

The Use of Synchronous Videoconference in Bipolar Patients: A Novel Study on Therapist Mentalization Capacity, Therapeutic Process, and Efficacy within Videoconferencing Psychotherapy (VCP) Intervention Context

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ABSTRACT

Background: A considerable literature has developed around demonstrating the clinical relevance of mentalizing as a construct. However, much of the emphasis has been on patients' deficits rather than therapist's abilities. Although it may be the case that therapist's mentalization capacity can facilitate better outcomes in psychotherapy, there is a dearth of empirical evidence concerning the impact mentalization has on therapist competencies in psychotherapy and the implications of this in clinical practice dyads.

Methods/Design: A pilot study will use an integrated design. A longitudinal case series alongside a qualitative grounded theory approach will be utilized to develop a context-specific, grounded micro theory model of therapeutic alliance rupture and resolution during online psychotherapy with patients with bipolar disorder. 10 dyads of therapists and patients will be assessed by pre-and post-session outcome ratings, as well as baseline and post-therapy performance ratings during the four-month intervention period. In addition, semi-structured grounded theory interviews will be conducted with participants to gain a deeper understanding of their experiences during the therapeutic process.

Discussion: New research findings on videoconferencing-enabled clinical interventions have been needed since the COVID-19 pandemic began. According to an assessment of the available evidence, little is known about psychotherapy, and significant gaps remain. This paper describes a protocol of a pilot aimed to capture the explicit and implicit knowledge that emerge from therapists and patients during the therapeutic process in order to investigate the complex process of therapeutic interaction beyond "outcome effects".

Keywords: severe mental illness, bipolar disorder, mentalization, therapeutic alliance, rupture, videoconferencing psychotherapy

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1. Background

In mental health, the COVID-19 outbreak has forced many healthcare professionals and their patients to shift to remote therapy and changed the way psychotherapy was delivered (Sammons et al., 2020). COVID19 posed some unusual circumstances that caused many therapists to feel overwhelmed by the demands placed upon them (Wind et al., 2020). As a result, the ability of therapists to adapt their own reflective functioning to the reflective complexity of a patient was essential to enhancing a sense of security in patients (Fisher et al., 2020).

Health care has been challenged globally in the wake of the COVID-19 pandemic, and individuals with bipolar disorder are likely to be disproportionately impacted. Bipolar disorder is a chronic and debilitating condition that causes considerable financial hardship and premature mortality (Angst et al., 2019; Bauer & Pfennig, 2005; Murray & Lopez, 1996). Due to an alternating pattern of mania and depression, treatment is difficult, requiring both pharmacological and psychological approaches (Colom, 2014). Bipolar disorder patients are usually aware of their suffering. The first manic prodrome is characterized by an increase in energy and social purpose along with decreased sleep needs (Goossens et al., 2010). Eventually, the patient starts to deny his illness as the episodes escalate and eventually fails to recognize his manic symptoms (Mantere et al., 2008). Once the mania begins, the person is not aware of the potential for the pain they create around them. The episodic nature of this disease may interfere with the appropriate dynamics between the patient and therapist, thus complicating the therapeutic process, prognosis, and outcome.

Although the effects of COVID-19 pandemic on individuals with bipolar disorder are not clear, lockdowns, social isolation, and reduced access to preventive and maintenance care may have contributed to irregular social rhythms, risk-taking behaviours, and substantial medical complications (Xue et al., 2020). Under these circumstances, individuals with pre-existing psychiatric conditions may require additional support (Inchausti et al., 2020).

During the transition from face-to-face psychotherapy to videoconferencing psychotherapy (VCP), these highly complex patients may experience a risk of mistrusting social information communicated by others and may distrust their therapists as well (Lopes et al., 2020). Despite several studies using VCP have shown promising results, including those with depression (Backhaus et al., 2012; Chavooshi et al., 2016), anxiety and stress-related disorders (Backhaus et al., 2012; Chavooshi et al., 2016), videoconferencing differs from face-to-face psychotherapy in that technical problems may arise during the videoconference and disrupt the therapeutic alliance.

