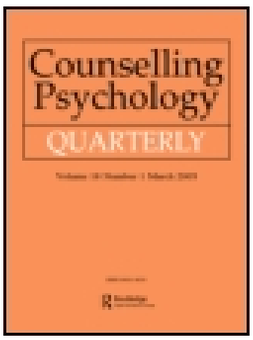

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Clinical management of common presentations of patients diagnosed with BPD during the COVID-19 pandemic: the contribution of the MBT framework

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ABSTRACT

The coronavirus (COVID-19) pandemic has both a profound effect on mental health and affects how psychosocial interventions are delivered. In this paper, we outline particular difficulties patients with Borderline Personality Disorder (BPD) may encounter as a result of the pandemic. We also consider changes in the provision of treatment, specifically the transition from face to face encounters to remotely delivered sessions. Building on a mentalization-based developmental framework, we use clinical vignettes to chart some of these challenges for patients, clinicians and teams. We then make practical recommendations for adaptations to work during the pandemic via the phone or video-link with BPD patients and other groups characterized by a vulnerability to unstable and imbalanced mentalizing. We conclude that the response to these challenges benefits from an existing treatment context that aims at fostering mentalizing and resilience, in which practitioners address the hierarchy of patient needs and their individual responses to the experience of remote treatment during the COVID-19 pandemic.

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COVID-19; borderline personality disorder; mentalization; epistemic trust; remote therapy

Introduction

The Coronavirus disease 2019 (COVID-19) pandemic has had significant disruptive effects on society, and has increased the burden on mental health in individuals previously diagnosed with psychiatric conditions, as well as in those presenting with psychological distress associated with the pandemic itself (Inchausti, Macbeth, Hasson-Ohayon, & Dimaggio, 2020). As a result, COVID-19 has posed substantial challenges to the provision of mental health services and required adaptation in technique and service delivery (Inchausti et al., 2020; Zhang, Wu, Zhao, & Zhang, 2020).

Epidemiological data on mental health problems related to the COVID-19 pandemic is still sparse (Duan & Zhu, 2020; Gunnell et al., 2020; Liu et al., 2020; Qiu et al., 2020).

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However, in a study conducted during the initial phase of the COVID-19 outbreak in China, more than half of the respondents rated the psychological impact of the pandemic as moderate to severe, and about one third reported moderate to severe anxiety (Wang et al., 2020). Depressive and anxiety symptoms, as well as posttraumatic stress disorder have commonly been associated with major disasters (Dell'Osso et al., 2011; Di Giuseppe, Gemignani, & Conversano, 2020; Lee et al., 2007; Martino et al., 2019; Maunder et al., 2006) and studies of the SARS epidemic indicated that social distancing increased depressive (X. Liu et al., 2012) and post traumatic symptoms (Inchausti et al., 2020; Lau et al., 2005; Wu et al., 2009).

While each individual's coping strategies and resilience resources are called upon during the pandemic, patients with severe psychopathology and particularly those diagnosed with a Borderline Personality Disorder (BPD) may be especially vulnerable to experience symptom deterioration due to the pandemic and the associated social and economic uncertainty and disruption. Uncertainty in particular and a subjectively experienced lack of agency and control over circumstances are significant causes of distress, especially in patients with BPD, leading to more pronounced difficulties in emotion regulation, impulsive and risk-taking behaviours (Mortensen, Evensmoen, Klensmeden, & Håberg, 2016; Pakpour & Griffiths, 2020). Social isolation, financial hardship, exposure to domestic violence, substance misuse, uncertainty about easing of restrictions, worry about significant others or bereavements, limited access to means and irresponsible media reporting have all been identified as challenges in the current situation (Álvaro et al., 2020; Polizzi, Lynn, & Perry, 2020). In addition, even for those currently in treatment, the necessary changes in therapy delivery – remote sessions – may impact BPD patients. This includes heightened anxieties about one's own health situation but also those evoked by the possibility that a therapist may have to self-isolate or get ill with sessions being suspended or the planned end of treatment falling within a lockdown period. Furthermore, COVID-19 affects both therapist and patient, which may offer the opportunity to relate through shared experience but also lead to challenges brought about by a new symmetry of circumstances.

These anxieties may interact with the typical problems of this group of patients. For example, the physical distance and isolation requirements may worsen the individuals' feelings of abandonment, identity problems, social withdrawal, and emptiness. The high level of stress may trigger intense paranoid thoughts and feelings which, in turn, may aggravate interpersonal relationships. In contrast, for some it could lead to a reduction in symptomatology due to a reduced exposure to interpersonally triggering interactions which often lead to a temporary loss of the patient's mentalizing capacity. Thus, the patient may appear to be more stable due to decreased social contact rather than as a result of improved mentalizing.

In this paper, we aim to describe the main clinical presentations of patients diagnosed with BPD that have been associated with or triggered by the COVID-19 pandemic – including the impact of transitioning treatments from face to face to phone or video-link sessions. We make clinical recommendations to psychotherapists regarding how to address these presentations using interventions inspired by the mentalization-based therapy (MBT) framework. Due to the transdiagnostic potential of fostering mentalizing and social learning, we believe there is much to be gleaned from working with these patients during the pandemic in relation to the treatment of other severe forms of psychopathology. To illustrate that, we will first

characterise BPD and provide a developmental model of the origins of its clinical phenomena before outlining key aspects of MBT, in order to demonstrate suggestions for the clinical management of patients- with the help of clinical vignettes.

Borderline personality disorder

Borderline Personality Disorder has been empirically characterised as a disorder with profound social cognitive deficits, with patients suffering from a pervasive pattern of instability in self-image and intense and dysfunctional relationships (APA, 2013; Fonagy & Luyten, 2009). Core clinical features of BPD include affect dysregulation (Euler et al., 2019; Reisch, Ebner-Priemer, Tschacher, Bohus, & Linehan, 2008), heightened risk for self-harm and suicidality (Black, Blum, Pfohl, & Hale, 2004), fear of abandonment, epistemic hyper-vigilance when evaluating the motives of others in close relationships (Fonagy & Allison, 2014), interpersonal hypersensitivity (Gunderson & Lyons-Ruth, 2008), difficulties in impulse control as well as a bias in attributing hostility to others (Critchfield, Levy, Clarkin, & Kernberg, 2008; Grootens et al., 2008; Gunderson & Lyons-Ruth, 2008).

