I See You as Recognizing Me; Therefore, I Trust You:

Operationalizing Epistemic Trust in Psychotherapy

Abstract

Epistemic trust (ET) is one's ability to trust others and rely on the information they convey as being relevant and generalizable. This concept has received considerable theoretical and clinical attention, suggesting it is a promising factor in effective psychotherapy, possibly consisting of three elements: Sharing, We-mode, and Learning. However, for it to be used in clinical practice and research, it is imperative to (a) enhance our clinical understanding of how ET may manifest in the context of treatment and (b) understand how the process of change may occur in the course of treatment. The current study aims to identify patients' trait-like ET characteristics upon initiating treatment and explore the possible state-like changes in ET characteristics throughout treatment. Taking a discovery-oriented approach, we examined how therapists can identify a patient's level of ET at the beginning of treatment. We also examined how, within a treatment for individuals with poor pre-treatment ET, the therapist and patient work interactively to bring about a positive change in ET. Identifying the process in which the therapist implements techniques in response to the patient's reactions may enable the active mechanism to be isolated and promote the first formulation of the way changes in ET occur in sequence.

As social beings, we lean towards deriving benefits from positive social interactions (Fonagy & Campbell, 2017). In moments of uncertainty or distress, we often seek out others to make sense of our experiences in the constantly changing social environment (Bowlby, 1988). However, to maintain social communications as beneficial, we must continually determine who we can safely turn to and who might potentially mislead us. The ability to accurately identify specific others as trustworthy and, therefore, to rely on the information they convey as personally relevant and generalizable is termed Epistemic Trust (ET; Fonagy & Allison, 2014).

Theoretically, ET is postulated to emerge within attachment relationships during early childhood (Fonagy & Allison., 2014). When parents provide consistent support, infants are likely to perceive them as dependable and, as a result, trust their communication (Sroufe, 2016). Thus, secure attachment relationships form a crucial foundation for discriminating trustworthy from misleading information later in life (Fonagy et al., 2019). However, if parental support is inconsistent or absent, infants are less likely to comply with or trust caregivers' guidance (Sroufe, 2016). Thus, insecure attachment impedes the later ability to distinguish between trustworthy and potentially deceptive social information due to excessive wariness toward learning from others (Campbell et al., 2021).

Depending on their distinct developmental trajectories of attachment, individuals may react differently to environmental changes when assimilating new information from others (Cassidy, 2016). A growing body of evidence in developmental psychology supports the association between attachment style and establishing ET (Fonagy et al., 2019; Egyed et al., 2013; Corriveau et al., 2009).

ET in Psychotherapy

Much has been posited theoretically about ET's potential implications for psychotherapy (Fonagy et al., 2017a, 2019), yet, despite its clear clinical appeal, its definition within psychotherapy remains to be refined. Therefore, the overarching goal of the present study is to provide a clinical illustration of the conceptual model of ET in psychotherapy and explore how it changes throughout the course of treatment.

ET is a broad concept originating from philosophy of mind (Gallagher & Zahavi, 2008) and developmental psychology (Cassidy, 2016). The extensive body of work in attachment theory and the concept of sensitivity (awareness of another person's mental state) (Cassidy, 2016), along with work on mentalizing (Bateman & Fonagy, 2019), collectively inspired the consolidation of its definition within psychotherapy. Generally, ET in psychotherapy is defined as the patient's willingness to consider the information from the therapist, therapeutic relationship, or therapeutic context as personally pertinent and generalizable. However, compared with the fields of attachment and mentalization, about which a wealth of knowledge exists (Fonagy et al., 2016),

ET is relatively new to psychotherapy. Thus, empirical knowledge about how individual differences in ET manifest in psychotherapy is limited. Outside of psychotherapy, recent works have sought to develop empirical paradigms to measure ET during infancy and childhood (e.g., Tong et al., 2020). Still, only a few studies have assessed ET in adults, most of which are experimental in nature and thus of limited applicability within psychotherapy sessions (e.g., Shafto et al., 2012; Schroder-Pfeifer et al., 2018).

A Proposed Triadic Model for Epistemic Trust in Psychotherapy

Integrating essential aspects from attachment theory, mentalization, and philosophy of mind, we propose operationalizing ET in psychotherapy as comprising three verifiable elements: sharing, 'we-mode' (Fonagy et al., 2021), and learning. This structure also incorporates ET's trait-like and state-like components (Fisher et al., 2020, 2022).

Sharing

Drawing from attachment theory, the element of sharing pertains to the tendency to either engage with or withdraw from others during times of need. Thus, it involves one person communicating personal experiences, perceptions, understandings, and feelings about specific situations or objects to another person to process and make sense of them (Greene et al., 2006). Sharing enables interactants to clarify vague emotions, create a cognitive order in their experiences, broaden their perspectives, and even normalize or validate feelings and thoughts regarding the social world. Through sharing, partners can foster a sense of companionship, allyship, or mutuality, alleviating the sense of isolation. Psychotherapy, of any therapeutic modality, is fundamentally built upon this process of hopeful dialogue with another individual, who is assumed to empathize with the now shared experiences and the reactions they have elicited (Luyten et al., 2020). In psychodynamic therapies, patients share desires, fantasies, or needs that may be rooted in earlier relationships but provide the template for present relationships (Messer & McWilliams, 2007).

We-mode

Drawing from mentalization theory, the element of "we-mode" refers to a state where two individuals achieve mutual understanding of each other's perspectives, emotions, thoughts, and behaviors. It involves both parties engaging in joint attention, maintaining their distinct

minds while acknowledging their commonalities (Fonagy et al., 2021). Thus, we-mode moments entail seeing the other as a separate yet connected entity, sharing the experience of reciprocity (Benjamin, 2004). This shared higher-order mental state enhances the ability to understand oneself in a social context and provides the individual with novel ways of interacting with others (Gallotti & Frith., 2013).

Within the realm of psychotherapy, the we-mode relates to a mental construct jointly held by the patient and therapist, thus representing the shift from individuals discussing a problem to a 'team' working collaboratively on it. A crucial aspect of establishing the we-mode between patient and therapist is the therapist's 'inquisitive stance.' This refers to an openness regarding the ways in which the patient's thoughts and feelings shape their subjective experience. Therefore, we-mode moments between patient and therapist prime the patient to perceive therapy as a context for learning (Fonagy et al., 2019).

Learning

Drawing from the philosophy of mind, the element of learning relates to an individual's capacity for acquiring new knowledge, understanding oneself and others in new ways. It involves comprehending how the social environment operates, which can be applied to subsequent life situations (Csibra & Gergely, 2006; Fazey et al., 2005; Reed et al., 2010). Given our constantly evolving social environment, individuals are presented with countless opportunities for absorbing, processing and integrating this type of knowledge.

Communication plays a pivotal role in absorbing the message itself and discerning the communicator's intent to convey it to the learner (Csibra & Gergely, 2006, 2009, 2011; Sperber, 2001). Psychotherapy offers a safe context for patients to explore and reflect on their self-perception, interpersonal dynamics, and behaviors. This process kindles curiosity and supports

learning and generalizing from one social context to another (Fonagy & Allison, 2014; Fonagy et al., 2015). By revisiting their perceptions and experiences, psychotherapy can promote further learning outside of therapy to the patient's benefit (Fonagy et al., 2017b).

The Roles ET Plays in Psychotherapy

Much like any mechanism of change, each of the proposed three elements of ET comprises two components: a trait-like component and a state-like component. The distinction between trait-like characteristics and state-like changes has historically stemmed from the recognition of the therapeutic alliance as a multifaceted and complex construct. Over time, this distinction has been extended to various facets of psychotherapy, including ET, shaping our understanding of the therapeutic change process.

