"The Role of Mentalizing and Epistemic Trust in the Therapeutic Relationship

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Chief Executive, Anna Freud Centre
Slides from: P.Fonagy@ucl.ac.uk
The things I feel proud of
(just showing off, not relevant so you don’t need to listen!)
Some of the Mentalizing Mafia

- UCL/AFC/Tavistock
  - Prof George Gergely
  - Professor Pasco Fearon
  - Professor Mary Target
  - Prof Anthony Bateman

- University of Leuven
  - Dr Patrick Luyten
  - Dr Liz Allison
  - Professor Alessandra Lemma
  - Professor Eia Asen
  - Dr Trudie Rossouw
  - Dr Dickon Bevington
More mafiosi (The American branch)

Menninger Clinic/Baylor Medical College/U Laval/ Harvard

- Dr Jon Allen
- Dr Lane Strathearn
- Dr Karin Ensink
- Dr Read Montague

Yale Child Study Centre

- Prof Linda Mayes

UCL & Catholic University, Santiago

- Dr Carla Sharp
- Dr Efrain Bleiberg
- Professor Lois Choi-Kain
- Dr Elisabeth Newlin
- Nicolas Lorenzini
And European recruits to the ‘Family’

- Dawn Bales
- Dr Mirjam Kalland
- Professor Finn Skårderud
- Professor Sigmund Karterud

- Cindy Decoste
- Catherine Freeman
- Ulla Kahn
- Ilan Diamant
- Morten Kjolbe
- Benedicte Lowyck
- Tobi Nolte
- Marjukka Pajulo
- Svenja Taubner
- Bart Vandeneede
- Annelies Verheught-Pleiter
- Rudi Vermote
- Joleien Zevalkink
- Bjorn Philips
- Peter Fuggle

And Nicolas Lorenzini, Chloe Campbell, Liz Allison and Rose Palmer for help with the preparation of this presentation.
Results after 18 months of treatment and 2 years follow-up.
Group differential rate of change:
\[ \beta = -0.35, \text{ 95\% CI: } -0.64, -0.07, \ t(129) = -2.24, \ p<0.015, \ d=0.43 \]
Classifying Mental Disorder
A Brief Historical Perspective

Recent events that decreased the perceived significance of mental health

• June 2011 Big pharma withdraws from mental health
• May 2013 the American Psychiatric Association releases DSM-5
• May 2013 RDoC initiative of the US National Institute for Mental Health (NIMH)

  • Unequivocally declares that the traditional basis for identifying mental disorder (DSM/ICD) is flawed
  • DSM-5 and WHO-ICD-11 misguided and of no value in promoting mental health
  • APA gives evidence to ‘substantiate’ this view
The ‘NEW’ DSM

• Promise to revolutionize the practice of psychiatric diagnosis

• Two of its oldest and most limiting characteristics retained:
  • that diagnosis in mental disorders is based on clinical observation and patients’ phenomenological symptom reports
    • Disease is diagnosed as the symptom (anxiety is the diagnosis and its symptom)
  • polythetic and dichotomous (categorical) diagnoses (e.g. 5 out of 9 symptoms for BPD)
DSM-5 The reception

- 4.0 out of 5 stars **Now that’s what I call mental illness**

*Its boom time in the world of mental disorders - they are proliferating at such a rate that its sometimes difficult for drug companies to keep up.*

Are you moody, lazy, impulsive or irritable? Do you get nervous sometimes, or not feel life is great all the time? Well come on in - you might find a label right here - perhaps its self defeating personality disorder or a touch of social phobia ...

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“Fifth edition now worse than ever”

The astonishing failure of the categorizations of psychiatric diagnoses to self-vindicate is now even more evident. Instead of the 'true nature' of 'mental illness' becoming more clear and accurate over time, the efforts to 'carve nature at its joints' continues and it has never been more controversial. The BPS* have described this document as shrinking the pool of people who may be considered normal in society 'to the size of a puddle'.

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* The British Psychological Society
Rethinking the Transdiagnostic Structure of Mental Disorder
Life-course structure to psychopathology

Need for longitudinal research designs

• **Extant research** on structure of psychopathology focuses on individuals who report **symptoms within** a specified **period**
  – Biggest puzzle is why people change clinical presentations over time (adolescent conduct problem adult depression)

• **Mixing single-episode**, one-off cases with **recurrent** and chronic cases which differ in:
  • **extent** of their **comorbid** conditions
  • the **severity** of their conditions
  • **etiology** of their conditions.