In this context, therapists' mentalization ability has potential for aiding the success and uptake of VCP adoption. Across therapeutic approaches, it has been crucial to develop a higher self-reflective capacity to facilitate the implementation of VCP. The ability to understand one's own and others' behaviour as an expression of mental states (Fonagy & Allison, 2013) is essential to establishing the therapeutic alliance and responding to the context. Since encounters with bipolar disorder patients differ significantly from other therapeutic relationships, it is critical to examine the process between patient and therapist. In the light of the above, psychotherapy research should investigate quantitative parameters. Still, it is equally important to explore the experiences of patients and therapists at specific stages of the therapeutic process. This study is designed to provide additional information regarding mentalization in light of new data on how this construct works in psychotherapy. Additionally, this pilot attempts to capture the explicit and implicit knowledge that emerge from therapists and patients during the therapeutic process in order to investigate the complex process of therapeutic interaction beyond "outcome effects". In this sense and concerning the previously discussed effects of COVID-19 on mental health professionals, the present study aims to investigate the relationship between the therapist mentalization capacity and their impact on

the therapeutic alliance and therapy outcome with bipolar patients in the context of videoconferencing psychotherapy.

2. Methods/Design

2.1 Aims and hypothesis

The purpose of the present study is to investigate the relationship between therapist mentalization capacity and how this influence the therapeutic alliance and therapy outcome for bipolar patients who are receiving psychotherapy via videoconferencing.

2.1.1 Primary research questions:

- a) Is therapist mentalization capacity predictive of a better therapeutic alliance?
- b) Does the therapist's mentalization capacity predict better therapeutic outcomes?

2.1.2 Secondary research questions:

- a) Are therapists with greater mentalization capacities more effective?
- b) Does secure attachment lead to greater effectiveness of the therapist?
- c) Does MCT+ increase the quality of life and improve the metacognitive ability in patients with bipolar disorder?

2.2 Study design

A longitudinal case-series design is used to address the research question and examine possible relationships. This study design was chosen since it allows for the description and exploration of the variables under investigation in the intervention and the evaluation of how it is implemented and received. Furthermore, a case series analysis can help identify the factors that impact individual experiences.

2.3 Setting

The project is a collaboration between Hospital del Salvador dependant on the Valparaíso-San Antonio Health Service and the University of Valparaíso in Chile. Two sets of participants will be included in this study. Participants are outpatients from the Hospital del Salvador. The therapists' group will be therapists from the University of Valparaiso, and the Pontifical Catholic University of Valparaíso qualified to deliver synchronous online treatment for severe and enduring mental health patients.

2.4 Participants

Inclusion criteria for patients are as follows: (1) Speak Spanish (2) competent and willing to provide written, informed consent. (3) Are aged 18-65 years inclusive (4) Diagnosis of Bipolar Disorder Type I. Patients will be excluded based on the following criteria: (1) severe learning disability or pervasive developmental disorder (2) current involvement in other ongoing psychological treatment. Inclusion criteria for therapists are as follows: (1) Therapists trained to assess and deliver synchronous online treatment for severe and enduring mental health patients.

2.4.1 Sample size

This study evaluates pre-and post-session outcomes, as well as baseline and post-treatment ratings of performance on 10 dyads of therapist and patient (n=20). An acceptable number of participants for a small-N case series is not fixed. Researchers may conduct research based on how they believe the demand will be met. Some authors have suggested a range of participants between 5 and 25 (Creswell, 2007) others have suggested a range of 4 to 6 (Abu-Zidan et al., 2012). Even so, all formal calculations must be based on the resources available at the time of data collection.

2.5 Procedure

2.5.1 Patient recruitment

The main inclusion criteria will be the diagnosis of bipolar disorder type I current euthymia. In this study, euthymia will be defined as a score ≤ 12 on the Young Mania Rating Scale (Colom et al., 2002) assessed at the baseline. Additionally, patients will keep their pharmacological treatment. During the recruitment/consenting process, the researcher will ensure that the patient is fully informed about the therapy process and their chances of receiving online Metacognitive Training (MCT+) (Vitzthum et al., 2014).

The clinician will be asked to inform the patient about the study, provide them with participant information, and ask them if they would like to participate. Once patients agree to be contacted, the researcher will describe the study in more depth and explain that they will be recorded both visually and audibly during sessions and have to complete at least one video-recorded interview in which their experience in therapy will be discussed. An explanation of the consent form will be provided to the patient at the same meeting, and any questions or concerns raised by the patient will be addressed.