The trait-like component refers to individual differences among patients that manifest in their relationships with others outside of the therapy room, and in their interactions with their therapists, from the earliest moments of the first encounter. This trait-like ability is expected to determine the patient's capacity to benefit from specific therapeutic processes. It is theorized that ET forms early in life and solidifies upon reaching adulthood as a trait-like, stable characteristic of the individual (Fonagy & Campbell, 2017; Fisher et al., 2020). Building on Bowlby's notion of "from the cradle to the grave" (Bowlby, 1979, p. 129), we suggest that individuals develop relatively stable trait-like characteristics of ET that may guide their approach to social and interpersonal interactions as adults.

Depending on their trait-like ET characteristics, patients enter treatment with a particular propensity for sharing, engaging in we-mode, and learning from the therapeutic relationship. Individual differences in ET may manifest in all or some of the three components (Fisher et al.,

2022). The trait-like component is considered the common factor in the model and a facilitating environment for other mechanisms to drive therapeutic change.

But in addition to the deterministic qualities of the trait-like component, there is also a state-like component of ET. The state-like component refers to the potential of each element to change and drive subsequent changes in treatment outcomes throughout treatment (Zilcha-Mano, 2022). The state-like component is considered an active ingredient, transforming the ET elements into a mechanism of change, therapeutic in itself. Through the lens of ET, we expect that, in an effective therapeutic process, state-like improvements in ET may manifest in all or some of the three components but will eventually result in sustained openness to consider new information from the therapist, and subsequently from others, as relevant. This is particularly valid for trait-like mistrusting patients, who are susceptible to misidentifying the trustworthiness of information (Allen, 2021).

The Integration of the Three Elements: Sharing, We-mode, and Learning

The current model proposes sharing, we-mode, and learning as essential observable elements of an effective therapeutic process, characterized by the ubiquity of ET (Fisher et al., 2022). Marvin et al. (2016) suggest that, within the context of attachment relationships, an infant's capacity to establish and maintain joint attention for the purpose of sharing an experience may enhance learning about both the physical and social environment. Applying this premise to the therapeutic relationship, we propose that *when individuals put their overall experience into perspective and calibrate their thoughts and feelings to those of others (sharing), thus establishing a mutual discourse for the processing of ideas (we-mode), they can acquire new information pertinent to social adaptation (learning).*

In line with our model, patients are differentiated by their trait-like sharing, we-mode, and learning characteristics, which they bring into treatment and which may affect their response to the intervention. However, psychotherapy, as a form of social communication, may provide an opportunity to facilitate state-like changes in these elements. Feeling accurately reflected in the therapist's mind (we-mode) may act as a catalyst of change to enable state-like alternations in learning and sharing, first within the therapeutic context and then generalized outside of it (Fonagy et al., 2019; Fonagy & Target, 2006; Sharp et al., 2020). Figure 1 visually illustrates this concept.
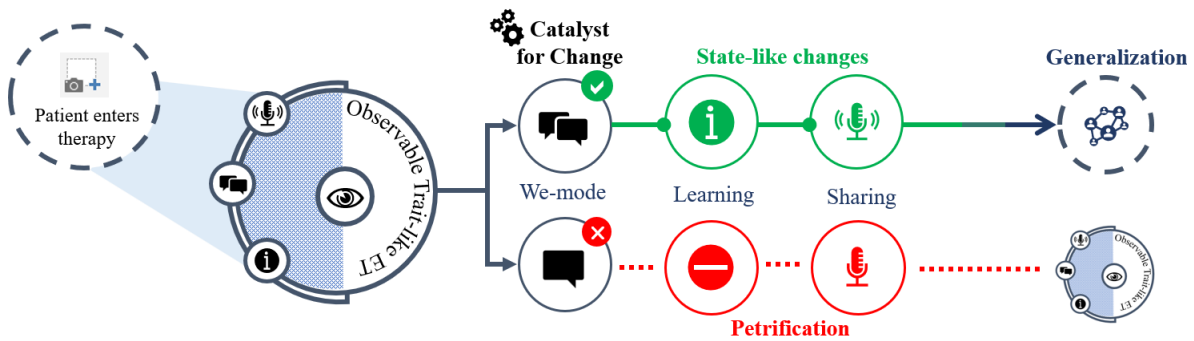

Figure 1. Patients enter treatment with observable trait-like ET characteristics, which are important for the therapist to identify. Yet state-like changes depend on the therapeutic process and may or may not occur. If we-mode is established within the treatment context, learning and sharing can take place. This has the potential to extend beyond therapy. But, if we-mode is not achieved, state-like changes will not occur, and the three ET elements will remain similar to the starting point. =Sharing =We-mode =Learning

The present study

The overarching goal of the present study is to examine how between-individual differences in ET manifest in psychotherapy sessions and how within-individual changes in ET can be facilitated. Thus, this study has two aims: first, to identify patients' trait-like ET characteristics at the onset of treatment; second, to detect potential state-like changes in ET characteristics

throughout the course of therapy. To achieve these aims, we focused on a complete, specific, supportive-expressive treatment case and adopted a discovery-oriented approach. Our approach was centered on particular moments when the therapist's intuitive actions appeared to foster state-like changes in ET. This exploratory stance allowed us to delve into the process of change. Thus, we identified a dynamic interactive process wherein the therapist implemented therapeutic techniques that encourage changes in ET while adapting the change process to the specific reactions and responses of the patient. As we explain subsequently and in more detail within the online supplement, we adhered to Mahrer and Boulet's (1999) discovery-oriented approach, which involved selecting the target of investigation (i.e., ET in psychotherapy), formulating a suitable research question, recruiting a large research team, and collecting and analyzing rich clinical data. Our research questions emerged as follows: Can manifestations of ET be identified during psychotherapy sessions? If so, is it feasible to track their changes throughout the course of treatment?

Method

Design

The selected case was extracted from a larger Randomized Controlled Trial (RCT) conducted for individuals with Major Depressive Disorder at the (masked location). A detailed trial protocol appears elsewhere (masked). The study received approval from the institutional ethics committee. All participating patients and therapists signed consent forms agreeing to have their treatment sessions videotaped and for all quantitative and qualitative data obtained from the treatment to be used for research purposes, with personal information anonymized.

Patient's Background

Leah, a 22-year-old single woman, is the elder of two siblings. When she was 11, her mother was diagnosed with a degenerative disease requiring constant nursing care. In an attempt to alleviate her parents' worries, Leah endeavored to be obedient and compliant. She excelled academically and competed professionally in sports with the national team. However, due to the family's financial difficulties, she had to retire from sports at 16 and help support her family financially. Upon graduating high school, she was offered employment at a high-tech company under the condition that she completed a Bachelor's degree in Computer Science at a prestigious university, a program funded by the employer. At the time of seeking therapy, Leah was concluding her third year of a four-year degree program.

Presenting Problem

Leah described herself as an effortlessly high-performing student throughout her school years. In contrast, her undergraduate studies were exceptionally challenging, requiring skills she believed she lacked. As a result, her academic performance fell short of her expectations, leaving her feeling like a constant failure. Consequently, she reported excessive sleep, a lack of motivation to engage in learning, infrequent social interactions, and anger towards herself for underperforming. Furthermore, she resented being thrust into a demanding program without the necessary tools to understand and manage its practical requirements.

The Therapist

The therapist is a licensed clinical psychologist in his early forties. He belongs to the same majority group as Leah, Israeli Jews, though he identifies as secular, while Leah comes

from a more religious background. The therapist has twelve years of clinical experience in psychodynamic psychotherapy, specializing in patients with depression. Before his enlistment to participate as a psychologist in the study, he attended a 20-hour training workshop in the RCT's protocol-based short-term psychodynamic psychotherapy. Prior to the trial phase, the therapist completed two pilot cases, demonstrating high adherence to the treatment protocol. During the course of the treatment, he received weekly supervision, using videotaped sessions for feedback.