• Some individuals more **prone to persistent psychopathology**.
Caspi et al., 2013 The p Factor One General Psychopathology Factor in the Structure of Psychiatric Disorders? *Clinical Psychological Science.*
A general psychopathology factor in early adolescence
Praveetha Patalay, Peter Fonagy, Jessica Deighton, Jay Belsky, Panos Vostanis and Miranda Wolpert

Background
Recently, a general psychopathology dimension reflecting common aspects among disorders has been identified in adults. This has not yet been considered in children and adolescents, where the focus has been on externalising and internalising dimensions.

Aims
Examine the existence, correlates and predictive value of a general psychopathology dimension in young people.

Method
Alternative factor models were estimated using self-reports of symptoms in a large community-based sample aged 11–13.5 years (N=23477), and resulting dimensions were assessed in terms of associations with external correlates and future functioning.

Results
Both a traditional two-factor model and a bi-factor model with a general psychopathology bi-factor fitted the data well. The general psychopathology bi-factor best predicted future psychopathology and academic attainment. Associations with correlates and factor loadings are discussed.

Conclusions
A general psychopathology factor, which is equal across genders, can be identified in young people. Its associations with correlates and future functioning indicate that investigating this factor can increase our understanding of the aetiology, risk and correlates of psychopathology.

Declaration of interest
None.
Bi-factor model with the item-loadings

Patalay, Fonagy, Deighton, Belsky, Vostanis and Wolpert (2015) community-based sample aged 11-14 years (N= 23, 477)

-.16, p<.001
Logistic regression predicting future caseness

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>Wald Chi-square</th>
<th>Odds-ratio</th>
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<tr>
<td><strong>N=10,270</strong></td>
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<tr>
<td>2-factor model</td>
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<td></td>
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<tr>
<td>Internalising</td>
<td>.49***</td>
<td>76.4</td>
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<td>689.64</td>
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<td>Internalising</td>
<td>.22</td>
<td>4.43</td>
<td>1.25</td>
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<tr>
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<td>1.43***</td>
<td>413.74</td>
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<tr>
<td>P-Factor</td>
<td>2.33***</td>
<td>479.01</td>
<td>10.30</td>
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</tbody>
</table>
BPD loads on internalizing and externalizing and shows invariance across gender (Sharp et al., 2014)

The scalar model did not result in a significantly worse fit than the configural model: robust $\chi^2_{\text{diff}}(6, N = 434) = 12.51$, $p > .05$, CFI = .95, TLI = .93, RMSEA = .05 (90% CI: .03-.07).
The p factor in personality pathology

Sharp et al., 2015 Journal of Abnormal Psychology

Current diagnostic classifications treat disorders as discrete entities, only to find that comorbidity is the rule

• Personality disorders have a typical comorbidity of 50% or more

It suggests the presence of a common latent dimension

General Criteria for Personality Disorders: DSM-IV

Criterion A: Moderate or greater impairment in personality (self/other) pathology
BPD as the ‘g/P-factor’ of personality pathology (Sharp et al 2015)

- Evaluated a **bifactor model** of PD pathology in which a **general (g) factor** and several **specific (s) factors** of personality pathology account for the covariance among PD criteria.

- **966 inpatients** were interviewed for 6 **DSM–IV PDs using SCID-II**

- Confirmatory analysis **replicated DSM-IV PDs**, with high factor correlations
P factor in PDs: the DSM factor structure

- **BPD**: Avoids abandonment, Interpersonal Instability, Identity disturbance, Self-harming impulsivity, Suicidality, Affective instability, Emptiness, Intense anger, Transient dissociation
- **AVPD**: Avoids social work, Socially inhibited, Views of self as inept, No risks or new activities
- **OCPD**: Orderly, Perfectionistic, Reluctance to delegate, Miserly, Rigidity
- **SZTPD**: Ideas of reference, odd beliefs, Odd behaviour/appearance, Lacks close friends, Social anxiety
- **NPD**: Grandiose, Preoccupied with fantasies, Lacks empathy, Envious, Arrogant
- **ASPD**: Failure to conform, Deceitfulness, Impulsivity, Irritable, aggressive, Disregard for safety, Irresponsible, Lacks remorse