In order to be eligible for participation in the study, the researcher will ensure that the patient meets the inclusion criteria requirements and will ask the patient if they feel safe enough participating. Patients will be informed that they do not have to decide immediately. Those patients who choose not to participate or be interviewed will be informed that the collected data will be discarded and not used for research purposes. Patients will be notified that their decision to participate or not participate in the study would have no effect on their current medical treatment at the hospital and that they have the right to withdraw from the study at any time. If the patient confirms an interest, the researcher will inform the therapist and will allow the therapist to voice any concerns about the patient's eligibility to participate.

Once informed and consent is sent online, baseline measures will be completed. All the assessments will be completed online, and patients should complete them within the next 24 hours. The MASC-SP (Dziobek et al., 2006) will be completed within a single 40-minute session online. Process measures will be completed online during the therapy before each session (CORE-10) and post-session (WAI-P) for the patients. Post-treatment measures will be carried out at the end of the process.

2.5.2 Therapist recruitment

The criteria for participation will be that therapists i) provide online synchronous telepsychology therapy, ii) have a recognised qualification in psychological treatment (e.g., PGCert), and iii) have at least one year of experience providing synchronous online treatment for severe and enduring mental health patients (e.g., internships in severe and enduring mental health patients).

The therapists have all received professional training in psychology, which entails a five-year full-time psychology program, which typically includes one or two years of clinical training. The curriculum is predominantly coursework in Chile, with internships typically

occurring during the final semester of training. Chile has four predominant theoretical orientations: cognitive, psychodynamic, systemic, and humanistic. In most psychology degree programs, including those represented in the present sample, students are trained in several theories and integrative approaches. All the therapists in the current sample have received formal training in psychotherapy after receiving their professional psychology degrees.

Potential participants will receive the therapist information sheet with relevant information about the study, inclusion and exclusion criteria, and details of what participation would involve. They have also been asked to complete a questionnaire to collect demographic information and ascertain their suitability. As well as therapists willing to participate will sign the Therapist Consent Form. Once informed and consent is sent online, baseline measures will be completed. All the assessments will be completed online, and therapists should complete them within the next 24 hours. The MASC-SP (Dziobek et al., 2006) will be completed within a single 40-minute session online. Process measures will be completed online post-session for the therapists (WAI-T) (Horvath & Greenberg, 1989). At the end of the therapy process, will be carried out the post measures. A 2-day training course in MCT+ will be provided by the researcher. It is expected that although the therapists have experience treating patients with severe mental illness, the training will provide additional information regarding diagnosis and psychological management of bipolar disorders.

2.6 Intervention

The individualized Metacognitive Training Program for psychosis (MCT+) will be implemented in Spanish. In MCT+, the process-oriented approach of metacognitive group training is combined with elements from individual cognitive-behavioural therapy (Vitzthum et al., 2014). The individual psychotherapy will comprise a weekly 1-h videoconference session via Zoom Enterprise. MCT+ helps patients deal with low self-esteem, depression, and stigma. The treatment will be tailored for 12 sessions (Table 1); thus, it will be possible to observe variations and changes during the treatment.

Professor Steffen Moritz, the author of MCT+ for psychosis, has approved its modification for Chilean patients. Due to the fact that the sample will include bipolar patients, we have modified terminology from previous MCT iterations that is written for a diagnosis of non-affective psychosis or schizophrenia. The revised material incorporates language specifically adapted to aspects of mood-dysregulation, mania, and depression in the context of bipolar disorder. However, the underlying structure of the treatment has not changed.

Group-specific adaptations in our MCT+ intervention will include several components: (1) modify some Hispanic-Spanish idioms to Chilean-Spanish tradition, (2) describing psychological problems in terms of idioms of aspects of mood-dysregulation, mania, and depression (e.g., using symptoms of mania instead of symptoms of psychosis), (3) discuss psychopathological characteristics of bipolar disorders by using context-specific cases and problems recognizable for the target group concerned, and (4) including recognizable examples of persons with bipolar disorders. The therapist determines how to use the modules. As such, evaluating the therapy itself will not be the focus of our research, but we will rigorously analyse each aspect of MCT+.