Historically, patients with BPD have often been hard to engage effectively in treatment as they bring disorganised attachment strategies and suspicion regarding clinician's intentions into their interaction with services and treatment (Fonagy, Campbell, & Bateman, 2017). This has commonly led to ruptures and crises during treatment (Eubanks-Carter, Muran, & Safran, 2010) and often to premature treatment termination (De Panfilis et al., 2012). Additionally, some BPD patients are likely to be frequent and continuous users of mental health and medical emergency services (Zanarini, 2012), often expressing a need for more or prolonged help. BPD diagnoses occur with a lifetime prevalence of 2%–6% (Grant et al., 2008). Despite the fact that patients with BPD often experience severe and persisting interpersonal impairments (Choi-Kain, Zanarini, Frankenburg, Fitzmaurice, & Reich, 2010; Liebke et al., 2017; Skodol et al., 2005), research has demonstrated favourable treatment response and improved symptomatic outcome (Bateman & Fonagy, 2008; Levy et al., 2017; Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012) with a range of treatments including MBT.

The mentalization-based developmental framework to understand BPD

Mentalizing is both an implicit and explicit process by which we make sense of others and ourselves, in terms of intentional mental states. Mentalizing is conceptualized as a multi-dimensional and complex social cognitive process which entails forming beliefs about the internal states of those with whom we interact. Importantly, the capacity to represent one's own actions in mental state terms is developmentally rooted in the depth and accuracy of the psychological understanding that the children's carers evidenced and forms the foundations of the mentalizing and affect regulatory capacities of the individual.

The developmental interdependence of self and other mental state understanding makes the capacity to mentalize a developmental achievement and its attainment dependent on the quality of early social relationships, as they reflect the extent to which the child's subjective experiences were adequately mirrored and contingently responded to by trusted figures in the child's life (Fonagy, Gergely, Jurist, & Target,

2002; Fonagy & Luyten, 2009). Individuals with BPD often employ ways of thinking and appraising interpersonal events that reflect inadequate mentalizing. These modes of experiencing have been heuristically grouped as psychic equivalence mode, teleological mode, and pretend mode (Table A1). As these strategies of social cognition share features with the thinking of children before the full development of mentalizing the categories have been referred to as pre-mentalizing modes of social cognition.

The main features of BPD from an MBT perspective are: (a) an instability of mentalizing in the context of emotionally intense relationships; (b) the re-emergence of modes of thinking that antedate full mentalizing during times of stress; and, (c) the pressure for externalization of internal states which has been understood as the projection of painful and disorganized or intolerable self-states. Indeed, MBT for BPD was developed on the understanding that susceptibility to loss of mentalizing – particularly during emotionally charged interpersonal interactions – is the underlying pathology that brings about the characteristic symptoms of BPD. Therefore, it has been suggested that a key mechanism of symptom change is the enhancement of mentalizing and the reduction of pre-mentalizing modes of experiencing (Fonagy & Luyten, 2009).

A central tenet of the MBT framework pertains to the influence emotional arousal exerts on mentalizing (Debbane & Nolte, 2019; Fonagy & Luyten, 2009). Simply put, optimal arousal works in favour of good and balanced mentalizing, whereas suboptimal levels (too high or too low) perturb it. Patients diagnosed with BPD use attachment hyperactivation or deactivation strategies in the face of stress, both of which lead to the use of pre-mentalizing modes (Bateman & Fonagy, 2013). The bio-behavioral switch model (Fonagy & Luyten, 2009; Nolte et al., 2013) asserts that with increasing stress (fear, excitement, feeling overwhelmed) the attachment behaviour system is activated and subsequently a switch occurs between slow, controlled and reflective modes of mentalizing to more rapid, automatic and reflex-like ones which give way to pre-mentalizing modes of processing.

What is common to the recourse to each of these pre-mentalizing modes under heightened arousal, when the attachment system is activated, is not only a momentary but sometimes a prolonged shutdown of mentalizing. As a further consequence, when operating in any of these modes, the individual's capacity to reappraise self-states and those of significant others and to learn from the social environment can be severely compromised (see Table A2).

The MBT approach

Of particular importance to effect the primary aim of stimulating mentalizing is the way interventions are organised and delivered focusing on the symptoms of BPD. The attitude and stance of the clinician is one of authentic interest in mental states and how they play out in managing emotions and impulses and in understanding social and interpersonal interactions. This is known as the not-knowing stance. Using this, the clinician follows a hierarchy of interventions in both individual and group therapy with the overall aim to stop non-mentalizing and to engender a process that brings mentalizing back: from first a supportive and empathic recognition of a patient's interpersonal experiences, then exploration of the way in which those experiences are processed (which is often in low mentalizing modes), followed by interventions to improve those mentalizing processes

within the context of the initial affective and relational experience. The interventions are organised in these steps in order to titrate in-session arousal in order to effectively rekindle mentalizing and to reduce iatrogenic effects.

Clinical vignettes

In this section, we describe specific clinical presentations of BPD patients that have taken place during this early stage of the COVID-19 pandemic. In addition, we discuss how clinicians could address the clinical challenges associated with the pandemic using relevant MBT principles in relation to five clinical vignettes.[1]

Risk of infection associated to COVID-19: health anxiety in BPD patients during the pandemic

Clinical presentation

Patients with severe psychopathology (e.g. psychosis, severe depression, anxiety and OCD) and particularly those diagnosed with BPD may be especially vulnerable to worsening symptoms due to the pandemic and the associated uncertainty and anxiety about their own health and those of others important to them (including worrying about whether a therapist might fall ill, have to self-isolate etc). Furthermore, the pandemic has also led to anxieties regarding access to both health and social care – would appointments and treatment be available, was someone a virus carrier and therefore at risk – also to others, when would testing for a potential infection become available etc. This, in turn, often increased feelings of helplessness.

Clinical vignette

Paul, 28, had recently begun the transition from being a man to a woman with hormone therapy underway. He had already completed his 18 months MBT program and his mentalizing ability and relationships had improved. Three weeks into the lockdown he called the service one evening and left three messages on his therapist's voicemail asking for someone to return his call as he was in urgent need to talk. His therapist called him the following morning.

Paul: Thanks for calling; I waited the entire night, slept 4 hours only. I knew someone would get in touch but at some point, I felt like I couldn't wait any longer. I was pacing up and down my room, thinking that I can't bear staying any longer with my Mum, but where can I move during a lockdown? And I screwed up during a zoom call at work as well yesterday – all I do is think about this virus! And Charlie (his new partner) is on his way out of our relationship, I bet. And this whole hand-washing thing is clearly not going to protect me from any virus in this big city – and now I can't even have one of my follow-up sessions with you face to face and feel like I will never see you in person again if this carries on. So, there you go …

Clinician: My impression is that you're still quite agitated now and I'm sorry to hear this. Let's slow down and see where we go. What about a look at what happened yesterday.

Paul: I don't know; I'm just too anxious. It's everything, I'm not sure where to start!