**UNACCEPTABLE MODEL FIT**

Comparative Fit Index (CFI) <95
Tucker-Lewis Index (TLI) <95

N=966 inpatients

Sharp et al., 2015 *Journal of abnormal psychology*
## P factor in PDs: the DSM factor structure

N=966 inpatients

<table>
<thead>
<tr>
<th></th>
<th>BPD</th>
<th>AVPD</th>
<th>OCPD</th>
<th>SZTPD</th>
<th>NPD</th>
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<tr>
<td><strong>BPD</strong></td>
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<td>.18</td>
<td>.55</td>
<td>.01</td>
<td>-</td>
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<td>.31</td>
<td>.04</td>
<td>.16</td>
<td>.56</td>
<td>-</td>
</tr>
</tbody>
</table>

In spite of internal coherence at a criterion level, DSM personality disorders, within individuals, are not neatly separable. They are not discrete phenomena.
P factor in PDS: does EFA replicate the DSM factor structure?

Excellent model fit:
\[ \chi^2_{(897)} = 1110.58, \ p < .001 \]
RMSEA = .02 [ .01, .02 ], \( p = 1 \)  
CFI = .97  
TLI = .97

N=966 inpatients

Sharp et al., 2015 Journal of abnormal psychology

Factor 1
- Avoids abandonment
- Interpersonal Instability
- Identity disturbance
- Self-harming impulsivity
- Suicidality
- Affective instability
- Emptiness
- Intense anger
- Transient dissociation

Factor 2
- Avoids social work
- Must be liked
- Restraint in intimacy
- Preoccupied with rejection
- Socially inhibited
- Views of self as inept
- No risks or new activities

Factor 3
- Orderly
- Perfectionistic
- Workaholic
- Moral inflexibility
- Hoarding
- Reluctance to delegate
- Miserly
- Rigidity

Factor 4
- Ideas of reference
- Odd beliefs
- Odd perceptions
- Odd thinking/speech
- Suspicious
- Constricted affect
- Odd behaviour/appearance
- Odd behaviour/appearance

Factor 5
- Grandiose
- Preoccupied with fantasies
- Believes s/he is special
- Needs admiration
- Entitlement
- Exploitative
- Lacks empathy
- Envious

Factor 6
- Failure to conform
- Deceitfulness
- Impulsivity
- Irritable, aggressive
- Disregard for safety
- Irresponsible
- Lacks remorse
- Lacks close friends
- Social anxiety
- Arrogant
P factor in PDs: Exploratory bifactor model

Excellent model fit:
χ²(897) = 1030.09, p < .001
RMSEA = .02 [.01, .02], p = 1
CFI = .98
TLI = .97

Only factor loadings >|30| are shown

Sharp et al., 2015 Journal of abnormal psychology
The ‘P’ Factor (Caspi et al., 2013)

Ungendered chronic Psychotic conditions

Partially gendered Personality disorder

Gendered ‘Neurotic’ conditions

Increasing vulnerability
Increasing prevalence of maltreatment

Impairment

Externalizing
Internalizing

Gendered Style

Male ← Gendered Style → Female

Persistence

Persistence
Understanding the continuum underlying the ‘P-factor’: social cognition and attachment
A working definition of mentalization

Mentalizing is a form of imaginative mental activity, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).
Summary of the evidence for MBT

RECENT RELEASE!
NEW! IMPROVED!

Washes brains whiter!

But hurry! Only 2,000 copies left!

Longer than all previous versions!

Bottom line: The mentalization based approach to treatment is quite effective in treating BPD & other disorders

American Psychiatric Publishing, Inc 2013
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For more information, visit MENTALISATION.UNIGE.CH ...

... or write to mentalisation@unige.ch

VENUE: University of Geneva
Articles Published Citing Papers About Mentalizing or Mentalization
Google Ngram of “mentalization”

Google’s Ngram Viewer shows the percentage a word is present in a corpus of 5.2 million books published from the years 1500 to 2008.

Source: Google Ngram Viewer
certainty. Hammond¹ has conducted a series of careful urinal analyses, for the purpose of ascertaining the changes in the composition of the urine incident to increased mentalization. From these experiments he is led to draw the following conclusions:

(1.) That increased mental exertion augments the quantity of urine.