Table 1. Breakdown of participant progress through MCT+.

Session 1	Initial Approach Case Story
Session 2	Psychoeducation Psychoeducation and discussion on what bipolar disorder is.
Session 3	Introduction to Metacognitive Therapy Training for Psychosis (MCT+) ¿What is metacognition? Therapy Units of the MCT+ Contents that are relevant can be picked from the different therapy units. Problems and Goals
Session 4	Case Formulation Individual Case formulation Development of particular ideas
Session 5	Attributional Style Exercises and discussion on how a one-sided explanation style might get worse symptoms. Also, strategies for challenging attribution style e.g., consider that multiple factors might contribute to the outcome of a specific event.
Session 6	Decision Making Discussion and exercises on Jumping to Conclusions (JTC) and how this might lead to symptoms (for example, disengagement due to mind-reading and fortune-telling). Moreover, strategies for challenging the JTC should be developed (e.g., consider alternative interpretations and seek advice from others).
Session 7	Changing Beliefs Changing one's own point of view
Session 8	Empathizing Change of perspective Implicit social laws Application to everyday life
Session 9	Memory and Overconfidence What causes false memories? Types of memory errors
Session 10	Depression and thinking What are signs of depression? Discuss ways in which depression might worsen symptoms by reducing motivation and drive to engage with the world and social isolation due to the fear of rejection. This module involves exercises to overcome certain cognitive traps such as overgeneralization, selective perception, and catastrophic thinking, as well as strategies such as cognitive restructuring and writing down strengths, compliments, and positive experiences from the day in a "joy diary."
Session 11	Self-Esteem Self-esteem: What is it? Exercises and discussions on what self-esteem is, how it is affected by low self-esteem and rumination, and how low self-esteem might lead to a lower quality of life (e.g., refusing to participate in activities or not engaging in social interactions). In addition, strategies for overcoming low self-esteem and rumination (e.g., by becoming aware of social comparisons).
Session 12	Relapse Prevention A combination of psychoeducation, exercises, and discussion concerning the ways stigma contributes to and maintains depressive symptoms (e.g., internalisation of the incorrect view of the diagnosis portrayed in media) as well as strategies for educating others about mental illness.

3. Data Collection

3.1 Process measures

The following measurements will be taken in order to gain a better understanding of the therapy process (Tables 1 and 2):

Clinical Outcomes in Routine Evaluation (CORE -10) (Barkham et al., 2013). As a short version of the CORE-OM, the CORE-10 is intended to be used as an outcome measure in situations where the CORE-OM is considered too lengthy. A reliability and validity evaluation of the Spanish translation of the CORE-10 has not yet been conducted. However, the Spanish translation of the CORE-OM has been tested for reliability and validity (Trujillo et al., 2016). It has shown excellent psychometric properties, which supports the use of the CORE-10 to monitor the progress of Spanish-speaking psychiatric patients.

Working Alliance Inventory (WAI-P and T short forms) (Horvath & Greenberg, 1989). The working alliance inventory short form is a brief and easily understood alliance measure. It consists of 12 items structured into three subscales with 4 items each and the users must respond to a 7-point scale. It has demonstrated solid psychometric properties. (Andrade-González & Fernández-Liria, 2015).

3.2 Outcome measures

Baseline data are collected before providing therapy. After treatment ends, data is collected to determine whether the patient has changed.

Reflective Functioning Questionnaire (RFQ-54) (Fonagy et al., 2016). The reflective functioning questionnaire is a measure that attempts to evaluate mentalization individually. It was developed as an easy-to-administer. The measure has been found to have both good internal consistency and re-test reliability (Fonagy et al., 2016).

Movie for the Assessment of Social Cognition instrument (MASC-SP) (Dziobek et al., 2006). The MASC is a useful measure designed for assessing social cognition individually. According to the researchers (Luyten et al., 2012) MASC represents a good scale for testing automatic process in mentalizing (Table 3). It has been operationalized as a 15-minute movie cut into 43 segments where the users must try to understand what the actors feel or think. It has been presented as a valid instrument for assessing social cognition in the Spanish population (Lahera et al., 2014).