Clinician: My impression is that you're still quite agitated now and I'm sorry to hear this. Let's slow down and see where we go. What about a look at what happened yesterday.

Paul: I don't know; I'm just too anxious. It's everything, I'm not sure where to start!

Clinician: And we both know that you find it very difficult to make sense of how you got from being alright to things getting out of hand to the point of hurting yourself when you feel this agitated. Is it one of those moments that you have told me about before or does it feel different perhaps?

Paul: Yes, I think it's one of those situations that we called "anxious overdrive ". And I could see that afterwards. (Now calmer): I thought yesterday that I've been here before and actually I don't do well when I get myself into such a pickle trying to think about ten different things and the virus on top – that are out of my control – at once.

Clinician: Well, I'm glad that you got in touch with this. Let's see then how we can best help you during this call. You mentioned a number of different things, each of them quite stressful in their own right for anyone probably – and I want to understand better what we can do to help you manage your anxiety about the virus. It might be that we need more time to unpack and understand better what's made you feel this way. In that case I suggest we book in one of your remaining follow-up sessions later in the week. But I'm not sure whether that's what you're looking for right now, so perhaps we can decide that together once you have told me a bit more. Does that sound OK?

Paul: Mhm, yes.

Clinician: This is a bit unusual for me to ask, but when we met face to face, I could sometimes see in your face that you didn't quite agree with what I had said and that allowed me to check in with how you were feeling, to make sure I got you right. So I think while we speak on the phone, I may have to do that more often, as I can't see your face. Did you really mean you're OK with that plan?

He confirmed that he had agreed with the suggestion and he managed to slow down a bit. He talked about increased health-related worries. It emerged that what had frightened him the day before was that his mother was at heightened risk for a severe course of COVID-19 due to her age and previous respiratory problems. What made things worse was that he had failed again to get her to quit smoking and to spend more time inside the day before. He ended up rowing with her and insulting her. He only felt some relief after banging his forehead against the wall and biting his forearms. In the evening, he felt guilty and ashamed and had hoped someone would "magically" pick up the phone despite knowing that he had called the service out of hours. Although in the session Paul was able to think about the event in a mentalizing frame of mind- which reduced his anxiety temporarily-,, towards the end of this brief phone intervention he made clear that his health anxieties, "with COVID-19 everywhere, cannot just be helped by a session on the phone". He said that, as in the past, he would need to see his therapist in order "to get through this, at least through one of these video platforms".

Presentation framed in MBT terms

It has been recognised that uncertainty in particular and a subjectively experienced lack of agency and control over circumstances -here mainly triggered by coronavirus-are significant causes of distress, especially in patients with BPD, leading to more pronounced difficulties in emotion regulation.

The clinician was very familiar with the form that a breakdown in mentalizing could take with Paul based on a co-created formulation that was referred to several times by Paul during treatment, his "anxious over-drive", which corresponded to a state of psychic equivalence, use of teleological strategies and a certain lack of epistemic trust. On the phone, the clinician and patient had a pre-agreed 15 minutes to do a micro-slicing elaboration of the event that led to compromised mentalizing the day before. His attachment system seemed hyperactivated mainly related to his affection for his mother and his justifiable concern about her health and the threat of a coronavirus infection to himself.

Clinical management according to MBT techniques

It was important to validate Paul's new anxieties and to explore with him in some detail what had happened the day before and to identify where mentalizing was still possible and to assess how much his worries evoked by the pandemic affected this (how unsafe he really felt). The clinician lacks feedback from facial expression on the phone call and, being aware of Paul's somewhat deferential attitude in their relationship, partly fuelled by Paul's attachment processes, asks explicitly for confirmation that "OK" is actually OK. In telephone interaction, ostensive cues are muted or limited so a careful check about mentalizing synchronicity is useful. The therapist's focus on and marked mirroring of the affect associated with the difficult feelings that came up in the face of his helplessness related to the pandemic and anger towards his mother helped him to recognise his worries as "quite normal actually" and to be accepting of his frustration with mother. The clinician further commented on the fact that he thought Paul had managed to recover mentalizing quite quickly during the call and decided that further relational mentalizing was not required (e.g. enquiring about what had got Paul to call out of hours, the experience of talking to him on the phone only) and was not the focus of this short intervention as it may have exacerbated his hyperactivating strategy again. However, the therapist had underestimated and not explored sufficiently to what extent the impending end of this brief contact and the prospect of no face to face encounter would trigger Paul's attachment system again (or how sustained his apparent capacity for downregulation really was in the face of these relational challenges). This could not be further explored then and it remained unclear to what extent a feeling of abandonment in addition to his health anxieties (COVID-19-related and pre-existing) led him again to a state of epistemic hypervigilance which made him mistrust the possible benefits of a longer follow-up telephone call. A COVID-19-adjusted intervention would need to make more use of empathic validation (perhaps more than the clinician was used to with Paul), with a focus on his experience of COVID-19-related fears and on speaking to his therapist on the phone only where the patient's hope was to see him personally. Following the MBT

model of staged interventions, only after sufficiently assuaging the patient's hyperarousal could a mentalizing process be generated again.

This fosters further reflective capacities, helps affect regulation and builds additional resilience. The virtuous cycle of being better understood leads to better representation of thoughts and feelings which, in turn, enable greater sensitivity to the mental states underpinning the actions of others including their construal of our internal world, ultimately helping us understand ourselves better at the same time as increasing our sophistication when interpreting others' actions in mental state terms, and thus building additional resilience in the face of life stressors post treatment.

Social isolation in the context of the COVID-19 lockdown: increased fear of abandonment

Clinical presentation

The experience of intense inner pain associated with social situations that involve abandonment and rejection – that is commonly out of keeping with external events – is a characteristic feature of BPD (Zanarini & Frankenburg, 2007) frequently associated with disturbed relationships (Gunderson & Lyons-Ruth, 2008), and childhood abuse (Holm & Severinsson, 2008). This often prompts an intense sense of shame (Levy, Edell, & McGlashan, 2007; Rüsch et al., 2007), anger or dissociation (Philipsen et al., 2004) and risk (Fonagy & Luyten, 2009).

Patients diagnosed with BPD have often presented during the COVID-19 pandemic with an increase in the intensity and/or frequency of their feelings of abandonment. Social distancing including the lack of direct contact with loved ones or other supportive figures, social-isolation, the loss of structure and routine, as well as cancelled face to face therapy appointments may trigger these intense feelings.

Clinical vignette

Anna, 25, had been living on her own during the lockdown. She described an argument with her partner in the context of an intense attack of possessiveness and jealousy on her part that ended in accusations of infidelity.