The Research Team

The team consists of eight judges of varying levels of training and qualifications: four undergraduate students majoring in psychology (two men and two women, age M = 23.67 years, SD= 1.15), with at least a year of experience in administering various personality and psychopathology assessment tools; two Ph.D. students in clinical psychology (one man and one woman), one of whom is the primary investigator and a licensed clinical psychologist; and two supervisors (one man and one woman),who served as auditors for the qualitative analyses. One supervisor is the developer of the concept of ET and its theoretical implementation in psychotherapy, and the other is the developer of the trait-like/state-like conceptual model for understanding mechanisms of change and empirical research methods in the field of psychotherapy. For the present study, the judges underwent training in a 5-hour small-group seminar focusing on the hypothesized three elements of ET and its conceptualization as a mechanism of change in psychotherapy.

The team discussed the understandings and beliefs they formed from their acquaintance with the literature before studying the therapy sessions (Levitt, 2018; Hill, 2012). All members initially expressed their concerns about the ambiguity of the concept. They also sought to better understand the manifestations of ET in psychotherapy by relating them to more well-known

concepts, such as working alliance, mentalization, and attachment relationships, and differentiating between them. All members emphasized the therapist's contribution to enhancing ET. While most judges could relate to the concept of state-like changes, two were somewhat skeptical about the occurrence of such changes within the context of short-term psychotherapy.

Instruments

Hamilton Rating Scale for Depression (HRSD-17)

A 17-item semi-structured interview, ranging from 0 to 52, with higher scores indicating greater severity of depression (Hamilton, 1960, 1967). Inter-judge reliability for the current study was .98.

Experiences in Close Relationships (ECR-36)

A 36-item self-report measure of adult anxious and avoidant dimensions of attachment (Brennan et al., 1998). The internal reliability for the current study was .89 for avoidance and .90 for anxiety.

Working Alliance Inventory-Short Form (WAI-S, client version)

A 12-item self-report measure of alliance bond, tasks, and goals in therapy (Tracey & Kokotovic, 1989). Internal consistency in the current study was .93.

Inventory of Interpersonal Problems (IIP-32)

A 32-item self-report measure designed to assess interpersonal distress and social adjustment level. The internal reliability for the current study was .90 (Barkham et al., 1996).

Procedure

With the aim of studying the video-recorded therapy sessions in a targeted manner, judges met weekly and discussed in depth the three elements that constitute the conceptualization

of ET in psychotherapy (Fisher et al., 2020, 2022). Initial discussions revolved around the judges' personal perspectives regarding ET, which might bias their objective appraisal of the data. The team explored how the triad of theoretical elements could be mirrored in tangible behaviors, thus facilitating the identification of probable observable behaviors for each element. Ambiguities and discrepancies between team members were discussed and clarified thoroughly until a high level of consensus was reached.

Qualitative Data Collection

Following the formation of initial agreement, fifteen treatment sessions were selected, one at a time, to be explored in-depth. Since we did not expect any variations in ET manifestations among the different treatment arms (supportive and supportive-expressive), we randomly sampled cases from our larger RCT pool. The choice of random selection strategy was made due to the trans-theoretical nature of the ET construct. As such, ET is not expected to be confined to a single therapeutic approach but instead seeks to understand an individual's readiness to perceive new information as personally meaningful. Our focus was the fourth session of each treatment to identify ET manifestations, as this session is crucial according to the treatment manual (Book, 1998). Patients' trait-like patterns and themes might start to surface, illuminating their underlying dynamics and recurrent thoughts, emotions, and behaviors. In this session, the therapist explicitly generates and delivers the patient's unspoken formulation, providing an opportunity to probe the patient's receptivity to new knowledge. Thus, focusing on the fourth session, we could explore trait-like individual differences between patients at the onset of treatment (see the Supplemental Material, for more details).

Qualitative Data Analysis

To allow emergent findings and unexpected discoveries to shape the research process, we took a discovery-oriented approach (Mahrer & Boulet,1999). The discovery-oriented approach in psychotherapy involves closely exploring intriguing phenomena, focusing on asking questions rather than forming hypotheses. The advantage of this approach lies in the flexibility and openness to explore diverse aspects of a chosen phenomenon without preconceived notions, leading to new insights and potential discoveries. Adhering to this approach, we held weekly meetings to deliberate on the content of the observations, how they could be interpreted in the context of the theory, and how to identify pertinent verbatim statements or behaviors. In line with Mahrer & Boulet's (1999) guidelines, the team members reviewed the sessions and provided preliminary judgment regarding the extent to which the sessions included salient manifestations of the three ET elements. This process was done iteratively and included shifting between the model's elements and the observational data inductively until saturation was reached (Levitt et al., 2021). Citing the literature on qualitative methods (Constantinou et al., 2017; Hennink & Kaiser., 2022) and specifically on qualitative psychotherapy research (e.g., Levitt et al., 2017), a sample size of 10-17 cases is typically adequate for achieving saturation. Hence, we employed 15 cases to ensure data saturation. Through the iterative process, each newly observed case was compared to previous cases until no novel insights or information emerged from the data (see the Supplemental Material, for more details). With continuing iterations, we were able to identify and agree on the specific occurrences of each element in the process and even on the way in which all three interacted. This rigorous methodology ensured comprehensive saturation and provided a strong qualitative foundation. Once we formulated core understandings regarding how the three ET elements might manifest in the context of psychotherapy, we sought the counsel of a content expert, the originator of this therapy-centric concept. During these

consultations, we evaluated whether the behaviors that the judges had agreed upon were in line with the theoretical conceptualization (see the Supplemental Material, for more details).

Case Selection

The case study selection was made independently, and the exploration of ET was conducted after the fact. To study the precise manner in which state-like changes in ET occurred over the duration of treatment, we focused on the entire course of therapy (16 sessions) for a single case out of the 15. We chose a case from the 15 in which *impressive changes* (Mahrer & Boulet, 1999) were indicated in the initial three ET elements. In the context of ET, impressive changes were defined as verbal behaviors, actions, or reactions undertaken by either the patient or the therapist that touch any of the three elements in a way that indicated that the patient was transitioning into a new state of ET.

Thus, the specific case was selected for two reasons: first, for showing poor trait-like ET qualities at the onset of therapy, as indicated by low sharing, low we-mode, and low openness to learning; second, for showing significant state-like changes in ET. Adopting a discovery-oriented approach, we were able to identify specific moment-by-moment verbatim, indicating that the therapist's somewhat intuitive actions and reactions indeed appeared to facilitate state-like changes in ET during therapy. This might underscore the relevance of ET, even when therapy does not explicitly adhere to specific guidelines or protocols to enhance patients' ET.

Therapist Notes

We utilized the therapist's notes to obtain an evaluation that closely reflected the therapist's perspective. This experience-near approach enables comprehension of phenomena

15

from the perspective of those directly involved (McLeod, 2013), thus providing a multi-dimensional understanding of the therapy sessions. The thorough review of the therapist's records allowed the team to triangulate data and cross-reference between the observed interactions and the therapist's documented perspective (Bucci et al., 2012). Cross-referencing between the observed interactions and the therapist's documented perspective enabled (a) segmentation of the process of change in ET during treatment into clear stages and (b) revelation of the interplay between partners and their mutual contribution to the revival of ET throughout the treatment (see the Supplemental Material, for more details). On this basis, we draw a preliminary operational model for ET in psychotherapy.