Experiences in Close Relationships (ECR-12) (Wei et al., 2007). This self-report questionnaire assesses two dimensions of romantic attachment: avoidance (of intimacy) and anxiety (about relationships). The Chilean version of ECR (Spencer et al., 2013) showed adequate reliability, criterion validity, and a bifactorial structure similar to the original instrument (Brennan et al., 1998).

World Health Organization Quality of Life Questionnaire (WHOQOL-BREF) (Harper et al., 1998). It is a short subjective measure of global well-being that has been used in previous studies of bipolar disorder (Demant et al., 2015; Smith et al., 2011). WHOQOL-BREF is a condensed version of the WHOQOL-100 developed by the World Health Organization (WHO) and published in 1995. WHOQOL-BREF is a self-rating that includes multiple statements regarding the quality of life, health, and well-being of patients with and without disease.

Metacognitive Questionnaire—Short Form (MCQ-30) (Wells & Cartwright-Hatton, 2004). The Meta-cognitions Questionnaire 30 is a valid instrument for measuring metacognitive beliefs in the Spanish-speaking population (Ramos-Cejudo et al., 2013). The subscales of the questionnaire have shown internal consistency and adequate test-retest reliability. Also, it has expected relationships to theoretically related variables such as pathological worry, meta-worry, thought suppression and trait anxiety were obtained.

Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001). Originally derived from the Primary Care Evaluation of Mental Disorders (PRIME-MD), the patient health questionnaire is one of the most widely used instruments for screening for depression in primary care. A score of 0 to 3 is assigned to each PHQ-9 item, resulting in a severity range of 0 to 27. An overall score of 10 indicates major depression, while scores of 5, 10, 15, and 20 indicate mild, moderate, moderately severe, and severe depression.

General Anxiety Disorder-7 (GAD-7) Scale (Spitzer et al., 2006). GAD-7 is a one-dimensional questionnaire designed to assess the presence of Generalized Anxiety Disorder (GAD) symptoms as outlined in DSM-IV. Initially, a more comprehensive list of symptoms was used to develop the contents of the questionnaire. Since the Spanish version has inherited these contents, the content validity has been justified by the original version.

3.3 Qualitative Interviews

The researcher will conduct the interviews. In order to initiate exploration of the subject area, a semi-structured interview schedule with open-ended questions has been created. A pilot involving other clinical psychologists was conducted in order to refine the interview schedule. As the theory develops, the questions will be tailored to explore it in greater depth. This type of in-depth interview offers flexibility and control (Charmaz, 2014). Recordings of the interviews will be made using the Zoom Enterprise platform. The interview schedule will serve only as a guide, with points relevant to the research being discussed as they arise. Video recordings of the interviews will be transcribed verbatim. Interviews will be transcribed by the researcher who has been trained in transcription guidelines (Mergenthaler & Stinson, 1992). In addition to training in grounded theory interviewing, the interviewer has also undergone ethics training regarding interviewing. Further, as this study's purpose is to collect descriptions of ruptures and strains which occur during the process, the interviewer has been instructed to focus the discussion on "describing" the rupture rather than discussing the material which may have led to it.

Table 2. Measures for assessing therapists.

Scales	Construct	Baseline	Progress*	Outcome
Working Alliance Inventory (WAI-T) (Horvath & Greenberg, 1989)	Therapeutic Alliance		x	
The Reflective Functioning Questionnaire (RFQ-54) (Fonagy et al., 2016)	Reflective Function	x		
Experiences in Close Relationships (ECR-12) (Brennan et al., 1998)	Attachment Style	x		
Movie for the Assessment of Social Cognition (MASC-SP) (Dziobek et al., 2006).	Reflective Function	x		
Semi-Structured Interviews	Ruptures		x	x

* Session-by-session monitoring, review, or quick initial assessment (following each session, therapists will complete WAI-Therapist version). Research measurements and interviews will be conducted online by the researcher via Zoom.

Table 3. Measures for assessing patients.