Anna: No, I just couldn't stop myself … there was nothing that he could say that would reassure me that he was not sleeping with his flatmate … There is no one else around, it's just me on my own and he and she together in one place. And I have nowhere to go with this. My sister used to be the only person I talk such things over with but now I can't see her and she's got two crazy kids to homeschool so zooming her is not an option really.

Clinician: So you were on your own with all this going around in your head; then when you talked to him I am not surprised that you had to say something to him. But I wonder how someone may feel when nothing they say can change the situation and you are so sure you are right?

Anna: … helpless I guess …

Clinician: Is that all that they would feel?

Anna: I guess they could also feel angry and frustrated

Clinician: Do you think Andrew felt that way?

Anna: … probably, that's why he threatened me …

Clinician: It seems that although now you are becoming more aware of what may have been happening, at the time perhaps you didn't know the effect you were having on him. Would that be fair to say?

Anna: I think so, I didn't really mind then … I had to go on and on … I'm going crazy during lockdown, being away from him while he is away, living with her … I had to get reassurance from him, otherwise I was going to go mad with all these thoughts about him.

Clinician: It sounds to me as though you felt quite desperate?

Anna: Yes, I felt I was about to lose him and that I'd be more alone, and even lonelier during the lockdown …

Clinician: In what way did you think you would lose him?

Anna: I don't know … I wanted him to come to my place … so I kept calling him, every time after we hung up the phone …

Clinician: So perhaps you "wouldn't leave off," as you said, to make sure that you weren't left on your own … It may be that him threatening you in a way also reassured you?

Anna: I think we have to stop threatening each other though. It is always awful.

Presentation framed in MBT terms

The lockdown and separation from her partner triggered feelings of abandonment and rejection in Anna, which she experienced in psychic equivalence. This was recognised by the clinician and by the patient retrospectively but at the time Anna was unaware of the break in her mentalizing capacity. While it was possible that the partner was unfaithful, this was by no means the only possibility. Anna also requested "teleological" evidence of her partner 's love and concern by asking him to come to her flat, despite the lockdown, and by demanding him to reply to several phone calls. She believed that these actions would show the constancy of his affectionate state of mind for her and his faithfulness.

The intense feelings of abandonment arise from specific failures in social cognition in patients diagnosed with BPD. This can be rooted in the teleological interpretation of the experience of social isolation and/or in the catastrophizing cognitions that come out of the panicked thinking of psychic equivalence or misinterpretation of the intentions of others and conceptualising the need for isolation in terms of a sense of badness. Thus, social isolation in the context of the stress associated with the pandemic disrupts the mentalizing capacities in this group of patients who within the social isolation have no reference point with which to calibrate their feelings and thoughts.

Clinical management according to MBT techniques

The clinician addressed the patient's presentation by first clarifying her experience, eliciting from her how her inability to understand her partner's behaviour led her to believe that he had been unfaithful. The way she described the events indicated to the clinician that she was functioning at a level of psychic equivalence, which indicated a failure in her capacity to mentalize her experiences, juxtapose them with the experiences of her partner and create a joint subjectivity of what was happening between them.

The clinician began by empathically validating the patient's experience, her feelings of loneliness and the uncertainties she had about her partner during the lockdown period. The clinician rekindled the patient's mentalizing capacities, allowing a shift from psychic equivalence to mentalizing on this occasion. In this way, a shared platform was established in which both, patient and clinician, were able to start thinking and elaborating the situation further.

In elaborating the patient's mental state thereafter, it becomes clearer that the lockdown self-isolation associated with the physical separation from her partner prompted intense feelings of abandonment, which in turn led her to experience intense jealousy. Only then it was possible for her to elaborate further and mentalize the effect of her actions on her partner, which initially were not evident to her. Finally, the clinician presented an alternative view of the interaction, as he suggested that possibly the partner's threats were in some way reassuring the patient as they suggested that he was still attached to her and was not indifferent or abandoning her. Only at this point it was possible for the patient to take this in and integrally mentalize what had taken place.

New living conditions associated with COVID-19: emotional and interpersonal instability

Clinical presentation

A core symptom experienced by patients diagnosed with BPD is disturbed interpersonal functioning (Hill et al., 2008), which is in line with a characteristic pattern of fearful/disorganized attachment, hypersensitivity to the social environment, and an expectation of social hostility, among other features (Critchfield et al., 2008; Fonagy & Luyten, 2009; Gunderson & Lyons-Ruth, 2008). BPD patients are vulnerable to losing their sense of self, separateness and individuality in interpersonal interactions and that the tendency to control and impacting the minds of others may be a way of defending the threatened integrity of the self within attachment contexts (Fonagy & Luyten, 2009). The intimacy of interpersonal interactions more readily prompts a loss of mentalizing in patients with BPD than in other individuals (Bateman & Fonagy, 2013).

During the COVID-19 pandemic, several BPD patients have presented an increase in their interpersonal difficulties. This presentation has often been triggered by experiencing the lockdown in a flatshare, being confined in small indoor spaces with others, the lack of activities that help reduce stress (sport, work, therapy) which in the patient's perspective intensified the intimacy of these relationships.

Clinical vignette

James called his therapist on the phone and said, talking with a raised voice, that he could not bear being with his flatmates any longer; they were the only people he got to see, 24/7 and without reprieve. They were "too much in his face". The clinician remarked on how angry his voice sounded. This upset him and he strongly stated that he was not angry.

James: Why do you and my flatmates say I am angry all the time? I am not … they say that to dismiss the fact that they should be cleaning the bathroom and the kitchen … and now you're telling me the same thing!

Clinician: Well, I thought that you were angry because you were raising your voice … but the truth is that it is difficult to understand how you are feeling through the phone. If you are not angry, can you tell me how you do feel so that I can understand you better?

James: Not angry.

Clinician: I accept that. How would you then describe how you feel right now? Perhaps it could be helpful to start by telling me how your body feels.

James: I feel tense … actually I am really frustrated because people never listen to me.

Clinician: What would tell you that your flatmates and myself are listening to you?

James: I am not sure … you just don't see me as important …

Clinician: What you are saying is really helpful. I could now perhaps consider that when I see you angry you may be really feeling unimportant, which is something I could miss. Is there something that I am or your flatmates have been doing that makes you feel unimportant?

Presentation framed in MBT terms

As a consequence of the COVID-19 lockdown, the relationship between James and his flatmates had intensified, leading to a loss of balanced mentalizing. James resorted to psychic equivalence, as he was certain that the fact that his flatmates did not clean meant that they were dismissive of him. While it is possible that the flatmates may have been dismissive, other alternatives could be considered to explain their behaviour. James also employed psychic equivalence with the clinician, as the description of him as "angry" could only mean to him that the therapist was being equally dismissive towards him.