(2.) That, by its influence, the urea, chlorine, and phosphoric and sulphuric acids are increased in quantity.

(3.) That the uric acid, on the contrary, is very materially reduced in amount.

(4.) That diminished intellectual exertion produces effects directly contrary to all the above.

More recently, Byasson² has demonstrated that the increased expenditure of energy induces a corresponding increase in the production of phosphates, and has shown that increased efforts are associated with an increased circulation of mental fluid. It is not necessary to pursue the above subjects in greater length in the present paper.

¹ For a more detailed account of these experiments than is admissible in a work of this character, see my monograph on "Brain Exhaustion," D. Appleton & Co., New York.
Mentalization: The Movie

(Inside Our – an E-Motion Picture from Pixar)
The Curse of the Dodo Bird
Driesen et al., (2013), AJP

**Enrollment**

**Screen**
- N=4866

**Baseline 570**

**CBT**
- N=164
  - Allocated to CBT (n = 164)
    - HAM-D > 24 receiving additional pharmacotherapy (n = 66, 40.2%)
    - Did not start therapy (n = 8, 4.9%)
    - Started therapy (n = 156, 95.1%)
      - Completed < 8 sessions (n = 43, 27.6%)
      - Completed ≥ 8 sessions (n = 113, 72.4%)

**PDT**
- N=164
  - Allocated to psychodynamic therapy (n = 177)
    - HAM-D > 24 receiving additional pharmacotherapy (n = 63, 35.6%)
    - Did not start therapy (n = 11, 6.2%)
    - Started therapy (n = 166, 93.8%)
      - Completed < 8 sessions (n = 35, 21.1%)
      - Completed ≥ 8 sessions (n = 131, 78.9%)

**Lost**

**Lost 42%**
- Lost to HAM-D assessment (n = 69, 42.1%)
  - Week 5 (n = 23, 14.0%)
  - Week 10 (n = 14, 8.5%)
  - Week 22 (n = 10, 6.1%)
  - Week 52 (n = 22, 13.4%)

**Lost 45%**
- Lost to HAM-D assessment (n = 80, 45.2%)
  - Week 5 (n = 36, 20.3%)
  - Week 10 (n = 7, 4.0%)
  - Week 22 (n = 8, 4.5%)
  - Week 52 (n = 29, 16.4%)

**ITT analysis**
- Analyzed
  - Intention-to-treat (n = 164, 100%)

**ITT analysis**
- Analyzed
  - Intention-to-treat (n = 177, 100%)

**Excluded**
- (n = 4296, 88.3%)
  - Primary diagnosis not depression (n = 3457, 71.0%)
  - Use of efficacious antidepressants that could not be tapered (n = 292, 6.0%)
  - Unable to fill in questionnaires due to language problems (n = 182, 3.7%)
  - Alcohol/substance use or misuse (n = 147, 3.0%)
  - Unable to meet research demands (n = 80, 1.6%)
  - Other reasons, e.g. pregnancy, suicide risk (n = 138, 2.8%)

**Excluded**
- (n = 229, 40.2%)
  - Refused to participate (n = 73, 12.8%)
  - HAM-D-score < 14 (n = 49, 8.6%)
  - Not meeting MINI-Plus criteria depressive episode (n = 8, 1.4%)
  - Not meeting other inclusion criteria (n = 76, 13.3%)
  - Referred to other research project (n = 23, 4.0%)
CBT vs. Psychodynamic Psychotherapy for Major Depression (N=341)

- **CBT**
  - 16 individual sessions
  - Manualised (Molenaar et al., 2009)
  - N=164

- **Psychodynamic Therapy**
  - 16 individual sessions
  - Manualised (de Jonhge, 2005)
  - N=177
<table>
<thead>
<tr>
<th>Treatment Group</th>
<th>N</th>
<th>Assigned</th>
<th>Completed</th>
<th>Follow-up Assessments</th>
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<tbody>
<tr>
<td>PDT</td>
<td>80</td>
<td>80</td>
<td>53</td>
<td>3 months: 71, End: 63, 3-month: 57, 12-month: 58, Lost: 9</td>
</tr>
<tr>
<td>CBT</td>
<td>80</td>
<td>80</td>
<td>65</td>
<td>3 months: 74, End: 72, 3-month: 66, 12-month: 65, Lost: 6</td>
</tr>
<tr>
<td>TAU</td>
<td>82</td>
<td>82</td>
<td>65</td>
<td>3 months: 66, End: 53, 3-month: 48, 12-month: 46, Lost: 16</td>
</tr>
</tbody>
</table>

