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Debate: Mentalising remotely – The AFNCCF's adaptations to the coronavirus crisis

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In moving over to remote working (RW), the Anna Freud National Centre for Children and Families (AFNCCF) has, as have all institutions and mental health professionals, needed to think carefully and innovatively about how to continue to provide high-quality evidence-based care. Our immediate response has been surprise at how effectively the transition has been made. So far, we have found that both ongoing support and some aspects of therapy can be transferred to a remote platform with a surprising number of quite complex families – but with certain challenges.

So what have we learned? Our approach has been shaped by the principle that it is essential not to lose sight of the importance of individual relationships. The imperative has been to ensure that the experience of the child or young person (YP) and parent/carer receiving help should not become too remote from our thinking. And we have learnt there can be positives: some therapists have observed that RW generates a less pronounced power differential as the family no longer has to come to the therapist's office. Some of our YPs, as digital natives, have reported a preference for RW and having their sessions at home in a familiar environment.

We have found that difficulties fall into three main areas. The first is the issue of assessing risk and vulnerability. We have made progress but more is needed for methods of risk assessment to be robust for vulnerable children in remote therapy. Some children have told us they worry they do not have privacy to speak freely, and they may be anxious about sharing information via a screen. The risk is that RW exaggerates inequality of access; some children will find themselves on the wrong side of the digital divide without the support and advocacy that is essential to benefit from even a blended form of remote help. In our rush to 'virtual first', we must not compound inequity and social isolation.

The second challenge is that we have limited skills for establishing a therapeutic alliance and comprehensive engagement with the client using the virtual first approach from the start of therapy. We are developing methods involving play and screen sharing in order to mimic, for us, the all-important 'we-mode' of shared and joint attention that makes therapeutic change possible (Tomasello, 2016; Tuomela, 2007).

The third issue relates to creating the smoothness of interaction which supports the complex psychological processes that underpin change. In our view, epistemic trust motivates change – the child, YP or parent must trust the therapist and judge them to be a reliable and truthful source of information (Fonagy, Luyten, & Allison, 2015). To establish trust, we normally make extensive use of signals (known as ostensive cues), such as carefully titrated contingent responding in the expression of empathy. We show our client that we can see the world from their standpoint with sufficient clarity for them to be able to match their self-perception to what they perceive we have displayed of our understanding of their personal narrative. Developing a trusting relationship with a client can certainly be achieved remotely but requires the therapist to think clearly about how the client is experiencing their communication and to express clearly their interest and engagement in the client's experience.

In working to meet some of the challenges associated with RW, the AFNCCF has developed a risk assessment protocol based on one we have evolved in our face-to-face services, including putting in place emergency planning, and, where appropriate, requiring caregiver presence in the home during and after a session. Consent and confidentiality are managed according to NHSX protocol (Psychological Professions Network England, 2020). The primary consideration is providing access and advocacy for children, so that the difficulties associated with the rush to virtual first are not dumped into the laps of vulnerable children. In the longer term, we anticipate that practical ways to mitigate the risks associated with going digital may involve a blended form of human support and context. For example, one adaptation may be to collaborate with schools to create spaces in which RW can be undertaken, thus providing the required access to technology and a supportive, private environment, with follow-up in the form of on-site pastoral assistance. Joint working is key.

To support mental health professionals to develop good therapeutic relationships with clients, we have articulated particular adaptations for RW. In face-to-face work, the therapist responds to both explicit and implicit communications by the child (and parent) and makes sense of (i.e. mentalises) these by creating mental models of the intentional state of the client in a remarkably fluid way. Curiosity is an essential component of this process – we have termed this the not-knowing or inquisitive stance (Bateman & Fonagy, 2016). In RW, the adoption of the mentalising stance of not knowing is even more critical as the therapist has less access to more implicit forms of communication. The reliance on explicit communication may be beneficial if it highlights the therapist's genuine concern with the child's personal narrative (understanding of the state of affairs from their

standpoint). However, therapists report that this style of working is exhausting, underscoring the need for special training and the desirability of an ongoing quality improvement process – for example, adjusting the length of sentences to avoid instances when disruption can be caused by both a YP and therapist speaking at the same time.

Within our conceptual model, the primary aim of therapy, regardless of setting, is to enhance the client's capacity for mentalising, to consider thoughts and feelings in others and themselves in a flexible but realistic way that is protected by the structure of the process from being overwhelmed by anxiety. We are surprised and reassured that mentalising, this most human of all psychological processes, appears to survive in the digital medium.

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Ethical approval

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References

Bateman, A., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide* (2nd edn). Oxford, UK: Oxford University Press.

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

Psychological Professions Network England (2020). Remote Delivery of Services: Guidance for the Psychological Professions in England during the COVID-19 Pandemic. https://www.ppn.nhs.uk/resources/ppn-publications/31-guidance-for-psychological-professionals-during-covid-19/file

Tomasello, M. (2016). *A natural history of human morality*. Cambridge, MA: Harvard Univ Press.

Tuomela, R. (2007). *The philosophy of sociality: The shared point of view*. Oxford, UK: Oxford University Press.

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