Clinical management according to MBT techniques

The clinician addressed James' presentation by first identifying that his own remark – "the patient is angry"- elicited psychic equivalence in the interaction with James. Thus, the therapist was able to realise that his non-mentalizing stance generated further mentalizing difficulties in the patient. Thereafter, the clinician was able to use the "not-knowing stance" in his attempt to understand James' feelings. This reminded James that feelings are not facts, meaning that just because he felt that the clinician thought something it did

not mean that he actually did. Thus, it was then possible for James to begin considering alternative perspectives in how he perceived the clinician.

In this vignette, the clinician made his own mental states transparent to James by describing how he had experienced him. In addition, by asking James to identify his bodily state, the clinician helped him to focus on his internal state, which the clinician later translated into a mental representation.

The elaboration of the manifest feeling revealed an underlying state in James. In order to do this the clinician made careful use of his own experience of the patient to have a first indication of James' underlying state. Once James was able to express his underlying feelings, which had been covered by anger, it was possible for the clinician to be much more empathic about James' predicament.

Use of remote therapy during the COVID-19 lockdown: Attachment hyperactivation and risk in BPD patients

Clinical presentation

The reduced contact with services (both physical and in frequency) associated with the pandemic has been increasingly challenging for patients diagnosed with BPD given their problems with attachment. This has led to mentalizing difficulties which have in turn been associated with patients presenting at increased risk.

Clinical vignette

Helen had started looking forward to her sessions with her therapist in the weeks leading up to COVID-19 lockdown. When the service had to reduce its frequency of contact and move to remote working, Helen started overdosing again. She had frequent contact with emergency services, raising the clinicians' anxiety by being vague and unwilling to fully commit to the agreed crisis plan. The Personality Disorder (PD) service had offered her twice weekly appointments over videolink. We join a session 20 minutes in:

Helen: … I have this ongoing urge to kill myself – I just don't care.

Clinician: Well that is clearly of real concern. Let's think of what would be helpful – do you have thoughts of what we can do that you would find helpful?

Helen: I want to be admitted – even if it's for a few days, a weekend. Then I will feel 100% safe. (Helen then went into great detail of how previous ward staff had been kind to her)

Clinician: I can understand you want to be 100% safe, given how unsettled you're feeling. Let's talk about how you have been in yourself over the past few days anyway to see if hospital admission is the best solution here.

Helen: Well – you'll come to see me on the ward won't you?

Clinician: Well I would certainly think of doing so. Can you tell me what made you ask that now? What came into your mind?

Helen: I'm sick of not seeing anyone! I'm sick of self-isolating! Video video video – its rubbish. I need to get out of my flat or I'll go mad. I need to see someone.

Clinician: It is just not the same for you, is it. What do you not get from the video meetings that is so essential? Do you have any sense of what it is?

Helen: I don't know but I am right at the end of things now. I cannot manage on my own any longer.

Clinician: Well, I am understanding you feel the video is not enough. I will need to review our situation regarding PPE so we can meet face to face. Can I get back to you about this?

Presentation framed in MBT terms

Helen's response indicates hyperactivating strategies – she seems to have a low threshold for a hyperresponsiveness to stress, a strong activation of automatic mentalizing (i.e., the thinking which tends to be reflexive, is fast and requires little effort) and a slower recovery of controlled mentalizing (which tends to be more reflective, slower and demands effort). It seems that her attachment system was hyperactivated in the lead up to the COVID-19 lockdown, and this together with the reduced contact post lockdown contributed to her pre-mentalizing mode of thinking and urgent demand for proximity to someone.

Helen shows psychic equivalence as seen in the certainty of her thinking (an admission is 100% good). She also demonstrates teleological thinking (show me you care by admitting me), and in response the clinician tries to widen the frame of exploration to see if Helen can distance her immediate wish for admission in her mind to look at her experience afresh. Threats of suicide and demands for services to react in specific ways may indicate misuse of mentalizing in a very small subgroup of patients who consciously pre-plan interpersonal interaction and gain self-stability using repeated scenarios such as suicide threats or threats of violence or provocation. In these cases, the individual is capable of mentalizing but uses it to control another person's behaviour, to the advantage of the subject. This is rare in BPD albeit a little more common in antisocial personality disorder. Certainly, Helen was not known to misuse mentalizing.

Clinical management according to MBT techniques

In his responses to the patient's psychic equivalent thinking, the clinician did manage to follow MBT principles of validating the Helen's experience in an empathic way, being curious (how have you reached the conclusion an admission is helpful?) and to avoid iatrogenic interventions (e.g., did not get into an argument with the patient or resort to challenging the patient at a cognitive level). The genuine curiosity of the clinician regarding the Helen's wish for an admission may have enabled a clearer identification of her thoughts and wishes (i.e. a desire for contact with the clinician rather than an admission per se).

In this episode, the clinician did not think there was misuse of mentalizing. In view of the very real stressors in the COVID-19 situation including the patient's social isolation, and the limitations of remote therapy, he opted to be more supportive than challenging, and by responding in a more teleological way (an offer of increased contact, including

face to face) to the Helen's request. The clinician felt pressure to offer more contact and, subsequently, sought reflection upon this with his team in order to monitor and understand this pull regarding his interventions. By using the initial steps of MBT of support and clarification but electing not to proceed to challenging Helen's thinking, nor spending more time on clarifying the pre-mentalizing modes of thinking or elaborating on the patient's affect, the clinician's objective for this session was to be more supportive than increasing Helen's mentalizing ability.

Use of remote therapy during the COVID-19 lockdown: Exacerbation of epistemic hypervigilance in PD patients

Clinical presentation

Many patients had to accept therapy or assessment sessions being delivered in ways they are not used to. These changes challenge the idiosyncratic strategies patients have developed to assess how trustworthy their counterpart is, often with resulting difficulties in taking in new information. The lack of face to face contact (whether via video-chat or even more so over the phone) can compromise the repertoire of cues a patient requires in order to feel recognised and contingently responded to by a therapist. In more severe cases, this can lead to heightened suspicion regarding the clinician's intentions and a predominantly teleological need to interact in ways that reduce the patient's anxieties, or to blaming/externalising in order to establish a temporary sense of safety and agency.

Clinical vignette

Adam, 23, had been released from prison at the beginning of lockdown. His upbringing had been very traumatic and disruptive and he had experienced further abuse in prison (culminating in a very serious suicide attempt). He has to engage regularly with a probation officer as he is considered high risk due to his index offence. The following excerpt is from a first telephone assessment session to establish the level of psychological help he may want. A Children in Need meeting[2] with Adam, his probation officer, the therapist and his social worker was scheduled for the following day as – due to his index offence – he only has supervised contact with his three young children at the moment; something he is very upset about and views as contributing to his current low mood and anxiety.