Lost: 28% for PDT, 18% for CBT, 44% for TAU

Outpatients with Anorexia Nervosa (ANTOP) study Lancet, 2013
Outpatients with anorexia nervosa (ANTOP) study Lancet, 2013

Body mass index (kg/m²)

- Focal psychodynamic therapy
- Enhanced cognitive behaviour therapy
- Optimised treatment as usual

Measurement timepoints:
- Baseline
- 4 months of treatment
- 10 months of treatment
- 3-month follow-up
- 12-month follow-up

End of treatment

End of follow-up
The “Dodo Bird Verdict”

- In August 2012, the American Psychological Association approves:

  ...a variety of psychotherapies are effective with children, adults, and older adults

  ...comparisons of different forms of psychotherapy most often result in relatively nonsignificant difference

  ...different forms of psychotherapy typically produce relatively similar outcomes

  (1) most valid and structured psychotherapies are roughly equivalent in effectiveness and

  (2) patient and therapist characteristics, which are not usually captured by a patient's diagnosis or by the therapist's use of a specific psychotherapy, affect the results

  ...variations in outcome are more heavily influenced by patient characteristics e.g., chronicity, complexity, social support, and intensity—and by clinician and context factors than by particular diagnoses or specific treatment "brands"
What happens when you ask a room of psychotherapists whose approach is the most effective?

What can be done to end this unseemly behaviour?
The Uncommon Common Factor
The working alliance controversy
Castonguay et al. (1996)
Depressed patients treated with CBT

took measures of:

- level of **alliance**
- therapist focus on **distorted thinking**

- **alliance** significantly associated with outcome
- greater **focus on distorted thinking** associated with **poorer** outcomes
- effect **disappears if alliance** levels **controlled** for
A sample of 646 patients (76% women, 24% men) in primary care psychotherapy Administered the Working Alliance Inventory and CORE session by session,
Understanding the benefit from working alliance

Is it to do with learning about oneself?

- Most unlikely because improvement occurs between end of session and beginning of next session

So what is it about working alliance that actually improves the patient?

- a bizarre delayed reverse causality?
- attachment but mediated through what process?
- opening up a social learning process that benefits the patient between sessions
Can we do any better than agreeing with the Do Do Bird?

“Everybody has won, and all must have prizes.”
The DoDo bird sounds like a pigeon

If we can’t do better than say everything works than my career as a treatment developer is over and I might as well turn into a DoDo bird!
Oh dear!

“So the paradigmatic common factor is...”
The paradigmatic common factor is…

“Uh-oh...here we go again...”
Mentalize!
Honestly, how do you think your audience is feeling?
How do you think your audience might be feeling right now?

Bored  
Sleepy

Is it tea-time yet?

Fonagy should write a new talk.
Moving beyond dyadic attachment: The function of attachment in social adaptation
R/P 20% vs. BPD Prevalence

Ratio of average income of richest 20% to poorest 20%
Prevalence of BPD

R-squared=0.78, F=10.66, p<0.05
A historical overview of shifting frames

Changing one’s favourite instinct:

- Up to age 40: The **psychosexual AND aggression** instinct – Freud and classical psychoanalysis

- Age 40-60: The instinct for **attachment** – Bowlby, Ainsworth and early infant researchers
  - Attachment theory extended to mentalizing can encompass:
    - Sexuality – failure of early **mirroring**
    - Aggression – failure of **affect regulation** and impact awareness

- Age 60 to †: The instinct for **communication** – Tomasello, Gergely, and modern developmental research
  - Communication defines attachment relationships
    - Secure attachment ensures capacity to **learn from experience**
Criticisms of attachment theory

From psychoanalysis: “mechanistic”
“reductionistic”
“no real metapsychology”
“broad classifications that lose the subtlety and detail of the original material”