Quantitative Data

The use of different process and outcome measures allowed for integration between ET conceptualization and other relevant constructs. Figure 2 presents standardized z-scores on the scales throughout the treatment. The figure indicates that Leah began treatment with a high score on the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960, 1967), (22, z score=0.73), signaling severe depressive symptoms. High scores were also recorded on the Inventory of Interpersonal Problems scale (IIP-32; Alden et al., 1990; Horowitz et al., 1988), (80, z score= 1.88), Experience in Close Relationships Scale-avoidance (ECR; Brennan et al., 1998), (4.6, z score= 0.71), and ECR anxiety (4.8, z score= 1.04), all pointing to significant interpersonal distress. While the latter three showed a consistent linear decline pattern throughout treatment, depression displayed transient spikes of worsening symptoms. These spikes around sessions 5 and 9 are common during psychotherapy for depression (Keller et al., 2014). They may indicate

a temporary regression to maladaptive patterns, followed by an increase in emotional processing, and are considered to predict a better treatment outcome (Hayes et al., 2007).

By the end of treatment, all four indices fell below the clinical threshold, indicating a clinically significant change (Speer, 1992). The Reliable Change Index for HRSD (7.60), ECR-avoidance (4.54), ECR-anxious (6.89), and IIP (46.62) scores were all higher than 1.96, suggesting that the patient's changes during treatment were not due to a measurement error but represented solid and reliable recovery in symptoms (Wise, 2004). The WAI demonstrated a similar trend of improvement through the prism of relationship strengthening, as reflected in the patient's reports (RCI 2.68>1.96). These overall linear improvements indicate that the patient's response to the treatment was positive.
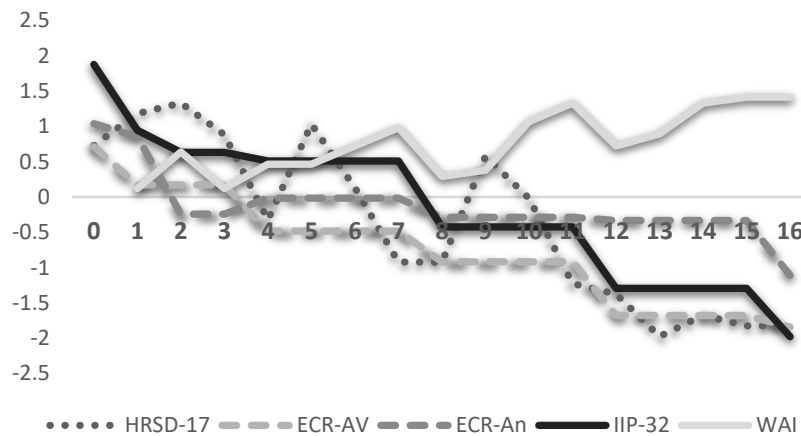

Figure 2: Symptomatic change throughout the treatment: HRSD=Hamilton Rating Scale for Depression; ECR_Av=Avoidant attachment; ECR_An=Anxious Attachment; IIP=Inventory of Interpersonal Problems; WAI=Working Alliance Inventory. Axis Y details Z scores, calculated with the entire sample.

Results

Therapeutic Process and Outcomes

The comprehensive examination of the video recordings allowed us to identify a six-stage process for the development of ET throughout treatment. Figure 3 visually represents these stages.
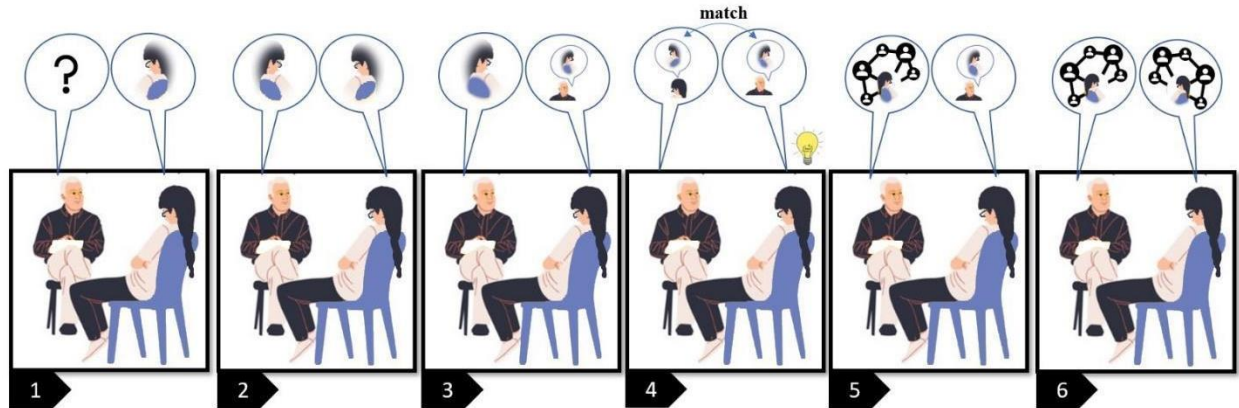

.

Figure 3: Six-Staged process of the development of ET throughout the treatment: (1) Patient presents a self-narrative which is pertinent to the setting. (2)Therapist develops an image of this imagined self-narrative. (3) Patient detects therapist's narration as illustrating her self-narrative. (4) Patient makes an epistemic match, a state-like change leading to the generation of ET. (5) Therapist is then in a position to modify enduring understandings that may be contributing to resolving the patient's difficulties. (6)The patient generalizes learning beyond the counseling setting.

Stage 1: Leah Presents a Self-Narrative/Demonstrated Trait-Like ET Level

Leah is a charming, shy young woman. She wears delicate glasses and a long braid carefully gathered around her head. Despite her age, she appears more like a teenager. She speaks in a quiet voice and looks weary and sad. In the first session, Leah seemed to struggle with initiating a conversation, requiring numerous guiding questions, which she answered sparingly in explaining why she sought treatment (low *we-mode*). Her distanced, inhibited, and estranged stance toward the therapist was reflected in her WAI score (5.5, z=0.1), which was as low as many patients at the commencement of therapy. In a few words, she shared her personal narrative of feeling angry most of the time but was unclear about the reasons. Leah narrated her story through micro-situations, recounting what she felt was an "atrocious injustice" done to her.

18

Her descriptions provided an initial understanding of her perception of her social environment: she felt her family was "conservative and outdated. Everyone must believe the same thing; you are not allowed to think differently, and you are required to respond to their every call immediately". Regarding her peers, she explained, "I almost constantly hide my difficulties from them because I don't think they'll understand me. There are no people around me who can understand my choices in life."

These statements reflected a non-*sharing* attitude towards others in her close environment. This estranged demeanor toward others was reflected in her IIP scores (80, z=1.9), with high scores in the Nonassertive and Overly Nurturant subscales (both 13). In the scant information she was able to share with the therapist, she presented a rigid outlook, especially about the possibility of change (closed to *learning*). Thus, at the onset of therapy, Leah seemed to rarely share her life with others (trait-like low *sharing*), withdraw from the therapist (trait-like low *we-mode*), and hold a fixed, closed attitude when operating in her social environment (trait-like low *learning*).

Stage 2: The Therapist Develops An Image Of Leah's Imagined Self-Narrative

In an attempt to comprehend Leah's narrative, the therapist primarily asked clarifying questions, encouraging Leah to recount her story. As guided by the supportive-expressive treatment protocol (Luborsky, 1984), the therapist aimed to understand Leah's perspective as her 'truth' without passing judgment (inquisitive stance).

L*: "I felt for a long time I made the wrong decision when I chose this academic track. In retrospect, I wasn't ready for it. I wasn't in the right mindset and wasn't mature enough."*

T:*" What do you know now that you didn't know then?"*

L: *"The amount of investment required, the commitment that needs to be taken up. It's all-consuming. These are all things I didn't have at 18 when I started. I'm not sure if I have them now."*

T: *"It's all consuming. Is it a lot of responsibility to take?"*

L: *"Yes, and I don't like being dependent on other people. It makes me feel weak."*

T: *" I understand that you feel that it weakens you. Do you prefer to manage on your own?*

L: *"Yes. I can't understand those students who come with their mom's lunch box in the morning, and mom drops them off on her way to work and pick them up in the afternoon."*

The therapist echoed Leah's perception of her experiences as closely as he could see it from her viewpoint (i.e., repeating her words and narrative). Thus, he briefly expressed his understanding, allowing Leah the opportunity to correct him (enhancing *we-mode*). A deepening understanding in the same vein was reflected in a rise of 0.4 in the standard WAI score (6, z=0.5). The more closely the therapist aligned with her perspective, the more Leah expanded on her narrative.