Adam: Oh, it's you, I had forgotten about the call. This isn't going to work anyway! This is not how this should be done. If I can't be seen in person, what's the point, it's just not appropriate.

Clinician: I agree, this really is not an ideal situation and a bit strange for me as well. I would much prefer to meet with you in person too. And I can hear how you're not happy with this. Let's see how this goes and maybe it won't work well but let's try.

Adam: This should really be about me because I have these anxieties now and my mood is low. (Very agitated now): I've had so much abuse, you won't believe it, and the system is

just all the same. And do you know what: All my probation officer wants is to see me back in prison. So, what's the point, why tell you more?

Clinician: I'm beginning to see your dilemma. How would you trust me when you feel people are so much against you and don't see your perspective. But I'm in a dilemma too here. I want to see what help we can offer you but to do so the two of us must get a good sense of how you're doing at the moment. And it's helpful that you've mentioned your mood and anxiety to me because we can use this consultation to look at that and how, as a psychological service, we can help you with both.

Adam: Well, there was this one psychologist in prison, one out of ten I've met and I started to trust him. I needed to see in his face what he was up to. What motives he had. That's how I read people!

Clinician: Now I can see that more, it must be really hard for you then not just talking to a stranger over the phone but only to have my voice to go by and no wonder this leaves you very suspicious then.

Adam relaxes somewhat and allows exploration on how he is currently feeling, his life circumstances, and the sadness about not being able to live with his family and getting a job during the lockdown. Towards the end of the assessment the clinician asks: We've talked for a while now and I'm impressed with how open you've managed to be with me. How's that initial suspicion you've had about this conversation with me now?

Adam: Better . . . But then you will just pass everything on to the other agencies, including to the probation officer, you're probably just part of the system as well.

Clinician: True, I may get asked to comment on how you're managing. In order to do so, I would want to get to know you more first as we've only made a start today. And we can think together how you are doing, what's difficult for you and what goes well – and if a report is required I will share that with you to see whether my view reflects how you see things.

Adam: I love the kids! But when I hear you mention a report, you guys are just all the same, just trying to bring me down again, I can't see what you're doing and you're probably already jotting things down about me

Clinician: Well let me stop you there for a moment as I can see you're getting worked up. We can come back to the report later as it clearly concerns you and I want to understand better why that is. But tell me a bit more about that last visit then. You said earlier, it really gave you a boost playing with your children. What was it that made you feel so good about it?

(Adam talks about how he had felt better seeing them for one hour last Sunday, what they mean to him and how they kept him going in prison).

Clinician: So, for a moment when you told me about the kids you were fine then. And I can hear how important it is for you that you get to see your children again, how hard you're working to make that happen. And how serious you are about it. And maybe that's

something the work with our service and the team can centre on; how we can help you with that.

Adam: I don't know. Let's get this meeting tomorrow out of the way first and see when we next speak.

Presentation framed in MBT terms

While it is important to recover mentalizing to make sense of one's own experiences and emotions, the capacity for orienting effectively to the mental state of others is dramatically reduced in patients diagnosed with BPD following adversity (Fonagy & Bateman, 2016). For patients like Adam, with a history of early abuse or neglect, we consider this deep-rooted suspicion to be an indication of the impact of trauma on cognitive functioning (Berthelot et al., 2015; Ensink, Bégin, Normandin, Godbout, & Fonagy, 2017; Lassri, Luyten, Fonagy, & Shahar, 2018). In this context however it may be seen as a potentially effective adaptation to an inherently untrustworthy social environment (in prison he felt constantly in danger, his reports of threat and abuse by other inmates and the physical assault by an officer had remained inconsequential). In such circumstances, it may be a better strategy to regard what others try to convey (including a therapist) as irrelevant, suspect, misleading or otherwise mal-intended. However, a strategy that may ensure survival in the short term, may turn out to generate significant difficulties later (McCrory & Viding, 2015). The problem with such a strategy is that in the longer-term, the patient is unable to reap the full benefits of social learning when key qualities of the social environment that can normally support psychological resilience in the face of challenges – being able to seek and receive help, having a social network, being open to change – are lost. The Child in Need meeting was called could only be perceived by Adam through a psychic equivalence lens and in very concrete terms: that it was taking place was equivalent to him being let down again and accused of failing to parent – instead of understanding that such an assessment would lead to thinking about how his family can be supported out of reach. The overemphasis on external indicators of internal states, unchecked by reflection, generates deeply disturbing expectations of other people's intentions and is often associated with anti-social presentations – a diagnostic feature in Adam's case (Bateman & Fonagy, 2019).

Clinical management according to MBT techniques

When faced with high levels of epistemic hypervigilance, the clinician can feel an urge to respond in a way that can become an argument with the patient (e.g.: "I don't think that those other parties are out there to get you"). Often, this will fail to engender a mentalizing process and, instead, getting alongside the patient in order to appreciate their experience and to empathically validate it is more helpful. As trust is at the heart of what it means to be human, a focus of the work with Adam will have to be on him becoming less suspicious. In Adam's case the clinician addressed reduced ostension and its impact on the patient ("I can see that it's really difficult to trust me at this point as there's nothing that can give you convincing confirmation of my intentions, like a warm and encouraging smile or look"). The clinician attempted to get alongside Adam and to

validate his experience of mistrust (generate experiences of epistemic matches). He avoided iatrogenic arguing or wishing to convince him that other people's intentions are benign. He attempted to move Adam away from being "stuck" in suspicion to have him think about the good experience of his last visit with children and partner and how that affected him positively. After this step, the clinician returned to an attempt to engage Adam with what he felt was important to him and to give him a sense of agency by asking: "You seem to care very much about your family. Can we help and support you in managing yourself better so that more contact can become possible again" and to further attempt to modify Adam's internal structures to accommodate and trust what services may have to offer and to see whether that could be extended, in part, to his appraisal of his wider social community (family and other agencies involved).

Working with a patient like Adam, an active stance, for instance in stopping him and moving away from the arousal topic, ("to park" this for a while) to where he managed well is required and it may then prove beneficial to have him mentalize his caring and more positive feelings for his family.

Ideally, in a case like Adam's, a further focus will be on joining up the team around the person (including the non-mental health agencies) in a shared mentalizing perspective.