From anthropology: “culturally blind”
“socially oblivious”
“misses different family configurations, e.g., alloparenting”
“empirically based on WEIRD people”

WEIRD: Western, Educated, Industrialised, Rich & Democratic

Fonagy & Target, 2007; Röttger-Rössler, 2014; Otto, 2011
Attachment not universal: Historically childhood is a state of enduring murderous abuse and brutality

(Ariès, 1973; Stone, 1977)

**Infanticide** in 19th C Milan was 30-40% (Marten, 2010)

**Women** living in extremely deprived conditions in **Brazilian ghettos**, allowing the **death** of their **infants** with apparently **little sorrow**, but become **loving** mothers to **subsequent** children or to children who they previously gave up on as hopeless cases, but appear to go on to survive

Different **social environment** are likely to **trigger** different **attachment styles** as more adaptive
Rethinking the **centrality** of attachment in developmental psychopathology

PDs are enduring behaviors; their features include an intrapersonal component (dysregulation of arousal, impulse, and affect), an interpersonal component (dysfunctional relationship patterns), and a social component (which creates conflicts with others and with social institutions). Attachment theory accounts for these four characteristics of PDs and provides an ideal standpoint to understand these disorders, integrating psychological, psychiatric, genetic, developmental, neuroscientific, and clinical perspectives.

OK! ATTACHMENT IS NOT EVERYTHING!
‘The universal socialization task for cultures regarding attachment concerns the learning of trust, not ensuring the “secure” attachment of an individual child to a single caregiver in a dyadic relationship. The question that is important for many, if not most, parents and communities is not, “Is [this individual] child ‘securely attached?’”, but rather, “How can I ensure that my child knows whom to trust and how to share appropriate social connections to others? How can I be sure my child is with others and situations where he or she will be safe.”

Thomas S. Weisner, 2014
Attachment and modern evolutionary theory

Attachment theory, as originally conceived by Bowlby, was an approach that sought to locate child emotional development in a way that made sense in evolutionary terms.

In line with a social-cultural perspective:

- Particular attachment styles are themselves one piece of social communication that the familial context is promoting about the most effective way to function in the prevailing culture.
- Attachment is part of a social signaling system telling the child to prioritize developing capacities particular patterns of behavior.
- BPD entails triggering particular style of adaptation to ensure survival, albeit one that causes pain to the person and is challenging to the immediately surrounding environment.
- For example, sexual risk taking behavior in adolescents with a childhood history of neglect is a way of ensuring that they will contribute to the gene-pool.

Clinical implication:

- Hard to change because genes communicate this adaptation is most likely to ensure survival (of the genome)
Mentalizing, attachment and the family

- **Lower levels of mentalizing**, greater aggressiveness and higher sensitivity to perceived threats are adaptive responses to certain cultural environments:
  - hypersensitivity to issues of shame and honour
  - lack of faith in the support of external authorities and institutions
  - families are charged with psychologically enculturating their children to maximise likelihood of survival.

- **Social learning** from the immediate family and culture can help us account for the relationship between individual behaviours – adolescent male gun crime, for example – and the culture that engenders it.

- **Mentalizing intervention** to succeed needs to occur in the context of the family, and enhance the quality of mentalizing within the family system.
The journey from attachment to communication: Epistemic trust or trust in the communicator of knowledge
The theory of natural pedagogy and epistemic trust (Gergely & Csibra, 2008; Fonagy & Allison, 2014)

- New form of evolution (late Pleistocene) based on learning and the transmission of cultural knowledge
The theory of natural pedagogy and epistemic trust (Gergely & Csibra, 2008; Fonagy & Allison, 2014)

- New form of evolution (late Pleistocene) based on learning and the transmission of cultural knowledge
- The challenge of discerning of epistemic trustworthiness and the need for EPISTEMIC VIGILANCE!
The theory of natural pedagogy and epistemic trust (Gergely & Csibra, 2008; Fonagy & Allison, 2014)

- New form of evolution (late Pleistocene) based on learning and the transmission of cultural knowledge
- The challenge of discerning of epistemic trustworthiness and the need for EPISTEMIC VIGILANCE!
- The pedagogic stance is triggered by ostensive communicative cues (E.G. turn-taking contingent reactivity, eye contact)
- Ostensive cues have in common
  - Person recognized as a self
  - Paid special attention to (noticed as an agent)
Innate Sensitivity to Contingency
Triggering the Pedagogical Stance