Occasionally, their conversation gave the impression of a singular person through two voices (state-like change in *we-mode* moments). Alongside this, a positive shift was reported in the IIP score (58, z=0.5), primarily due to a 6-point reduction in the Cold/Distant subscale. This variation was also manifested as Leah expressed her interest in potentially initiating friendships, perhaps an indication of an increased inclination towards the benefits of sharing (possible state-like change in sharing). However, at this juncture, Leah still appeared resistant to *learning*, describing her situation as a given fact that cannot be altered ("I wish I didn't feel this way, but I don't see any other way to approach it").

Stage 3: Leah Detects The Therapist's Narration Of Her Self-Narrative

In the subsequent sessions, Leah and the therapist focused on her relationships, with Leah sharing her interpersonal experiences in greater detail. This sharing enabled the therapist to empathize with Leah in her feelings of resentment about her experiences of unjust treatment. Thus, they discussed the anger she encountered in various contexts:

L: *"I thought about what we talked about last week. I remembered that I chose the most prestigious institution to gain an advantage. I have a friend studying for the same track at this trashy institution. He got screened for an outstanding job at the (high-tech) company while I wasn't even invited to an interview! How can one compare us? I work hard in a prestigious university, and he gets an opportunity that I don't. I should've picked another institution over a prestigious university. What's with the advantage they promised?"*

T: *"It gave you no advantage."*

L: *"All promises are blown with the wind."*

T: *"What you are saying sounds infuriating and outrageous. I can see why you are so angry. "*

L: *"I thought I was the only one who thought so." [seeing him as seeing her]*

T: *"Do you feel alone in how you see your situation, too...?"*

L: *"Mostly, yes. When I'm angry, I feel like I'm doing something forbidden. Anger is forbidden. So, when we talk here about what is "forbidden," it calms me down. You allow me to be angry."*

In this phase, it appears that Leah gradually recognizes that the therapist perceives her in a way that aligns with her self-perception (*we-mode* is established as a mutual understanding of a person grappling with injustice-related frustration). Her acknowledgment for the first time that

she had reflected on the topics they discussed in the previous session during the week was an initial sign of openness to reevaluating herself (an indicator of state-like change in *learning*).

Interestingly, concurrent with the growing acknowledgment that the therapist understands her, a 2-point increase in the Intrusive/Needy subscale of IIP was apparent, despite a general decrease in the total IIP score being reported (43, z=-0.34). This rise may indicate that Leah was beginning to perceive her social network as becoming more significant, thus allowing herself to become more reliant on others. Transitioning from viewing anger as dangerous, she attempted to tentatively and extensively explore the degree of anger that close relationships still permit. She intermittently considered the possibility of *sharing*, albeit ambivalently ("I would like to share with my father, but I'm not sure what will come of it").

Stage 4: Leah Makes An Epistemic Match, A State-Like Change Leading To The Generation Of ET

Leah appeared to be gradually responding to the therapist's efforts to accurately understand her, reflected in statements such as *"I knew you'd understand."* Leah initiated more frequent eye contact and maintained this as she became increasingly able to initiate conversation, or at least spontaneously elaborate on mental states without requiring constant encouragement (*we-mode* was becoming more prominent):

L: [describes a trip with some friends that left her feeling exhausted] "*So one of the friends kept complaining about how uncomfortable she was, how hungry she was, how sore her legs were... I couldn't hear it anymore! In the end, I snapped at her to stop complaining. It's hard for all of us! Five minutes later, I felt terrible for attacking her; it didn't leave me for a few days. Why couldn't I calmly talk to her?*

T*: "so are you saying it's the guilt that drained you?"*

L: *"Right. The guilt I feel following most incidents drains me* (using the same words). *After that incident, I was exhausted! I couldn't do anything; I couldn't think, and I couldn't learn. I just wanted to disappear into a sleep."*

T: *"I can understand that. It might be exhausting to feel angry and guilty about it simultaneously.* (again, using the same words to elaborate on her idea)*."*

L: *"I often feel like I have to prioritize the needs of others over mine. It makes me constantly angry.* (further elaborates). *So how can I set boundaries for others without being aggressive?"* (Curious about ideas that a therapist might have that she could learn from).

Using each other's expressions creates a sense of shared understanding between the therapist and the patient. The increase in WAI scores (6.6, z=1.06) signified Leah's perception of shared comprehension with the therapist regarding her struggles. Her reported feelings of agreement and correspondence between their representations are termed 'epistemic match'. An epistemic match pertains to the alignment or compatibility between a patient's understanding of their own experiences and the model of the mind provided by the therapist. It encompasses the patient feeling recognized, understood, and mirrored by the therapist, which results in a restoration of feelings of agency (Fonagy et al., 2019). This signified Leah's expectation that she would be understood, recognized, and affirmed in her communication with the therapist, thereby regarding him as a source of new information. The significance of this moment is well illustrated by Leah's inquiry about how she can behave differently. Here, a state-like change manifested as she opened up to *learning*, utilizing therapy as an opportunity to perceive herself and others in a new light.

Despite the growing readiness for learning and emerging change, or possibly because of it, Leah became ill, and the weekly meeting was canceled. In the following week, she contemplated her helplessness during her sickness, which led her to question whether the changes she had recently made were indeed stable or temporary. This concern about increased potential dependence and the consequent risk of painful abandonment was reflected in a sudden high spike in the Hamilton score (17, z=0.5). Consistent with this, IIP scores also showed a pause relative to the sloped change achieved throughout the treatment period so far.

However, WAI scores showed an increase of 0.75 points, suggesting the durability of a sense of collaboration (*we-mode)* achievements, even if these state-like achievements were accompanied by increased anxiety and relational worries. The heightened concern was temporary, and the increased sense of *we-mode* collaboration enabled Leah to open up further and share her current difficulties in therapy, enhancing WAI and the sense of a working partnership, setting the stage for new learnings.

As part of this new understanding, Leah and the therapist discovered that Leah's progress is significant, even if it is not linear. This fresh insight may be associated with dramatically improved mood (resulting in Hamilton scores falling below the clinical threshold for the first time). It may be speculated that opening up to new understandings about herself engendered hope regarding the possibility of more enduring positive change.

Stage 5: The Therapist Is Able To Modify Enduring Understandings

The new conditions under which collaboration and the sense of an effective *we-mode* were increasingly robust allowed the therapist to take the treatment process one step further. Beyond an inquisitive stance, open to Leah's understandings and the ability to accurately align with

Leah's perceptions, he was now actively seeking opportunities for 'teaching'; that is, attempting to modify her enduring understanding in the direction of providing a more adaptive perception of herself and her difficulties:

L: *"So I sat in my room and was focused, studying, as the neighbor came in and asked my brother to babysit her young children for two hours while she had to go somewhere urgently. My brother agreed. But instead of him babysitting them, he asked me to entertain them, play with them, help them with the computer, and so on. After an hour or so, I felt quite frustrated and impatient because it stopped me from studying. He was the one that agreed to babysit; why should I even have to bother with that? He saw that I was impatient and asked me what my problem was. I yelled at him that I had to study and couldn't babysit for him! He turned his back and walked away, and I felt terrible. I shouldn't have acted aggressively. I could have responded more politely."*

T: *"Wow that sounds very annoying, though. You are right. You felt you had a good reason to be angry with him."*

L: *"How come you justify my anger? I keep thinking my anger is not allowed, although I know I am right. And you suggest again that there is a good reason for my anger."*

T: *"Maybe we should look at it together for a moment. Let's see how you think you might have reacted differently and what you imagine the consequences would be."*

In these discussions, Leah's early self-narrative of needing to sacrifice her own needs for the benefit of others, subsequently leading to feelings of resentment and guilt, could evolve and expand. Rather than trying unsuccessfully to suppress her resentment, they now viewed her anger as an indicator of her self-actualization needs: *"I needed help,"*; *"I felt alone,"*; *"I feel I*

have been unfairly treated," etc. A significant decrease in the IIP score (29, z=-1.3) reflected Leah's transformation in how she positioned herself relative to her perceptions of others, markedly different from where she began at the start of her treatment.