Scales	Construct	Baseline	Progress*	Outcome
Working Alliance Inventory (WAI-P) (Horvath & Greenberg, 1989)	Therapeutic Alliance		x	
The Reflective Functioning Questionnaire (RFQ-54) (Fonagy et al., 2016)	Reflective Function	x		
Experiences in Close Relationships (ECR-12) (Brennan et al., 1998)	Attachment Style	x		
Movie for the Assessment of Social Cognition (MASC-SP) (Dziobek et al., 2006).	Reflective Function	x		
World Health Organization Quality of Life (WHOQOL) (Harper et al., 1998)	Quality of Life	x		x
Clinical Outcomes in Routine Evaluation (CORE - 10) (Barkham et al., 2013)	Patient progress		x	
Metacognitive Questionnaire—Short Form (MCQ-30) (Wells & Cartwright-Hatton, 2004)	Metacognition	x		x
Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001)	Depression	x		x
General Anxiety Disorder-7 (GAD-7) (Spitzer et al., 2006)	Anxiety	x		x
Semi-Structured Interviews	Ruptures		x	x

*Session-by-session monitoring, review, or quick initial assessment (CORE-10 will be administered prior to each session. WAI-Patient version will be completed following every session). Research measurements and interviews will be conducted online by the researcher via Zoom.

Table 4. Illustrative mentalization dimensions assessed by the mentalization measures proposed.

MEASURES	Self	Other	Cognitive	Affective	Internal	External	Automatic	Controlled
RFQ-54	x	x	x	x	x			x
MASC-SP		x	x	x	x	x	x	x

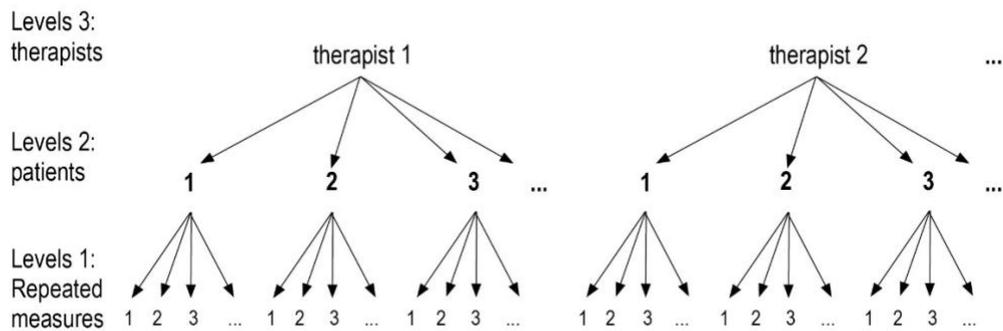
3.3 Data analysis

The data analysis will involve statistical modelling of the therapeutic process. The qualitative part will capture the explicit and implicit knowledge that emerge from therapists and patients during the therapeutic process. Both dimensions generated by each method will be integrated into an overall analysis based on a mixed-method methodology.

3.3.1 Quantitative data analysis

The use of Hierarchical Linear Modelling (HLM) that input predictor variables will allow the exploration of trends and effects across participants. HLM will be used to identify critical predictors of individual outcomes. HLM allows model changes to take place even when some participants have missing data, rather than relying on listwise deletions or imputations, assuming that the data are missing randomly. Because HLM primarily measures the rate and shape of change over time, data calculations can be computed separately for each participant. The change curve doesn't necessarily have to be the same for all participants where patients and therapists may differ quite a bit in the number and frequency of sessions. The formulation of HLM requires following certain assumptions. The fixed effects are the model's structural parameters, including the intercept (e.g., a group mean of the dependent variable therapist mentalization capacity at the first data point) and slope coefficients (e.g., the relationship between the independent variable time-session and the dependent variable therapist mentalization capacity). In this case, fixed effects imply a single constant value for all of the sample units. Random effects are covariance components. Covariance components represent the variances and covariances of the model parameters. On the outcome variable, intercept (i.e., initial status) and slope (i.e., growth rate) can vary across units of the sample. Additionally, HLMs are referred to as multi-level models because they are able to disaggregate sources of variation according to the identified hierarchical levels. This model estimates the proportion of variance of a dependent variable (for example, the level of therapist mentalization capacity) explained by each model level (for example, changes within patients, differences between patients, and differences between therapists).

Figure 1. The nested structure of the data.