Discussion

In this paper, we have described some of the main clinical presentations of patients diagnosed with BPD during the COVID-19 pandemic and their clinical management according to MBT interventions. The fundamental principle followed in MBT is that only safe, i.e. arousal-adjusted, interventions can be used when the patient is in a state of heightened emotionality. It is probably true for all of us that COVID-19 is associated with an increase in emotional arousal but obviously far more so for someone high background levels of anxiety. The positive feedback loop whereby emotional arousal drives down mentalizing and the equivalence of subjective and objective reality in psychic equivalence makes reality seem increasingly dangerous of course contributes to a clinical picture of crisis and deterioration. The vicious cycle must be interrupted. Safe interventions are the ones that decrease arousal and help reinstate mentalizing. In effect, when the patient is emotionally aroused it is safer for the therapist to begin by empathically validating their distorted subjective experience rather than addressing its inaccuracies. Therefore, the interventions which are focused on the affect shared in the session and on the relationship with the therapist are only delivered once the patient has been able to begin reflecting upon his/current mental states. Throughout the session, the therapist should be attentive to what is in the patient's mind *now*; even when they are reporting events from the past. Indeed, the therapist moves from being interested in the COVID-19-related events themselves, to the patient's current experience (thoughts and feelings) about the COVID-19-related aspects, and then to their present feelings while speaking about the events related to COVID-19. In the end, as affect is moderated by increased mentalizing of experience through the therapist validation and clarification, an alternative perspective can be presented so the patient can reflect on what emotionally affected them. In time, this helps to promote more robust mentalizing capacities less vulnerable to the dysregulation of emotion. In turn of course, more effective mentalizing will create reflective space,

making the dysregulation of affect less likely. The vicious cycle has become a "virtuous cycle".

Alternatively, as some patients presented with more pronounced deactivation strategies (perhaps contrary to what appeared to be their primary mode of relating to the clinician or service), these too need addressing by exploring what the underpinning mental states are or what the avoidance interpersonally is in the service of.

In addition to emotional arousal and breaks in the patient's mentalizing capacities, the COVID-19 pandemic has also been associated with epistemic hypervigilance. As mentioned, this is particularly relevant in patients with BPD who often struggle to tolerate ambiguity, uncertainty and lack of control in the interpersonal realm, and who therefore may become more suspicious and vigilant towards (or, conversely, more detached from) the therapy and the clinician. Furthermore, the use of remote therapies may also engender higher levels of epistemic vigilance in the patient, as misunderstandings or inaccurate beliefs about the therapist's intentions and a lack of feeling understood are more likely to occur (Lemma, 2017). The patient must contend with the absence of most of the therapist's non-verbal communication which to him would ordinarily indicate important aspects of their emotional availability, engagement and curiosity as much as their consternation, puzzlement or distancing (Shai, Dollberg, & Szepsenwol, 2017). It is therefore important that the therapist is able to find alternative ways of ostension and is able to pay careful attention to the detail of the ostension processes themselves as they play out in the therapy dialogue and therapy interaction (Fisher, Guralnik, Fonagy, & Zilcha-Mano, 2020). Joint recognition of the reciprocity of interactive cues between patient and clinician and an openness about what is perceived and interpreted by the patient and what is intended by the clinician and vice versa will enhance effective mentalizing when explored with compassion about the limitations of video/web-based interaction (Table A3).

Although the focus of this paper has been to address the clinical challenges of working with BPD patients during the coronavirus pandemic through the use of MBT, its main arguments and recommendations may extrapolate to the delivery of any psychotherapy during the pandemic that is aimed at fostering the patient's reflective functioning. Mentalizing, ostension and epistemic trust are fundamental psychological processes and so play a part in all major mental disorders and their clinical management. In providing a model for vulnerability to severe psychopathology including BPD, we wish to establish a link between openness to social learning and the feeling of being acknowledged or recognised as an agentive person. Developmentally speaking, if the caregivers around the infant were not reliably responsive, not benign and/or not able to recognise what is meaningful and relevant to the infant's self, this can undermine the development of epistemic trust. The first, and arguably the most damaging way in which this disruption to social learning can happen is via early adversity, severe neglect or maltreatment, perhaps the most generally agreed transdiagnostic cause of mental disorder (Fonagy et al., 2017). In such circumstances, a child might "switch off" their instinct for social learning, for entirely understandable reasons: a negligent, hostile or abusive caregiver cannot be trusted to be a reliable source of information who is invested in helping the child get the most from their environment. For BPD patients, this translates into epistemic hypervigilance and mistrust of what the other may have to offer creating an apparent rigidity and inaccessibility with implications for change through social learning including in the

context of the therapeutic relationship. When exposed to additional and potentially substantial stressors – such as a pandemic with not only health anxieties but an impact on all aspects of life – these developmental vulnerabilities can become more exacerbated. Therefore, the employment of mentalizing techniques offer an opportunity to manage such challenges as they can improve interpersonal functioning, affect regulation and a sense of selfhood across a range of disorders (Bateman & Fonagy, 2012). We suggest that regardless of whether a formal mentalizing approach is adopted in treatment of COVID-19 related phenomena, there is a need for any therapist to see the world from the patient's perspective, in particular during the pandemic, as its consequences may substantially change the patient's reality.

Finally, it is pivotal to promote a mentalizing culture within teams so as to continue monitoring the treatment adaptations made during the COVID-19 pandemic. This is particularly important given that our ability to mentalize as clinicians will also be increasingly challenged both by the effect of the COVID-19 pandemic on our personal lives, how we work, and how our patients may relate to us in increasingly pre-mentalizing modes.

Notes

1. All vignettes are composites of several clinical manifestations and therefore do not reflect an individual's material to ensure confidentiality.
2. Multidisciplinary professional meeting, that includes the child (where age-appropriate) and their family, with the aim of identifying the child's needs and agree on the most effective multi-agency plan to meet those needs with measurable outcomes and within stated timescales.

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Appendix

Table A1. Pre-mentalizing modes.

In **psychic equivalence mode**, the individual's experience of their thoughts and feelings becomes indistinguishable from their construal of physical reality. Mental states are "too real" to the point at which it is extraordinarily difficult to consider possible alternative perspectives. The psychic equivalence mode has been described as a "concrete" way of thinking, as thoughts are experienced as being true and real. Therefore, there is a tendency to experience absolute certainty, as the individual increasingly believes that their own perspective is the only one possible. This exaggeration of experiencing can be extremely frightening, which adds an intense sense of drama and risk to life experiences.
Example: A patient in this mode will, for instance, experience the therapist's looking out of the window when thinking about what they have just heard as evidence that they're bored by the patient and so that the patient is convinced the therapist wants out of the interaction with him.
In **teleological mode**, the individual only believes and recognises his own and others' states of mind if they are expressed through material changes in the physical world. Thus, the individual only recognises attitudes as being real if they are manifested, through directly observable action. An individual experiencing relationships in the teleological mode may only be able to express distressing and desperate states of mind through performing self-destructive actions and will attempt to generate subjective changes in others through generating behavioural changes in them.
Example: A patient in this mode may demand an action-based demonstration of care by the clinician, e.g. to extend the session time or to hand him a piece of written down information on how to cope until the next session.
In **pretend mode**, the individual experiences his thoughts and feelings as dissociated from reality. Thus, patients in pretend mode are able to discuss their thoughts and feelings but these are "pretend discussions" not contextualized in material reality. Because reality places no constraint on their imagination for thoughts and feelings, individuals in this state often hypermentalize elaborating on mental states far beyond evidence available to them, Hypermentalizing can manifest as a kind of intellectualisation when cognitive understanding shows little or no emotional traction. In psychotherapy, lengthy discussions of their mental states can occur sometimes over prolonged periods marked such discussions failing to be translated into material progress. Hypermentalizing may lead the therapist to believe that the patient has adequate mentalizing abilities, only subsequently to realise the inability to resonate with the emotions underlying their patient's mentalizing efforts.
Example: A patient in this mode may talk about a past experience of abuse, considering all possible explanations and interpretations behind the abuser's intentions while manifesting feelings incongruent with that experience, such as being playful or joyful.