Low scores in the Overly Nurturant/Self Sacrificing and the Exploitative subscales (both scored 4) reflected her increased acknowledgment of the legitimacy of her needs and the "cost" she bore for suppressing them. Low Hamilton scores (2, z=-1.6) suggested greater interest in leisure activities, an internal drive to fulfill her responsibilities, minimal anxiety, and no fatigue. Thus, her reporting of only a small number of depressive symptoms suggested the effectiveness of her therapy.

At this stage, Leah began considering new perspectives or alternative ways to conceptualize her needs: "I never thought of it that way; I always assumed I was the one who had to give in and give up" or "I was talking with a friend the other day, and I could suddenly see how deep and widespread this self-sacrificing attitude is in my life; it controls me." These statements reflect the onset of a new understanding of how Leah perceives herself and, as a consequence, her relationships with others. Her state-like change in openness to learning about herself through and from others – her social *learning* - was broadening, primarily, at this point, within the context of her therapy.

Stage 6: Leah Generalizes Learning Beyond The Counseling Setting

The cumulative interventions in therapy seemed to change Leah's expectations about the epistemic trustworthiness of others. She opened the penultimate session with this description:

"During the last week, I have not bothered too much with how bad I am and what I will do with my future. The truth is … I took what we talked about recently. I realized that there's room

for the things I feel. I tried to use what we said, so the other day, my dad asked me to fill out an insurance form for mom. I was busy with something else at that moment and signaled to him with my hand to wait just a moment. He became agitated. It seemed to me he thought I was rejecting his request, so he started to speak to me in an angry way. I stopped what I was doing and explained to him that it seemed to me that he didn't respect me and that I would be happy to help as soon as I was available, so he should just wait a moment. Actually, to my surprise, he immediately understood. I was pretty surprised. Instead of spending hours angrily in my room and letting guilt eat me up, I told myself and then told him that it hurt me when my needs were ignored and that I had a reason to be angry. Later, we even laughed about it."

Indeed, this marked a significant turning point (state-like change) in Leah's *learning* about what she could expect from others and how she viewed herself. This new understanding actually empowered Leah to act and respond differently. She recognized that she had made assumptions about her father's thoughts and feelings which she discovered were inaccurate. She could then interpret his reactions to her more positively, and this also helped transform her feelings about herself.

Perhaps most importantly, in this virtuous cycle, the greater closeness with her father (and others in her family) not only brought about changes in self and other representations but predictably fed back into enabling new behavior: *sharing* with others. The state-like change in her experience of closeness generated more opportunities for sharing and experiencing a community of understanding, which, in turn, encouraged changes in understanding and behavior. A way to summarize this state-like change is as an increase in ET, or rather, a decrease in the

dominance of the dysfunctional system of epistemic petrification which characterized her social understanding and resistance to change in relation to aspects of her social world.

In their last session, Leah summed up the treatment by saying: "I'm not sure how it happened, but I believed that you believed me, which was very important to me." WAI scores were elevated by 0.5 points, reaching their maximum (7, z=1.4), indicating Leah's epistemic channel for social communication was somehow unclogged in the consulting room. The benefits of the change are palpable in the reduction of depressive symptoms to zero (Hamilton=0, z=-1.8) and now low scores on ECR avoidance (2, z=-1.8) and anxiety (2.2, z=-1.1). These all fall below the clinical threshold. Underpinning this outcome is the changed way of seeing her social world as more trustworthy, hopefully to be sustained in the long term. By perceiving others as potentially understanding, Leah may continue to feel safer in learning from them about herself and others in the changing social settings to which she will have to adjust.

Discussion

This study presents novel insights into the role of ET in psychotherapy, grounded in its two core aims – identifying trait-like ET characteristics of patients at the beginning of treatment and exploring potential state-like changes in ET in the course of therapy. The case study of Leah demonstrates the identifiable presence of the three elements of ET - sharing, we-mode, and learning - prior to initiating treatment. Leah's limited inclination towards sharing was evident in her hesitancy to disclose personal experiences and her skepticism regarding the benefits of doing so ("What good will it do?"). Her constrained engagement in the we-mode was discernible through her succinct conversation style that seldom referenced thoughts, beliefs, or emotions ("I dunno" was a common response). Leah's diminished proclivity for learning was marked by her

lack of curiosity in the behaviors of others, including the therapist (see the Supplemental Material, for more details), as well as an apparent disinterest in self-reflection ("I live in a shell").

In addition, Leah's case study provides a rich illustration of how ET can evolve and progress throughout individual therapy under an established depression treatment protocol. We identified six stages of state-like change that we believe are associated with the development of sharing, we-mode, and learning during the course of the treatment process. The preliminary model of the six stages appears in Supplemental Table S1. By closely observing the therapist's implementation of techniques in response to Leah's reactions, we were able to isolate a potential mechanism of change and commence the formulation of a sequential process detailing how changes in ET can occur.

We-Mode as a Catalyst for Change in ET

Our preliminary model suggests that the transient achievements of we-mode moments may serve as a potential mechanism to bring about state-like changes for individuals with low initial ET. Accomplishing we-mode is linked with therapists' recognition and nuanced articulation of the patients' self-experiences (Fonagy et al., 2019). By prioritizing the we-mode element to work on, clinicians can effectively convey their intention to communicate pertinent knowledge to patients with low trait-like ET. As the patients discern a sense of personal truth in the therapist's communication and find it both accurate and beneficial, their openness to new information may start to unfold. This newfound openness enables them to assimilate additional personally relevant information. This dynamic may set off a positive feedback loop where the patient's trust in the

therapeutic process escalates, leading to increased receptiveness to specific recommendations, thereby fostering their overall adaptation to their social environment.

Future Directions

The present study serves as a pioneering effort in establishing the building blocks for reliably identifying observable elements of ET and positing that changes in ET may be a key driver of enduring therapeutic change. The discovery-oriented approach that guided this study permitted us to embark with open-ended questions rather than preset hypotheses, an essential provision given the elusive nature of the ET concept. Integrating the therapist's, patient's, and external observer's perspectives led us to the formulation of a consensus understanding of the roles ET plays in therapy. Utilizing this discovery-oriented methodology allowed us to delve into the unexplored terrain of ET, unveiling hidden aspects and nurturing a more profound comprehension of its manifestations within psychotherapy. Our intention in crafting this discovery-oriented study was to broaden our understanding, encounter unexpected outcomes, and explore beyond anticipated findings. We did not pre-assume that we would identify six stages of ET development in treatment. In this regard, the six stages of the preliminary operational model emerged from our discovery-oriented approach to intensive analysis, as indicated by the case study formulation.

Upon establishing its basic elements, it is also critical to meticulously examine unsuccessful cases and build evidence around effective and ineffective strategies. Future research should consider not just the therapist's interventions but also the patient's agentic role in attempting to reestablish ET (Silberschatz, 2020). Based on these initial insights, further research has the potential to develop a systematic tool for assessing ET in psychotherapy (see the

Supplemental Material, for more details). Implementing such a measure would bolster the validity of results, facilitating an exploration of how these elements of ET manifest within pertinent constructs such as working alliance and attachment orientation.