A series of three-level MLMs is built to examine patients-variations over time, therapeutic alliance, and distress in the moment (ruptures, challenges, and disengagements) over the course of treatment. Level 1 consists of patients' scores on each symptom measure completed repeatedly administered throughout the process. Level 2 consists of patients nested within therapists, and level 3 consists of therapists.

3.3.2 Qualitative data analysis

Data management and analysis will be performed using the latest version of NVivo. A grounded theory approach will be used in this study in order to develop a theoretical framework. There are several distinctive characteristics of grounded theory (Charmaz, 2015) including the integrated nature of data collection and analysis, the coding and analysis based on the data, the development of theories to explain results, memo-making, theoretical sampling of participants, as well as the delay of the literature review.

3.4 Ethics approvals

This study will be carried out in strict accordance with international research ethics agreements in addition to Chilean legislation on respect for confidentiality. All procedures performed in the patient study will follow the ethical standards of the Declaration of Helsinki of 1964 and its subsequent amendments or comparable ethical standards. The identity of patients and therapists will only be known by the investigator conducting the study, and the recordings of the interviews and sessions produced will only be reviewed by himself and possibly by supervisors/examiners. Every effort will be made to guarantee confidentiality and safeguard anonymity. The recordings of the interviews and sessions produced will be encrypted and stored in the Data Storage of the University of Edinburgh following the provisions of General Data Protection Regulation ("the GDPR") and the UK Data Protection Act 2018 ("the DPA") that safeguards the proper handling of personal data. The study was approved by the School of Health in Social Science at the University of Edinburgh and the Chilean Ethical Committee, depending on the Valparaíso-San Antonio Health Service in Chile.

4. Discussion

The psychotherapy process has received relatively little research in comparison with other theoretical orientations and therapeutic techniques. This study is designed to provide therapists with additional information regarding mentalization in light of new data pertaining to how this construct works in psychotherapy. Given that this research focuses on therapist variables in relation to treatment outcomes, its training implications will be substantial.

5. Strengths and Limitations

An integral methodological approach is the strength of this project. Utilizing a qualitative methodology to recognize, define, and describe important therapeutic rupture events in conjunction with a continuous comparative methodology in order to build contextually rich and sophisticated theoretical models directly validated by empirical data allows a more comprehensive examination of highly complex therapeutic events across treatment contexts. Also, the addition of quantitative analytical components to a primarily qualitative, discovery-oriented methodology enhances the credibility and security of a resulting theoretical model. It is acknowledged, however, that the use of a small sample limits the generalizability of the findings. Moreover, discovery-oriented methods, particularly those concentrating on small samples and relying primarily on qualitative methods, require that the researcher becomes “immersed” in the data in question. Thus, researchers become an “instrument” of analysis and are expected to observe data sympathetically. Therefore, it has become widely recognized that their theoretical biases and personal experiences of the phenomenon under consideration must also be considered.

6. Conclusions

Although it is intuitive to conclude that the therapist mentalization may produce better outcomes accordingly on psychotherapy, findings from this project could provide helpful information for improving our understanding of therapy and therapists. Studies regarding mentalization have suggested that it plays an essential role in protecting people from the effects of attachment trauma and helping them to overcome childhood difficulties (Slade et al., 2005). Based upon this assumption, it is likely that persons who have developed a better mentalization capacity can be among those persons who make good therapists.

List of Abbreviations

COVID-19	Coronavirus Disease 2019
VCP	Videoconferencing Psychotherapy
GTM	Grounded Theory Method
YMRS	Young Mania Rating Scale
MCT+	Metacognitive Training
MASC-SP	Movie for the Assessment of Social Cognition- Spanish
ECR	Experiences in Close Relationships
CORE-10	Clinical Outcomes in Routine Evaluation (CORE - 10)
WAI (P and T)	Working Alliance Inventory – Patients and Therapists Forms
RFQ-54	Reflective Functioning Questionnaire – 54
WHOQOL-BREF	World Health Organization Quality of Life Questionnaire
MCQ-30	Metacognitive Questionnaire-30
PHQ-9	Patient Health Questionnaire – 9
GAD-7	General Anxiety Disorder – 7
NVivo	Qualitative Data Analysis Software
HLM	Hierarchical Linear Modelling

Declarations

Availability of data and material: The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests: The authors declare that they have no competing interests.

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