Allen, Fonagy, and Bateman (2008)

Table A2. Ostensive cues, epistemic trust and social learning.

Fonagy and Allison (2014) extended the notion of ostension (Csibra & Gergely, 2011; Sperber et al., 2010) to incorporate all communication where social learning takes place. Ostensive cues for adults involve more than, e.g., the raising of eyebrows in response to what one has heard. We have suggested that feeling recognised appears to generate a particular attentional state in the patient. As a result, natural disbelief is momentarily suspended and the patient feels that the subsequent communication contains information specifically relevant to them. Such information can be about an object of factual knowledge, but also about what someone may have to communicate in terms of how they understand the patient, their psychological functioning, their current life situation and how their feelings may arise. Once trust in knowledge (epistemic trust following Sperber) has been established, we are open to internalize and assimilate new knowledge offered by the trusted social world and in turn to navigate it better – trust catalyzes learning (Sharp et al., 2020).
Putting it at its simplest, if I feel that I am understood, I will be disposed to learn from the person who understood me. This will include learning about myself but also about others and about the entire world I live in.
How is epistemic vigilance lowered and epistemic trust created in adults? How can this be achieved, particularly in patients who have learned that it is more adaptive not to trust others? We have sought to clarify our account of the significance of mentalizing for psychic development and entry into the social world, and to articulate its importance in the therapeutic process more precisely (Fonagy & Allison, 2014; Fonagy et al., 2017; Fonagy, Luyten, & Allison, 2015; Fonagy, Luyten, Allison, & Campbell, 2017). We have argued that mentalizing is important because it confers epistemic trust: the attitude we need in order to benefit fully from opportunities to learn from others. That experience is based on detecting how one is seen – what we could term the epistemic match or shared intentional structures for opening learning systems.
Example: A patient in a state of epistemic mistrust operates in interpersonal hypervigilance: "I hear you but I'm not listening". The benign communication intent from the therapist does not get through, seems irrelevant and as is rejected as "this doesn't help me, you don't get me or, if anything, you're out to get me too".

Table A3. Modifications in technique during telephone or video-chat sessions and their link with the MBT approach.

What the therapist says or does:	What it means in the MBT framework:
"I'm realising that this call might have more complexity than when we meet face to face. I wonder whether that's the same for you. It's a bit more difficult as I can't see you and what your face might be showing, so I think I might say a bit more and ask a bit more as I want to make sure we're on the same page"	Explicit ostensive cueing
"I can see that in addition to what you had been struggling with before, the pandemic has really intensified your fears" Or "It must be extra hard for you at the moment with your mother in hospital and we in the team are aware that you may need extra support."	Validating additional stressors due to the current situation
"I can't tell you yet when we resume groups as I still don't know when that may be … "	Modelling a mentalizing mind- transparency about the therapist's own mental states and ability to tolerate uncertain situations -
"We are talking to the other members in your group as well while the group is suspended and they mainly say they miss the opportunity to talk to the others and to hear about their experiences."	Holding the group in mind
"Let's think about a plan of what we do if we get disconnected again or your screen freezes like last week, … "	Mentalizing the new therapy setting
"I'm aware that this is not how we used to communicate and how much that had frustrated you last week." or "All in the team are aware that it is an extra challenge for you that your therapist is changing jobs/being relocated at this time and you won't be able to say goodbye to one another in person. We too wish this could have been avoided. And we can hopefully think together with you what that's like for you."	Empathic validation
"My sense is that you are more upset even though I can't see you but I thought I heard it in your voice and the way you were talking, is that right?"	Epistemic check-in. Marking affect in the tone of voice (Ostensive cueing)
Seeking discussion with team members/supervisor when working remotely	Ensuring mentalizing with other minds and not only in isolation
"How have you been feeling about doing the sessions via video chat?"	Actively exploring and repeatedly checking in on and discussing experience of phone or video sessions (including what may feel helpful about them).
"I don't know but I am really curious to understand how you've been experiencing the threat of COVID-19 and the lockdown?" Or "It would be good to hear more from you how you think these sessions work best for you – with the video on all the time or only for greeting and saying goodbye."	Maintaining humility with openness to learn from patients and their pandemic context
"So, on one hand you are telling me that you felt angry at your mother because she is not taking care of her health, but on another you also understand why she felt a need to go out and meet a friend. Have I understood you well enough?	Identifying and understanding different perspectives in the patient's experience
"I feel that it has been difficult for me to follow what you've said today with the background noise … I wonder if you have enough space and privacy at home to do telephone sessions at this time of day?"	Actively asking the patient to describe their experience with the added aim to understand what makes no sense and to create epistemic matches ("we"-modes of relating)

(*Continued*)

Table A3. (Continued).

What the therapist says or does:	What it means in the MBT framework:
"I can see that you are anxious that I could get COVID-19 and you might potentially lose this space. On the other hand, that also tells me how much use you have made of these sessions which has been evident in how you've lately been handling the relationship with your partner. Do you feel it's fair to say that?" (said compassionately, modulating the tone of voice)	Fostering epistemic trust by delivering contingent and marked interventions, including explicit and marked use of ostensive communication
"It's a shame that there was a drop in the internet connection, especially when you were telling me how difficult this last week had been. I wonder how this made you feel?"	Monitoring the effect of lack of being in the room/only on the phone/having a disconnected video-chat session
"I couldn't follow you there, and I know the phone does not make things easier … what did you think I wanted to express when I said that?"	Trying to understand misunderstandings
Not returning a video call after the line is disconnected can lead the patient to heightened arousal and to resort to pre-mentalizing modes.	Being aware that non-mentalizing generates non-mentalizing (in dyad, within team, in liaison with other services)