Future studies should also discern differences between related concepts, like mentalization, that intersect with ET to improve conceptual clarity and deepen our understanding of their unique contributions. The co-creation of meaning by the patient and therapist involves mentalizing. However, while mentalization refers to the ability to speculate about what might be in another person's (or one's own) mind, ET involves the acknowledgment that the contents of another person's mind may hold relevance to oneself, making it worth attending to and potentially acquiring new knowledge from. Mentalizing may play a crucial role in the therapeutic process (Fonagy & Allison, 2014; Fonagy et al., 2015). Still, it is insufficient to facilitate state-like changes in ET. Instead, it is the we-mode - being recognized by the therapist - that bolsters the inherent human propensity to benefit from interpersonal experiences (Fonagy et al., 2017b). Further exploration of the impact of mentalization on the development of ET can provide invaluable insights into therapeutic processes and interventions.

Clinical Implications

These findings yield clinical implications that provide an integrated view of the trait-like and state-like components of ET in psychotherapy. The observable trait-like manifestations are particularly pertinent when patients begin therapy. Certain patients may readily adapt to psychotherapy given their higher trait-like ET, whereas others may exhibit a lower level of trait-like ET. For the latter group, psychotherapy cannot rely on high trait-like ET to safely challenge internal working models (Bretherton & Munholland, 2008), making the establishment of ET a priority. The state-like changes in ET become crucial throughout the course of treatment.

However, achieving state-like changes might be more challenging for patients with low-trait-like ET, as they may struggle to accept new information that pertains to their experiences, thus risking epistemic isolation (Bateman et al., 2018).

Limitations

This report is subject to several limitations that should be considered. First, our analysis is based on a single case, thus restricting the generalizability of our findings to larger populations. Furthermore, the preliminary stage model discussed here is derived from the understanding of a single case by clinician-researchers. It is conceivable that researchers adhering to other methodologies may have arrived at divergent conclusions or formulated differing yet equally valid interpretations. Therefore, caution is warranted in interpreting the observed patterns of ET evolution. It is imperative to reproduce this study using more rigorous coding methods and diverse case materials.

Conclusions

This study contributes to illuminating the identification process and the trajectory of change in ET within psychotherapy. The discernment of trait-like and state-like components and their potential role as catalysts for therapeutic change suggests promising directions for personalized interventions. As researchers persist in developing reliable measures, we can expect a more holistic understanding of ET and its bearing on successful psychotherapeutic outcomes. However, it is important to note that, at present, there exists no ET-based therapy manual guiding clinicians on implementing interventions targeted at reestablishing ET. These advancements carry the potential to amplify the effectiveness and individualized nature of therapeutic interventions, ultimately enhancing the welfare of individuals seeking psychological help.

References

Alden, L. E., Wiggins, J. S., & Pincus, A. L. (1990). Construction of circumplex scales for the

Inventory of Interpersonal Problems. *Journal of Personality Assessment, 55*, 521–536.

https://doi.org/10.1080/00223891.1990.9674088

Allen, J.G. (2021). *Trusting in psychotherapy*. Washington, DC: American Psychiatric Press.

Barkham, M., Hardy, G. E., & Startup, M. (1996). The IIP-32: A short version of the Inventory

of Interpersonal Problems. *British Journal of Clinical Psychology, 35*(1), 21-35.

https://doi.org/10.1111/j.2044-8260.1996.tb01159.x

Bateman, A., Campbell, C., Luyten, P., & Fonagy, P. (2018). A mentalization-based approach to

common factors in the treatment of borderline personality disorder. *Current Opinion in

Psychology, 21*, 44-49. https://doi.org/10.1016/j.copsyc.2017.09.005

Bateman, A., & Fonagy, P. (2019). (eds). *Handbook of mentalizing in mental health practice*,

second edition. American Psychiatric Publishing.

Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness. *The

Psychoanalytic Quarterly, 73*(1), 5-46. https://doi.org/10.1002/j.2167-4086.2004.tb00151.x

Book, H. E. (1998). *How to practice brief psychodynamic therapy: The core conflictual

relationship theme method*. Washington, DC: American Psychological Association Press.

Bowlby, J. (1979). *The making and breaking of affectional bonds*. London: Tavistock.

Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. New

York: Basic Books.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult

attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment

theory and close relationships* (pp. 46-76). New York: Guilford.

Bretherton, K., & Munholland, K. A. (2008). Internal working models in attachment

relationships: A construct revisited. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of*

attachment: Theory, research, and clinical applications (2nd ed., pp. 102-127). Guilford

Press.

Bucci, W., Maskit, B., & Hoffman, L. (2012). Objective measures of subjective experience: The

use of therapist notes in process-outcome research. *Psychodynamic Psychiatry*, *40*(2), 303-

340.

Campbell, C., Tanzer, M., Saunders, R., Booker, T., Allison, E., Li, E., . . . Fonagy, P. (2021).

Development and validation of a self-report measure of epistemic trust. *PLoS One, 16(4),*

e0250264. doi: 10.1371/journal.pone.0250264

Cassidy J. (2016). The Nature of the Child's Ties. In Cassidy, J., Shaver, P. R. (eds). *Handbook*

of Attachment, Third Edition: Theory, Research, and Clinical Applications (pp.3-24).

Guilford Press.

Constantinou, C. S., Georgiou, M., & Perdikogianni, M. (2017). A comparative method for themes

saturation (CoMeTS) in qualitative interviews. *Qualitative research, 17*(5), 571-588.

Corriveau, K. and Harris, P.L. and Meins, E., Fernyhough, C., Arnott, B., Elliott, L., Liddle, B.,

Hearn, A., Vittorini, L. & De Rosnay, M. (2009). Young children's trust in their mother's

claims: longitudinal links with attachment security in infancy. *Child Development, 8*0 (3).

750-761.

Csibra, G., & Gergely, G. (2006). Social learning and social cognition: The case for pedagogy.

Processes of change in brain and cognitive development. Attention and Performance XXI,

21, 249-274.

Csibra, G., & Gergely, G. (2009). Natural pedagogy. *Trends in Cognitive Sciences, 13*(4), 148-153. https://doi.org/10.1016/j.tics.2009.01.005

Csibra, G., & Gergely, G. (2011). Natural pedagogy as evolutionary adaptation. *Philosophical Transactions of the Royal Society B: Biological Sciences, 366*(1567), 1149-1157. https://doi.org/10.1098/rstb.2010.0319

Egyed, K., Király, I., & Gergely, G. (2013). Communicating Shared Knowledge in Infancy. *Psychological Science*, *24*(7), 1348–1353.

Fazey, I., J. A. Fazey, & Fazey, D. M. A. (2005). Learning more effectively from experience. *Ecology and Society 10*(2): 4. [online] URL: http://www.ecologyandsociety.org/vol10/iss2/art4/.

Fisher, S., Guralnik, T., Fonagy, P., & Zilcha-Mano, S. (2020). Let's face it: video conferencing psychotherapy requires the extensive use of ostensive cues. *Counselling Psychology Quarterly, 34*(3-4), 508-524. https://doi.org/10.1080/09515070.2020.1777535

Fisher, S., Zilcha-Mano, S., & Fonagy, P. (2022). Conceptualizing Epistemic Trust in Psychotherapy: A Triadic Model, *Psychotherapy Bulletin, 57(2),* 29-35.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy, 51*(3), 372–380. Doi: 10.1037/a0036505.

Fonagy, P., & Campbell, C. (2017). Mentalizing, attachment, and epistemic trust: how psychotherapy can promote resilience. *Psychiatria Hungarica*, *32*(3), 283-287.