- **Ostensive cues function to trigger epistemic trust:**
  - **Opening** channel to receive knowledge about social and personally relevant world (CULTURE)
  - Going **beyond the specific experience** and acquire knowledge relevant in many settings
  - Triggers opening of an evolutionarily protected **epistemic channel** for knowledge acquisition

- **Mimicry** may be protected by human evolution because it generates epistemic trust
  - **Social smile** (recognition of self) increases imitation because smile generates epistemic trust and opens channel to receive knowledge
Experimental illustration of ostensive cues

Gergely, Egyed et al. (2013)

Subjects : 4 groups of 18-month-olds

Stimuli: Two unfamiliar objects
1: Baseline – control group
No object-directed attitude demonstration

Simple Object Request by Experimenter A

Subjects: n= 20 Age: 18-month-olds
Ostensive Communicative Demonstration

Requester: OTHER person (Condition 1)
Learning from Attitude Expressions

18-month-olds

Ostensive Expression - Generalization

Percent
Giving
Positive
Object

71

[Images of individuals in different expressions]
Non-Ostensive (Non-Communicative) Demonstration

Requester: OTHER person (Condition 2)
Learning from Attitude Expressions

18-month-olds

Ostensive Expression - Generalization

Non-Ostensive Expression - No Generalization
Condition 4: Non-Ostensive (Non-Communicative)

Demonstration Requester: SAME person
Learning from Attitude Expressions

18-month-olds

Ostensive Expression - Generalization

Non-Ostensive Expression - No Generalization

Non-Ostensive Expression - Person-Specific Attribution

Egyed et al., in prep.
Social Cues that Create Epistemic Trust

- **Attachment to** person who responded **sensitively** in early development is **special condition** for generating epistemic trust $\Rightarrow$ **cognitive** advantage of security $\Rightarrow$ including neural development (Van Ijzendoorn et al.)

- Generally any **communication** marked by recognition of the listener as **intentional agent** will increase **epistemic trust and** likelihood of communication being coded as
  - Relevant
  - Generalizable
  - To be retained in **memory as relevant**

- **OSTENSIVE CUES TRIGGER EPISTEMIC TRUST WHICH TRIGGERS A SPECIAL KIND OF ATTENTION TO KNOWLEDGE RELEVANT TO ME**
Implications for understanding and treating persistent disorders
The nature of psychopathology in PD

- Social adversity (most deeply trauma following neglect) is the destruction of trust in social knowledge of all kinds → rigidity, being hard to reach
- Cannot change because cannot accept new information as relevant (to generalize) to other social contexts
- Personality disorder is not disorder of personality but inaccessibility to cultural communication relevant to self from social context
  - Partner
  - Therapist
  - Teacher
  → Epistemic Mistrust
Most important consequence is that the **regular process of modifying stable beliefs** about the world (oneself in relation to others) remains closed.
Implications: The nature of psychopathology

- Epistemic mistrust which can follow perceived experiences of maltreatment or abuse leads to **epistemic hunger** combined with mistrust
- Therapists ignore this knowledge at their peril
- Personality disorder is a **failure of communication**
  - It is not a failure of the individual but a **failure of learning relationships** (patient is ‘hard to reach’)
  - It is associated with an **unbearable sense of isolation** in the patient generated by epistemic mistrust
  - Our inability to communicate with patient causes **frustration in us** and a tendency to **blame the victim**
  - We feel they are not listening but actually it is that they find it **hard to trust** the truth of what they hear
Openness to the (social) environment is usually adaptive...
Openness to the (social) environment is usually adaptive...
Openness to the (social) environment is usually adaptive...
...but so is hypervigilance under certain circumstances
Epistemic hypervigilance

High ‘P’ factor/ absence of expected resilience

Epistemic trust

Resilience/ low ‘P’ factor
Building a social network
When the capacity to form bonds of trust is shaky and tends to break down...
...we lose our safety net
Reconceptualising PD: understanding not in terms of disease mechanisms...
...but as an absence of expected resilience or lack of epistemic trust...
...which may once have been adaptive
Thank you for bearing with my meanderings!

And once again the slides: P.Fonagy@ucl.ac.uk