Fonagy, P., Campbell, C., & Bateman, A. (2017a). Mentalizing, attachment, and epistemic trust in group therapy. *International Journal of Group Psychotherapy, 67*(2), 176-201. https://doi.org/10.1080/00207284.2016.1263156

Fonagy, P., Campbell, C., Constantinou, M., Higgitt, A., Allison, E., & Luyten, P. (2021).

Culture and psychopathology: An attempt at reconsidering the role of social learning.

Development and Psychopathology, 1-16. https://doi.org/10.1017/S0954579421000092

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*(5), 575-609.

10.1521/pedi.2015.29.5.575.

Fonagy, P., Luyten, P., Allison, E. & Campbell, C. (2016). Reconciling Psychoanalytic Ideas

with Attachment Theory. In Cassidy, J., Shaver, P. R. (eds) *Handbook of Attachment,*

Third Edition: Theory, Research, and Clinical Applications (780-804). Guilford Press.

Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2017b). What we have changed our minds

about: Part 1. Borderline personality disorder as a limitation of resilience. *Borderline*

Personality Disorder and Emotion Dysregulation, 4(1), 1-11.

Fonagy, P., Luyten, P., Allison, E. & Campbell, C. (2019). Mentalizing, epistemic trust and the

phenomenology of psychotherapy. *Psychopathology, 52*(2), 94-103.

https://doi.org/10.1159/000501526

Fonagy, P., & Target, M. (2006). The mentalization-focused approach to self-pathology. *Journal*

of Personality Disorders, *20*(6), 544.

Gallagher, S., & Zahavi, D. (2008). *The phenomenological mind: An Introduction to Philosophy*

of Mind and Cognitive Science (pp. 171-196). Routledge.

Gallotti, M., & Frith, C. D. (2013). Social cognition in the we-mode. *Trends in Cognitive*

Sciences, 17(4), 160-165. https://doi.org/10.1016/j.tics.2013.02.002

Greene, K., Derlega, V. J., & Mathews, A. (2006). Self-disclosure in personal relationships. *The Cambridge handbook of personal relationships,* ch.22, 409-427.

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery & Psychiatry, 23*, 56-62.

Hamilton, M. (1967). Development of a rating scale for primary depressive illness. *British Journal of Social and Clinical Psychology, 6*, 278–296. doi:10.1111/j.2044-8260.1967.tb00530.x

Hayes, A. M., Feldman, G., Beevers, C., Laurenceau, J.-P., & Cardaciotto, L. (2007). Discontinuities and cognitive changes in exposure-based cognitive therapy. *Journal of Consulting and Clinical Psychology, 75*, 409 – 421. doi:10.1037/0022-006X.75.3.409

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social science & medicine*, *292*, 114523.

Hill, C. E. (2012). *Consensual qualitative research: A practical resource for investigating social science phenomena*. American Psychological Association.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of interpersonal problems: psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*(6), 885. https://doi.org/10.1037/0022-006X.56.6.885

Keller, S. M., Feeny, N. C., & Zoellner, L. A. (2014). Depression sudden gains and transient depression spikes during treatment for PTSD. *Journal of Consulting and Clinical Psychology, 82*(1), 102. https://doi.org/10.1037/a0035286

Levitt, H. M. (2018). How to conduct a qualitative meta-analysis: Tailoring methods to enhance methodological integrity. *Psychotherapy Research, 28*(3), 367-378.

Levitt, H., McLeod, J., & Stiles, W. B. (2021). The Conceptualization, Design, and Evaluation of Qualitative Methods in Research on Psychotherapy. In Barkham, M., Lutz, W., & Castonguay, L. G. (eds). *Bergin and Garfield's handbook of psychotherapy and behavior change*. John Wiley & Sons.

Levitt, H. M., Pomerville, A., Surace, F. I., & Grabowski, L. M. (2017). Metamethod study of qualitative psychotherapy research on clients' experiences: Review and recommendations. *Journal of Counseling Psychology, 64*(6), 626.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment*. New York, NY: Basic Book.

Luyten, P., Campbell, C., Allison, E., & Fonagy, P. (2020). The mentalizing approach to psychopathology: State of the art and future directions. *Annual Review of Clinical Psychology, 16*, 297-325. 10.1146/annurev-clinpsy-071919-015355.

Mahrer, A. R., & Boulet, D. B. (1999). How to do discovery-oriented psychotherapy research. *Journal of Clinical Psychology*, *55*(12), 1481-1493.

Marvin, R. S., Britner, P.A., & Russell, B.S. (2016). Normative Development: The Ontogeny of Attachment in Childhood. In Cassidy, J., Shaver, P. R. (eds) *Handbook of Attachment, Third Edition: Theory, Research, and Clinical Applications* (273-290). Guilford Press.

McLeod, J. (2013). *An introduction to research in counselling and psychotherapy* (pp. 9-35). Sage.

Messer, S. B., & McWilliams, N. (2007). Insight in Psychodynamic Therapy: Theory and Assessment. In L. G. Castonguay & C. Hill (Eds.), *insight in psychotherapy* (pp. 9–29). American Psychological Association. https://doi.org/10.1037/11532-001

Reed, M. S., Evely, A. C., Cundill, G., Fazey, I., Glass, J., Laing, A., ... & Stringer, L. C. (2010). What is social learning?. *Ecology and Society*, *15*(4).

Schroder-Pfeifer, P., Talia, A., Volkert, J., & Taubner, S. (2018). Developing an assessment of epistemic trust: a research protocol. *Research in Psychotherapy: Psychopathology, Process and Outcome, 21*(3), 123-131.

Shafto, P., Eaves, B., Navarro, D. J., & Perfors, A. (2012). Epistemic trust: Modeling children's reasoning about others' knowledge and intent. *Developmental Science, 15*(3), 436-447.

Sharp, C., Shohet, C., Givon, D., Penner, F., Marais, L., & Fonagy, P. (2020). Learning to mentalize: A mediational approach for caregivers and therapists. *Clinical Psychology: Science and Practice*, *27*(3), 50. https://doi.org/10.1111/cpsp.12334

Silberschatz, G. (2020). Riflessioni sulla fiducia epistemica e sul suo ruolo in psicoterapia (Reflections on epistemic trust and its role in psychotherapy). *Psicoterapia e Scienze Umane*, *54*(1), 54-58.

Speer, D. C. (1992). Clinically significant change: Jacobson and Truax (1991) revisited. *Journal of Consulting and Clinical Psychology, 60*, 402–408. https://doi.org/10.1037/0022-006X.60.3.402

Sperber, D. (2001). An evolutionary perspective on testimony argumentation. *Philosophical Topics, 29*(1/2), 401-413. https://doi.org/10.5840/philtopics2001291/215

Sroufe, A. L. (2016). The Place of Attachment in Development. In Cassidy, J., Shaver, P. R. (eds) *Handbook of Attachment, Third Edition: Theory, Research, and Clinical Applications* (997-1011). Guilford Press.

Tong, Y., Wang, F., & Danovitch, J. (2020). The role of epistemic and social characteristics in children's selective trust: Three meta-analyses. *Developmental Science, 23*(2), e12895. doi: 10.1111/desc.12895

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory.

    Psychological Assessment: *A Journal of Consulting and Clinical Psychology,1*(3), 207

    210.https://doi.org/10.1037/1040-3590.1.3.207

Wise, E. A. (2004). Methods for analyzing psychotherapy outcomes: A review of clinical

    significance, reliable change, and recommendations for future directions. *Journal of*

    Personality Assessment, 82(1), 50-59. https://doi.org/10.1207/s15327752jpa8201_10

 Zilcha-Mano, S. (2022). It matters not only where you come from but also where you're going,

    and the interplay between the two. A commentary. *American Psychologist*.

    https://doi.org/10.1037/amp0000996